



ASSESSMENT OF  
PALLIATIVE CARE  
SERVICES

2021



# ASSESSMENT OF PALLIATIVE CARE SERVICES

TBILISI  
2021



## ASSESSMENT OF PALLIATIVE CARE SERVICES IN GEORGIA

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## INTRODUCTION

The rapid development of the medical field has led to the extension of the life of people with chronic and progressive illnesses, as well as patients with life-threatening conditions, and aging of the population. Increased life expectancy, ageing of the world's population, growth in the number of individuals with chronic diseases, rising share of the population aged 65 years or over (as people age, they become more susceptible and often suffer from chronic diseases) with increasing incidence of incurable diseases need complex medical and social care due to the painful symptoms, addressed by palliative care.

The goal of palliative care is to improve the quality of life of patients with lifethreatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (“WHO | Definition of Palliative Care,” 2012).

Based on the Lancet Commission on Palliative Care **the palliative care should be aimed** at “alleviating severe (serious) health-related suffering” (the Lancet Commission, 2018). The Commission defines that suffering is health-related when it is associated with illness or injury of any kind”; and suffering is serious when it cannot be relieved without professional intervention and when it compromises physical, social, spiritual, and emotional functioning“ (Knaul et al., 2018).

According to the World Health Organization's (WHO) latest definition, palliative care must be available to all people, whose life may be at risk due to life threatening condition. WHO defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with lifethreatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.

The WHO has submitted to the 67th World Health Assembly A67/4 (WHA67/2014/REC/3) a document - “Strengthening palliative care as a component of integrated treatment throughout the life course”, and according to WHO, “palliative care should be integrated into all levels of the general health system”... state policy

should be aimed at developing and strengthening of human resources ... palliative care should be incorporated into primary care education” (Sixty-Seventh World Health Assembly, N.D.).

Recommendation 2003 of the Committee of Ministers of the Council of Europe states that palliative care is a vital and integral part of health services and „any person who is in need of palliative care should be able to access it without undue delay”. The Committee underlines that “palliative care integrates psychological and spiritual aspects of patient care”. The Committee recognizes that “palliative care seeks to address physical, psychological and spiritual issues associated with advanced disease. Therefore, it requires a coordinated input from a highly-skilled and adequately resourced interdisciplinary and multiprofessional team” and “involving a physician and a nurse and other health care workers who have the expertise needed to respond to the physical, psychological, and spiritual needs of the patient and the family“ (Recommendation Rec (2003) 24 of the Committee of Ministers to Member States on the Organisation of Palliative Care, N.D.).

## Legislative Framework for Palliative Care in Georgia

In 2019, legislative amendments to the Law of Georgia on Health Care and Law of Georgia on Patient’s Rights entered into force. A new definition of palliative care changed the term “incurable” to “chronic and/or life-threatening disease” and more emphasis was placed on early intervention rather than just end-of-life care. The definition provides the **basis for holistic care: “Multidisciplinary care that improves the quality of life of patients and their families facing the problem associated with chronic disease and/or life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.**

In the same year, the Law of Georgia on Health Care and Patient’s Rights first introduced the definition of **hospice care**, that is part of palliative care and is intended for “incurable patients whose estimated life expectancy is limited. In hospice care, medical treatment focused on curing the disease are no longer used and only medical interventions aimed at managing the symptoms of the disease and improving the quality of life are performed.

**In addition to the definition, articles related to palliative care are found in the following laws:**

1. Law of Georgia on Health Care (Law of Georgia on Health Care, 2002);
2. Law of Georgia on Patient's Rights (Law on Patient's Rights, LEPL Legislative Herald of Georgia, 2000);
3. Law of Georgia on Medical Practice (Law of Georgia on Medical Practice, 2005).

Based on these changes, Georgian legislation has recognized palliative care as a continuous, comprehensive and coordinated medical service available to every member of society. To implement palliative care, the medical intervention and services should have continuous character (Law of Georgia on Health Care). Palliative care should entail an uninterrupted service and correspond to nationally recognized professional and ethical standards and the medical practitioner has the right to intervene to provide palliative care (Law of Georgia on Medical Practice, Article 49).

The amendments to the four laws of Georgia (Laws on Health Care, Medical Practice, Patient's Rights and on Narcotic Drugs, Psychotropic Substances and Precursors and Narcological Assistance) contribute to the development of palliative care in Georgia and its integration into the national healthcare system.

In 2007, the state took obligation to provide access to opioids to patients in need: "the State shall ensure availability of narcotic drugs and psychotropic substances in required amount and form .... under international standards" (Article 8, point 4). In 2012, Article 1 of the same law recorded an obligation to ensure availability of narcotic drugs for medical purposes (Article 1, point 3e).

Therefore, the Georgian legislation defines palliative care and determines its main goal as: to improve the patient's quality of life through symptom control and pain relief, recognizing the need of access to palliative care and other essential (basic) medicines. The palliative care is integral part of continuous medical care and the the physician should perform it without hindrance.

In Georgia, palliative care development began in the 2000s. Practical implementation of palliative care (as a pilot project) started in 2004. In 2005-2006, with the initiative and support of the Open Society Georgia Foundation and with the engagement of the state, non-governmental organizations and international experts, palliative care gained ground. Despite the commitments undertaken by the state, up to the present time palliative care in Georgia remains to have a rare and mon-

odisciplinary character. A research was planned and conducted to evaluate and assess the existing palliative care services. The main goal of the research was to find out how holistic is the care provided and what are the current challenges and obstacles of palliative care in Georgia.

## RESEARCH GOAL AND OBJECTIVES

The research goal is to assess the palliative care needs of the adult population.

The objective of the research is to determine:

- Number of adults in need of palliative care in Georgia;
- Specific nosologies requiring palliative care;
- Current practices in relation to adults with palliative care need in Georgia (what types of assistance and services do they receive and where); A description of all palliative care providers (how many beds do they have, etc.);
- What is the state funding for the adult palliative care

## RESEARCH METHODOLOGY

At the initial stage, a review of the analytical documents on palliative care was conducted to meet the defined objectives. Secondary data was analysed, defined (WHO & WPCA, 2014) and assessed to identify the need of palliative care. A WHO-recognized Palliative Care Triangle was used to evaluate services (Stjernsward, Foley, & Ferris, 2007).

In order to evaluate the services, a survey was conducted among the heads of different institutions. At the beginning stage, passport/demographic data of these institutions were collected (see Annex N1). For a more detailed study of the palliative care services and needs in Georgia, electronic questionnaire (see Annex N2)



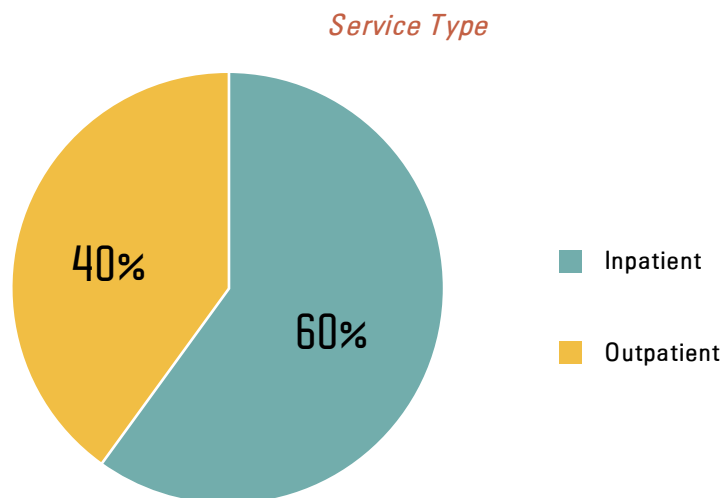
was sent out to 19 palliative care service providers at a later stage. The questionnaire was based on a 2002 WHO publication used by international palliative care experts. The research team translated and adapted the form.

## MAIN FINDINGS

### Existing Palliative Care Services and their Scope

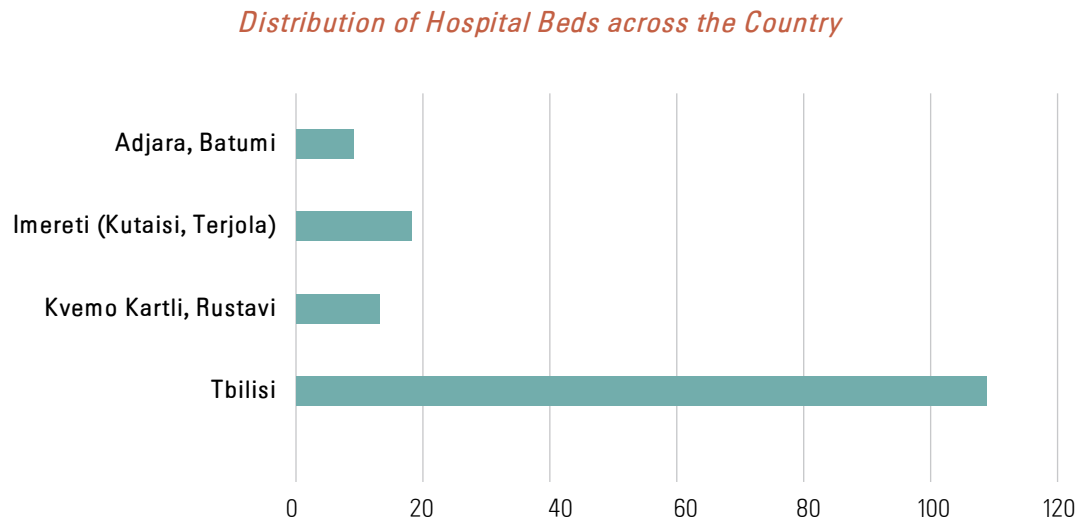
By 2021, there are 19 palliative care (PC) institutions in Georgia. (Annex N1). Of these 19 facilities, 11 (60%) are inpatient, with a total of 148 palliative care (PC) beds; out of this – 73% (108 beds) operate in Tbilisi. 27% (40 beds) in the regions, most of them in the Western Georgia. PC beds in the regions operate in Kvemo Kartli, 13 beds in Rustavi; in Imereti at 3 hospitals with a total of 18 beds (Kutaisi – 2 and Terjola – 1); and Adjara – in Batumi – 9 beds (see Figure 1 and 2).

*Figure 1:*  
*Types of Palliative Care Services:*



A six-bed Transfiguration Hospice also functions in Tbilisi at the premises of Transfiguration Convent Mercy Center and provides inpatient services for women only, while home care for women and men, for an average of 70–75 patients per month throughout the capital.

**Figure 2:**  
**Number and Distribution of Palliative Care Beds:**



In total, there are seven outpatient clinics in Georgia, which have a combined palliative care service. Practically half of them are in the capital (three are in Tbilisi), one - in Gori (Shida Kartli), one - in Imereti; one - Samegrelo at Zemo-Svaneti Oncology Center and one - in Poti (the latter suspended its services due to the COVID-19 pandemic).

Out of the 19 service providers, 18 (95%) participate in the state palliative care program. Transfiguration Hospice operates with the help of individual donations. As it turned out, only 26% of these institutions deliver multidisciplinary services, mainly while providing outpatient services and only one provider has a chaplain. Spiritual support is also available in two outpatient clinics. Only one out-patient clinic has two social workers. The same clinic also provides a psychological support. Psychological services are available in two additional out-patient facilities (3 in total).

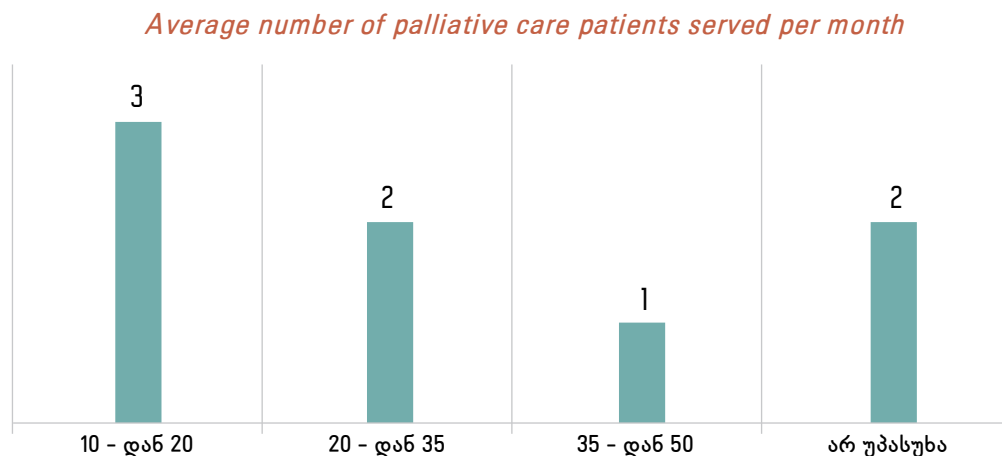
Of the 19 questionnaires sent, 8 (42%) were returned. Respondents offered palliative care in the following settings: 37.5% - out-patient (3); 50% - in-patient (4); - 12.5% - provide both. The research revealed that 50% of them offer only bio-medical palliative care services; and 37.5% - multidisciplinary. Moreover, when asked about the professional background of their team members, the research showed that only medical staff works in 37.5% of the providers, while 50% have an interdisciplinary care team. However, general picture of these 19 providers should also be taken into account (the result of the first stage of the research - 26%, see above).

## ASSESSMENT OF PALLIATIVE CARE SERVICES

When asked in which geograpal areas do they currently deliver palliative care services (according to districts/regions), it was found that 75% are limited to local services and 12.5% are not limited. 37.5% of them provide palliative care to an average of 10-20 patients per month, 37.5% - to 21-35; and only one - to 36-50 and more patients.

**Figure 3:**

**Average number of palliative care patients served per month**



75% of the service providers say they use protocols/guidelines, but when asked to name specifically which documents do they use, only 25% gives an answer and 62.5% do not provide response at all. 87.5% of these organizations give holistic definition of palliative care and 75% of them correctly name the main principles of palliative care. Out of the 8 respondents surveyed, the majority (7 respondents) considers alleviating pain, taking care of a dying person, providing relief from distressing symptoms and offering support to patients and their families as main principles of palliative care. One respondent thinks that spiritual support as well as bereavement care are of primary importance and another respondent reflects that they are aimed at alleviating the suffering.

### Access to Palliative Care Services – Structure and Process

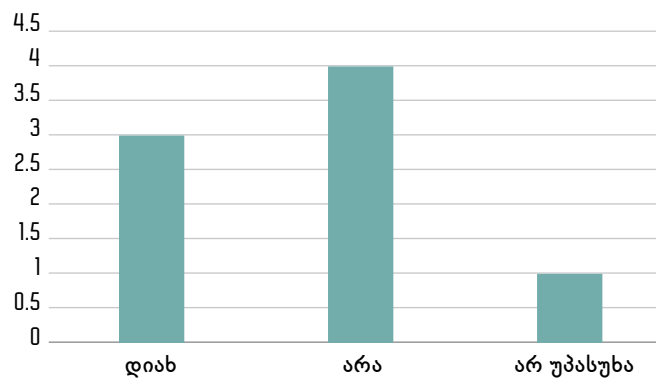
87.5% of palliative care service providers state that they have a system to collect patient's medical record; 75% say they have a connection with other district or regional health services. However, if needed, only 37.5% confirms and half (50%) declines to have a referral system (e.g. Social Assistance programme) or legal

services for a patient or his/her family member. One of the respondents names the types of legal services: “Beneficiaries can receive free legal aid service in the frames of the memorandum signed between the Open Society Georgia Foundation and the Georgian Bar Association ...” (see Figure N4).

**Figure 4:**

*If necessary, do you have a referral system in place for a patient or family member?*

*If necessary, do you have a referral system in place for a patient or family member?*



25% of the service providers speak about the challenges in access to their services. One of them names scarcity of funds. “Under the current program, a visit to the doctor is financed by 11 GEL (around 3.5 USD), and this is a barrier to quality medical care,” said the respondent. Two respondents also find the strict criteria for patient inclusion in the state palliative care program to be problematic and believe that the limited number of visits to the family doctor and nurse should also be looked over: “A period of six month is very vague. Fair criteria should be developed for patient involvement in this program. Number of visits (family doctor and nurse) and the final cost of the program should be reviewed”.

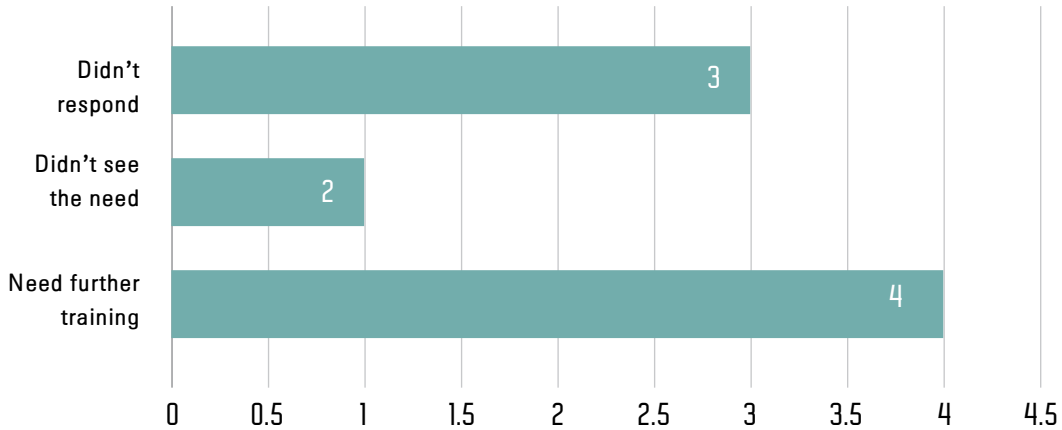
Only 50% of palliative care service providers have access to opioids. In addition, only one out of four outpatient service providers or 25% prescribe opioid medications; One of them states that “our doctors do not have access to opioid pain medications”. 50% thinks a physicians is responsible for opioid prescribing, 37.5% did not answer the question. Nevertheless, 75% say they do not experience any difficulty in administering opioid drugs. Interestingly, however, none of them (75% - refuse; 25% did not respond) have a morphine tablet form available at work.

### Education and Training

The research found that 87.5% of palliative care service providers have received palliative care training, the duration of which in 50% was 1-3 months; 12.5% - 4-6 months, while 25% did not answer the question. It is noteworthy that in 50% the main topics of the training covered only medical issues (symptom control) and 25% indicated that their training also covered issues such as: communication, etc. 25% did not answer the question.

50% say they are aware of the need or the staff is willing to further pursue education in palliative care. Moreover, 50% are self-critical and see the training needs. However, only 25% can name issues of relevance (mainly related to medical issues). 25% is unable to specify issues; and 50% did not answer the question at all. One service provider believes that “the clinic has certified specialists” and therefore, does not consider it necessary for staff to receive further education in palliative care.

**Figure 5:**  
*Expressing the need for further training*  
*Do you need additional training?*



### Data Collection and Information Management

25% of palliative care service providers say patient assessment only covers medical aspects. 62.5% note that the assessment also relates to other issues (physical, social, psychological, spiritual, etc.) and that they have standard assessment template/scales to collect information; 25% did not any, while 12.5% did not answer. “Together with a physical examination, patient’s psychological state is also

assessed” – says one of the service providers. 50% said they have a treatment quality control system, however, respondents were unable to characterize this system; 37.5% stated that they do not have a similar system in place.

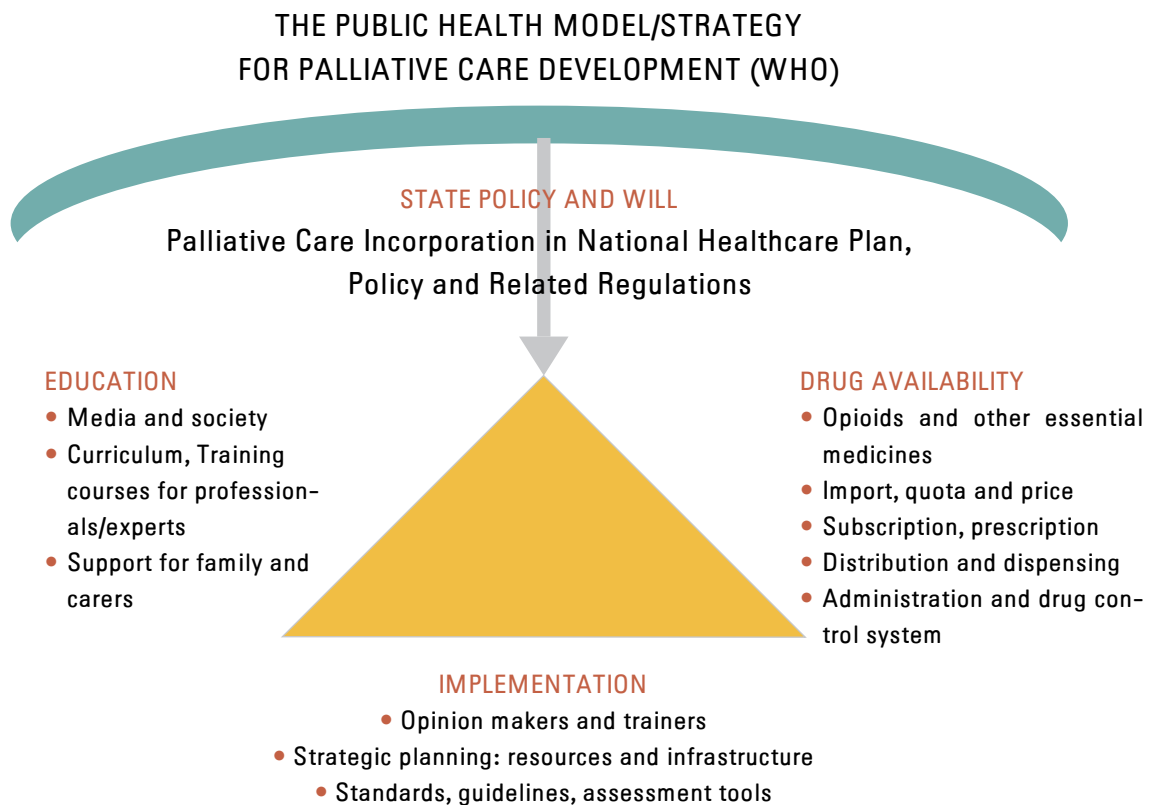
**The research revealed following problems and challenges:**

1. Disproportionate development of services – home-based care and its limitations. Barriers to the development of outpatient services – state program and education of healthcare workers;
2. It is noteworthy, that due to lack of funds, three service providers put an end to palliative care services in 2020;
3. Only 26% of providers implement multidisciplinary services. The state program finances only the remuneration of medical staff (non-holistic approach);
4. Palliative care services are not integrated with other services – half (50%) of the respondents indicate that their service does not have a referral system for a patient or family member to other services.
5. Policy and education – as a rule, service providers do not use relevant protocols/guidelines, only 25% of them named specific documents/materials. Palliative care services are mostly medical in nature and do not cover psycho-social and spiritual needs, only 25% of providers said that their training also covers other non-medical aspects of palliative care. 50% see the need of additional training. Most palliative care service providers do not use holistic approach to assess the patient. In addition, they lack self-assessment tools necessary for the evaluation of the treatment quality.
6. A severe shortage of opioids, essential for the effective functioning of palliative care services (indicator for assessment of palliative care) has been identified. Only 50% of service providers have access to opioids – out of which three are inpatient. Only one out of four for outpatient providers – 25% prescribe opioids and therefore, manage pain at home. The results indicate that patients in need of palliative care services are suffering and failing to receive adequate care. In addition, barriers for patients staying at home also leads to their unnecessary and preventable hospitalization and irrational waste of resources. The latter, serves neither the interest of palliative care development nor the improvement of quality of life of patients.

# ANALYSIS AND DISCUSSION OF RESULTS

The World Health Organization together with the Worldwide Hospice Palliative Care Alliance (WPCA) - (Global Atlas of Palliative Care at the End-of-Life) refer to WHO Strategic Triangle as to the main assessment instrument for palliative care development. The Triangle emphasizes the importance of a supportive legislative and regulatory framework (legislation, national policies and programs), access to education and medicines; and introduction and implementation of relevant guidelines and standards (WHO & WPCA, 2014). The Triangle was used to evaluate development of palliative care services. (Stjernswärd, Foley, & Ferris, 2007)

*Figure N6:*  
*Strategic Triangle of the World Health Organization*



Development of palliative care is based on WHO public health model that underlines the importance of policy, education and availability of medications. WHO experts believe that it is virtually impossible to develop palliative care without appropriate supportive policies. Hence, the **policy** is considered as a fundamental component as it lays the foundation for other changes. This may include:

- Laws that recognize and define palliative care as part of universal health-care system;
- National standards for palliative care;
- Clinical recommendations and protocols;
- Recognition of palliative care as a medical specialty/sub-specialty;
- Palliative care is regulated as a recognized type of medical service with accompanying licensed services;
- National palliative care strategy.

### Education

Since palliative care is considered an integral part of universal and continuous medical care, all medical and nursing schools should be able to conduct a basic palliative care course for future physicians and nurses. For this it is desirable:

- To train all health professionals and giving a basic overview of palliative care;
- Intermediate level training for those who work on a daily basis with patients with life-threatening illnesses;
- Palliative care training for specialists - for those who need to acquire more knowledge than the routine symptom management in palliative care.

### Drug Availability

Access to essential palliative care medications, especially opioid analgesics, is essential to providing quality palliative care. Access to opioid analgesics is considered as an indicator to measure the development and availability of palliative care. There are many types of barriers to accessing opioids. These barriers include:

- Unduly strict regulations;
- Restrictions on the availability in multiple forms, especially oral opioids;



- Absence or deficiencies in supply and distribution systems, restrictions on who can prescribe/subscribe;
- Lack of education;
- Fear of law enforcement interference in medical activities, etc.

### Challenges for Effective Palliative Care in Georgia

#### State Policy:

In 2012, the Georgian National Program for Palliative Care and corresponding Action Plan for 2011–2015 was approved. But besides several components, the introduction of the program was not followed by further development. A new action plan (2021–2025) has been drafted and the document is still under consideration in the legislature and the executive.

**Medicines** – Morphine injection is the most widely used analgesic in Georgia. Purchasing and importing of morphine in the sustained –release form have been resumed since 2009 and of the immediate–release tablets since 2012. However, morphine suspension for the pediatric population is not imported to Georgia at all.

All four different types of morphine belong to WHO’s model list and essential medicines for palliative care (WHO Model List of Essential Medicines, 2017). If a patient has severe side effects from morphine, no other medicine of similar effect is available in the country for the same purpose, allowing rotation to another opioid if necessary. WHO Step–2 medicines such as Codeine and Tramadol are virtually unavailable to patients with moderate pain. Uneven distribution of opioids throughout the country, as well as inept system informing physicians and medical staff/administration/pharmacies is an additional problem. Furthermore, the availability of medicines is affected negatively by the regulatory environment for subscribing/ prescribing opioids.

**Education** – Palliative care education as compulsory or optional courses have been introduced in the curricula of medical, nursing, pharmaceutical and social workers’ faculties since 2005–2006. From 2011 to 2012, chronic pain management was included in the residency training programs and licensing examination of family medicine physicians and related specialties. Since 2017, training for healthcare professionals in palliative care has been launched. Numerous guidelines have been developed and translated about palliative care. Since 2008, with the support

of the Open Society Foundations, a number of educational courses have been conducted for medical staff in Tbilisi and the regions. In 2012, the Ministry of Labor, Health and Social Affairs of Georgia approved the Guidelines for Chronic Pain Management. In 2019, new national guideline on palliative care was approved.

As for continuing education for healthcare professionals, it may be noted that the volume of existing courses is insufficient to deepen and extend the knowledge base in palliative care and pain management. It is also noteworthy that these courses have been introduced over the last 13–14 years, meaning that most physicians have not received any education in the relevant field. Integration of palliative care education into existing residency is highly advisable. At this stage, it is integrated only into the residency programs of oncologists and general practitioners. This means that in case of other nosologies, palliative care will depend on the patient's luck (when the GP graduated and whether s/he completed the residency program). As for the rest of the specialists, palliative care remains to be a very vague notion having connection with the medical field and might be recommended only at the end-stage.

There is practically no holistic approach in education in Georgia and the main focus is only on managing physical symptoms.

As stated by WHO expert Dr. Scholten, the lack of knowledge in palliative care and pain management may be due to the existing policy on palliative care and opioid medications and the corresponding impact of this policy on education, in particular how much time is spent on palliative care and pain management in pre-degree, post-degree or professional development programs (Silbermann et al., 2015) (Allen, Asbridge, MacDougall, Furlan, & Tugalev, 2013).

For an objective assessment, it is important to define the scope of the problem, how many people are in need of palliative care in Georgia, how many receive this service, and what is the extent of the problem.

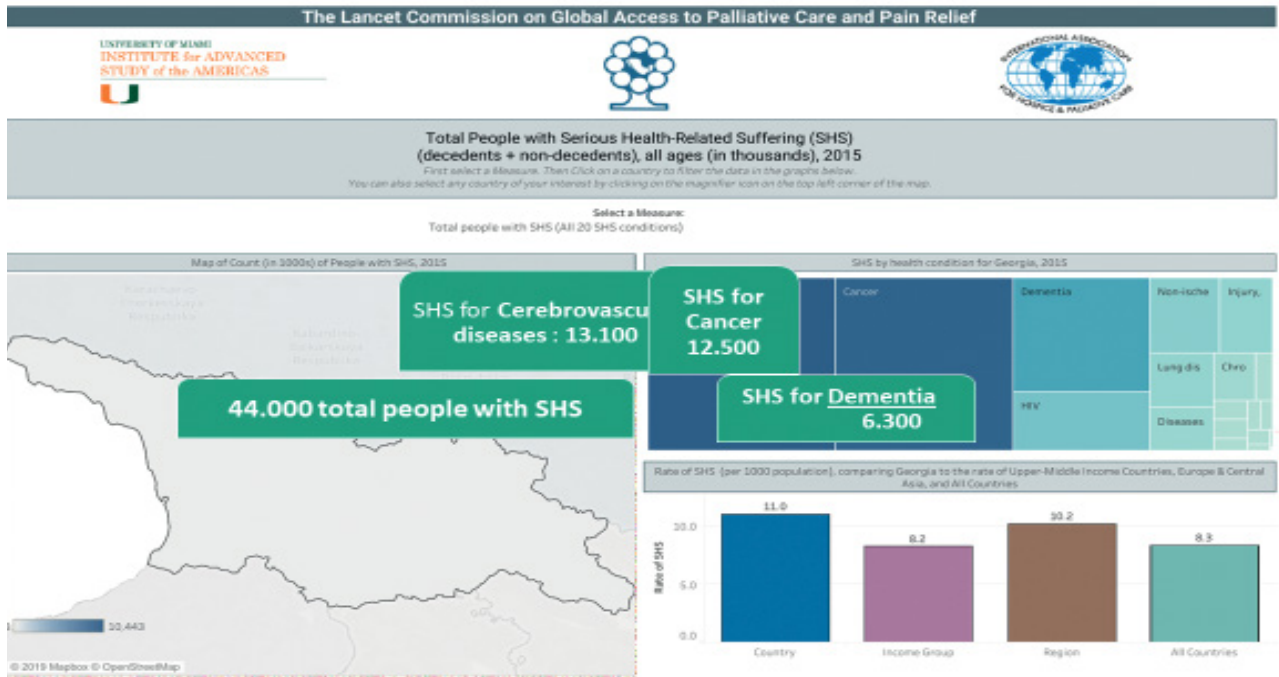
### **Defining and Estimating the Palliative Care Population**

How can we determine how many people need palliative care in Georgia? The Global Atlas of Palliative Care at the End-of-Life provides a methodology for determining the scope of palliative care services needed and understanding how many people may need end-of-life palliative care. There are other similar methods of determining the need. For example, the Georgian National Program for Palliative Care 2011–2015 (Action Plan for 2011–2015) was based on the Gomez method, where approximately

60% of deaths need palliative care and pain relief for some time. A similar method is mentioned in the review of the 2019 National Palliative Care Guideline for Persons with Chronic Diseases. Based on the Gomez method, the number of people in need of palliative care in the country (60% of the total number of deaths) is estimated at approximately 28,700 people in 2017. The same document also mentions Higginson’s methodology, that uses cause of death and estimates that almost 100% of patients with cancer and 66% of patients with other major underlying causes need palliative care. This means that in 2017, approximately 33,000 patients needed palliative care in Georgia. Both of these calculations are consistent with data presented by the expert Tom Lynch in his 2011 report. Mr. Lynch estimated that approximately 25,000 to 30,000 adults per year need palliative care in Georgia.

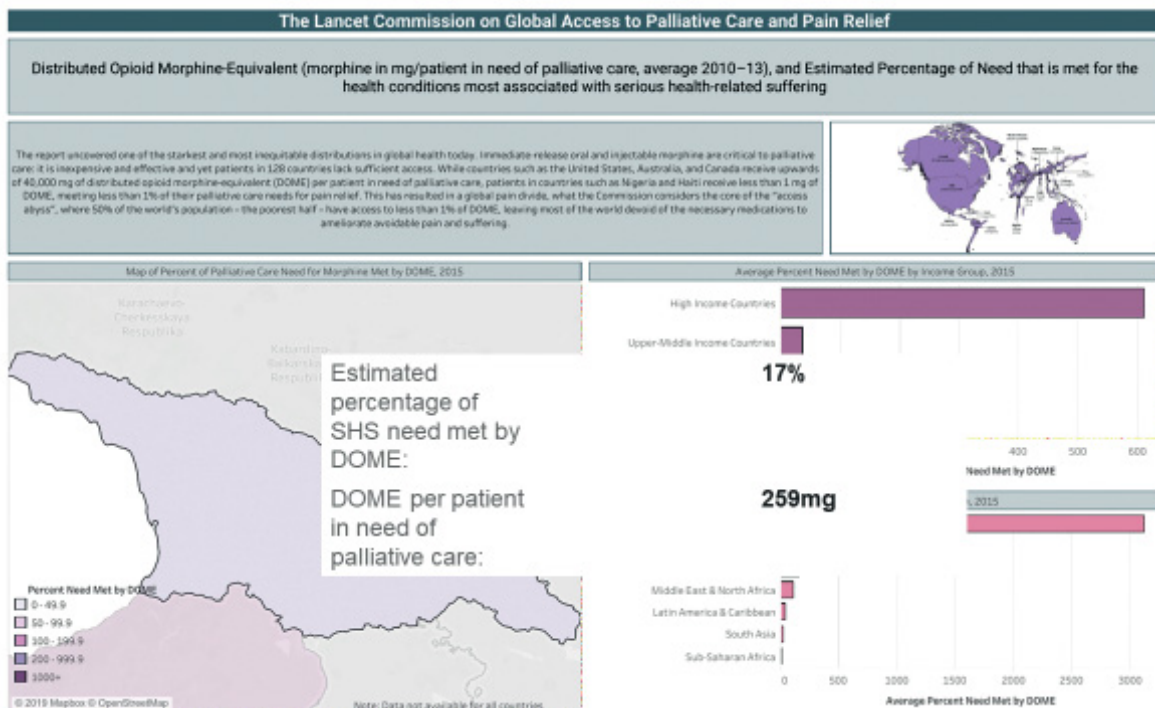
If the focus is not only on the incurable but on all types of medical conditions (e.g. traumas) that cause human suffering, then that number will increase significantly. Based on statistics (morbidity structure), the Lancet Commission on Palliative Care and Pain Relief has proposed an automated tool which found that ‘44,000 people with severe health-related suffering’ needed palliative care in Georgia in 2015 (see Figure 7).

**Figure 7:**  
*The Lancet Commission on Palliative Care and Pain Relief, Total People with Serious Health-Related Suffering in Georgia*



According to International Classification of Diseases (ICD 10), WHO conducted two Delphi studies in patients in need of palliative care. The results review the diseases that are most often accompanied by pain that causes “serious health-related suffering”. Since pain is the most common symptom in patients in need of palliative care, adequacy of pain management is therefore an indicator of access to palliative care. Thus, it is considered that these are the diseases that usually require palliative care at the end-of-life; where the end-of-life is the last year of life. Based on the same system, access to pain relief medication - opioids was calculated in Georgia. The study found that only 17% of patients in need (distributed opioids morphine equivalent) had access to analgesics. See Figure 8: [Serious Health-Related Suffering Database File](#) created on: 10/12/2019 10:15:49 AM). While, access to and spending on opioid medications is an indicator of access to palliative care (WHO & WPCA, 2014)

**Figure 8:**  
*The Lancet Commission on Global Access to Palliative Care and Pain Relief, Estimated Percentage of Need that is met for the health conditions most associated with serious health-related suffering*



The Delphi study showed the following results (according to the International Classification of Diseases (ICD 10)) - **diseases** that most often require palliative care at the end-of-life (population older than 15 years):

- Alzheimer's disease and different types of dementia;
- Cancer;
- Cardiovascular diseases;
- Liver cirrhosis;
- Chronic obstructive pulmonary disease;
- Diabetes;
- HIV/AIDS;
- Renal failure;
- Multiple sclerosis;
- Parkinson's disease;
- Rheumatoid arthritis;
- Multi-drug resistant tuberculosis.

The Global Atlas experts note that caution is needed when using only diagnoses for the assessment, because not all patients with a certain 'severe' diagnosis are in need of palliative care. In general, there are three groups of patients:

1. Those who have a palliative period of advancing progressive disease;
2. Those who have a stable or no disease, relatively few symptoms but then deteriorate or die suddenly; and
3. Those who suffer from chronic disease, where the disease is not clearly progressing, but who might have periods of progression and symptoms where they would benefit from palliative care and then periods of remission.

Because it is not precisely known what the proportions are of those three groups of patients requiring palliative care, symptoms experienced in the last year of life can be used as indicator of palliative care needs. Pain is one of the most prevalent symptoms at the end of life for both adults and children suffering from malignant and non-malignant chronic conditions. While estimating, the authors of the study took pain prevalence as one of the most frequent symptoms in individuals who need palliative care.

A method for estimating how many people at the end of life are in need of palliative care – for this purpose, the mortality data from the relevant diseases/conditions were considered (covering the reporting year) and corresponding percentage of pain prevalence was derived. Which suggests that the following number of people with such and such disease need palliative care (see Table 1).

**Table 1:**  
**List of Diseases, Pain Prevalence %**

Disease types in need of palliative care at the end of life	Pain Prevalence % at the end of life
<b>Adults</b>	
Cancer	84%
HIV/AIDS	80%
<b>Progressive Non-malignant Conditions</b>	
Alzheimer’s disease and different types of dementia	47%
Cardiovascular diseases	67%
Chronic obstructive pulmonary disease	67%
Liver cirrhosis	34%
Diabetes	64%
Multiple sclerosis;	43%
Renal failure	50%
Parkinson’s disease	82%
Rheumatoid arthritis	89%
Multi-drug resistant tuberculosis.	90%

If we use the data provided in Table 1 for patients who died from cancer in 2019 (7873) in Georgia, it turns out that at least 6613 patients (84%) who died of cancer, at one time or another needed pain management with opioids. However, the number of beneficiaries of the program didn’t exceed 3344 patients (2020). There is almost no other way to receive opioids for outpatients in Georgia.

From a practical point of view, and given the fact that in many countries the most accurate data is available about the deaths caused by specific diseases, WHO and

the Worldwide Hospice Palliative Care Alliance identify the need for palliative care (only) for patients at the end-of-life. When considered as a percentage of total mortality, 37.4% of all deaths from all causes need palliative care. This is an average number and varies considerably by region and income category. In higher income countries the percentage may exceed 60% of total mortality, while in low and middle-income countries the figures are much lower due to higher mortality from infectious diseases and injuries.

**Table 2:**  
*Georgia, estimating how many people at the end-of-life are in need of palliative care based on total mortality rate*

Year	Annual Mortality Rate	Number of people in need of palliative care at the end of life (37.4%)	Number of people who received care
2017	47 822	17885	1891 (10.5 %)
2018	46 524	17400	2810 (16%)
2019	46 659	17450	2986 (17 %)
2020	50537	18900	2227 (12 %)

Service providers involved in the palliative care program show a tendency towards inpatient care (see Table 3), which by 2019, covers a total of 17% of end-of-life patients, with an outpatient share of only 28%. In 2020, outpatient services and their share were further reduced to 25%. This means that only 3% of patients in need of palliative care received this service on an outpatient basis. During the last two years, inpatient services have increased almost 2.5 times, while at the same time there is a tendency to reduce home care services. This indicates that development of palliative care services is not moving in the right direction.

In 2019, in the case of inpatient palliative care, the average incurable patient waiting time was 17 days. By 2020, that figure rose to 21 days. Outpatient palliative care amounted to an average of 21 visits per patient. Considering the monthly limit of the state program (8 visits) – it may be concluded that on average a patient can benefit from the program only for two and a half months.

**Table 3:**

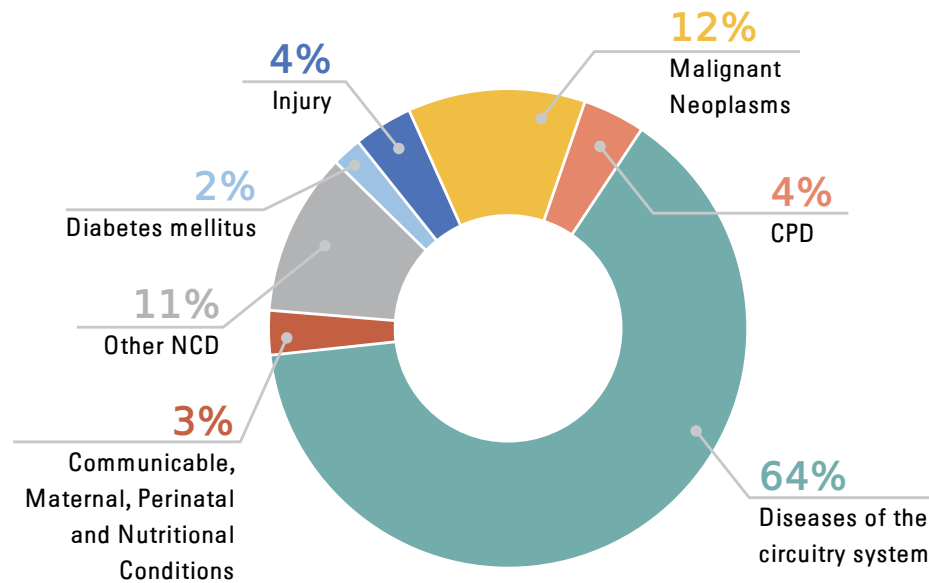
*N / % of Inpatient and outpatient services provided under the State Program on Palliative Care of Incurable Patients*

Year	N/% Outpatient Palliative Care	N /% Inpatient Palliative Care	Total N/% of palliative care services provided
2017	894 (47%)	997 (53%)	1891 (100%)
2018	957 (34%)	1853 (66%)	2810 (100%)
2019	826 (28%)	2160 (72%)	2986 (100%)
2020	574 (25%)	1703 (75%)	2277 (100%)

According to the World Health Organization 2018 report, 97% of deaths in Georgia are caused by non-communicable diseases and injuries. At the same time, 64% of the total mortality comes from cardiovascular diseases, 12% - from oncological diseases, 2% - from diabetes, 4% - from chronic respiratory diseases, 11% - from other non-communicable diseases, and 4% - from trauma (see Figure 9). According to GEOSTAT, the percentage of cancer deaths in recent years has increased to 14.8% in 2017 and 15.8% in 2018 (see Table 4). These are the diseases that require palliative care and strong analgesics at the end stage.

**Figure 9:**

*Mortality Structure Georgia, 2018; WHO (Health Care Statistical Yearbook; 2019, National Center for Disease Control & Public Health)*





**Table 4:**

*Distribution of deaths (%) by main causes of death (National Statistics Office of Georgia (GEOSTAT) 2018 data; Natural Movement of the Population in Georgia)<sup>1</sup>*

Chapter	Main causes of death	2016	2017	2018
I	Certain infectious and parasitic diseases	1.1	1.5 / 1.3 (2018)	
II	<b>Neoplasms</b>	<b>13.5</b>	<b>14.8</b>	<b>15.8</b>
III	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	0.7	1.2	1.1
IV	Endocrine, nutritional and metabolic diseases	1.5	2.1	1.5
V	Mental and behavioral disorders	0.2	0.2	0.1
VI	Diseases of the nervous system	0.9	1.3	1.1
VII	Diseases of the eye and adnexa	0.0	0.0	0.0
VIII	Diseases of the ear and mastoid process	0.0	0.0	0.0
IX	Diseases of the circulatory system	35.4	41.5	46.3
X	Diseases of the respiratory system	4.9	5.5	7.9
XI	Diseases of the digestive system	3.1	2.9	3.4
XII	Diseases of the skin and subcutaneous tissue	0.1	0.1	0.0
XIII	Diseases of the musculoskeletal system and connective tissue	0.1	0.1	0.1
XIV	Diseases of the genitourinary system	1.2	1.7	1.4
XV	Pregnancy, childbirth and the puerperium	0.0	0.0	0.0
XVI	Certain conditions originating in the perinatal period	0.7	0.7	0.6
XVII	Congenital malformations, deformations and chromosomal abnormalities	0.2	0.3	0.2
XVIII	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	33.1	22.1	14.9
XIX	Injury, poisoning and certain other consequences of external causes	3.2	3.8	4.3
<b>Total</b>		<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

It is apparent that cardiovascular diseases and tumors still dominate in the list of major causes of mortality (see Tables 4 and 5). In addition, there is an increase in the rate of tumors.

1. <https://www.geostat.ge/media/26802/2019-09-25---VS-Report-%28geo%29.pdf>

**Table 5:**

*Mortality by underlying cause of death (rate per 100000 population) Georgia, 2018 (Health Care Statistical Yearbook, 2019, Georgian National Center for Disease Control and Public Health)<sup>2</sup>*

	Number	Rate
<b>Total</b>	<b>46524</b>	<b>1247.4</b>
Certain infectious and parasitic diseases	588	15.8
<b>Neoplasms</b>	<b>7329</b>	<b>196.5</b>
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	491	13.2
Endocrine, nutritional and metabolic diseases	675	18.1
Mental and behavioral disorders	52	1.4
Diseases of the nervous system	521	14.0
Diseases of the eye and adnexa	0	0
Diseases of the ear and mastoid process	0	0
<b>Diseases of the circulatory system</b>	<b>21549</b>	<b>577.8</b>
<b>Diseases of the respiratory system</b>	<b>3676</b>	<b>98.6</b>
<b>Diseases of the digestive system</b>	<b>1,587</b>	<b>42.6</b>
Diseases of the skin and subcutaneous tissue	20	0.5
Diseases of the musculoskeletal system and connective tissue	30	0.8
Diseases of the genitourinary system	642	17.2
Pregnancy, childbirth and the puerperium	20	0.5
Certain conditions originating in the perinatal period	297	8.0
<b>Unidentified conditions</b>	<b>6927</b>	<b>185.7</b>
<b>Injury, poisoning and certain other consequences of external causes</b>	<b>2015</b>	<b>54.0</b>

As for mortality rate and palliative care needs by regions in 2019, based on the data it appears to be the following (see Table N 6)<sup>3</sup>:

2. <https://test.ncdc.ge/Pages/User/News.aspx?ID=a9ee8a02-ef7a-4d3a-b510-39aefd5872da>

3. <https://www.geostat.ge/ka/modules/categories/320/gardatsvaleba>

**Table 6:****Mortality rate and palliative care need by regions of Georgia**

Region	2019	Need of Palliative Care - 37.4%
Adjara	3370	1260
Tbilisi	12 549	4693
Kakheti	4 520	1690
Imereti	8 008	2995
Samegrelo-Zemo Svaneti	4 874	1822
Shida Kartli	3 275	1224
Kvemo Kartli	4 372	1635
Guria	1 749	654
Samtskhe-Javakheti	1 945	727
Mtskheta-Mtianeti	1 311	490
Racha-Lechkhumi and Kvemo Svaneti	686	256
<b>Georgia</b>	<b>46 659</b>	<b>17450</b>

Based on GEOSTAT 2019 death toll data (see Table 7), by region, urban or rural, the number of the end-of-life patients in need of palliative care can be estimated in urban (urban settlement) or rural Georgia (37.4%).

**Table 7:****GEOSTAT 2015 Data - Number of deaths and estimating the need of palliative care in the regions of Georgia**

Region	Total Deaths	Total Palliative Care Need	Deaths Urban	Need of the Palliative Care - 37.4% Urban Areas	Deaths Rural	Need of Palliative Care in the Rural Areas
Adjara	3475	1300	1805	675	1670	625
Tbilisi	12377	4630	12032	4500	345	130
Kakheti	4957	1854	1101	412	3856	1442
Imereti	8725	3263	3936	1472	4789	1791
Samegrelo and Zemo Svaneti	5397	2018	2366	885	3031	1133

Shida Kartli	3570	1335	1296	487	2274	848
Kvemo Kartli	4444	1662	1782	667	2662	995
Guria	1786	668	467	175	1319	493
Samtskhe-Javakheti	2086	780	757	283	1329	497
mTskheta-Mtianeti	1464	547	452	169	1012	378
Racha-Lechkhumi and Kvemo Svaneti	840	314	145	54	695	260
Georgia	49121	18370	26139	9775	22982	8595

Although there is a solid basis for integrating palliative care into the health-care system in Georgia and a number of important steps have been taken since 2000 to develop the field, adult palliative care is available to a maximum of 17% of the end-of-life patients.

The data points to a difficult, complex problem, as 83% of the end-of-life patients for whom the opioid analgesics are available legally by prescription and who meet the criteria for inclusion in a state palliative care program are left beyond.

### State Program on Palliative Care of Incurable Patients

State Program on Palliative Care of Incurable Patients has been operating in Georgia since 2006. The program initially designed for incurable patients, was modified and starting from 2013 only patients with an end-stage disease and need of palliative care at the terminal stage are considered eligible. Accordingly, since 2013, as per Article 3 (a) of the program, eligible beneficiaries are the incurable patients who need specialized palliative care **at the end of life ...**”

### Beneficiaries of the program can be:

The patients with the following conditions are eligible for the program:

- patients with malignant tumors of the clinical group IV;
- terminally ill AIDS patients;
- patients with non-oncological chronic progressive disease in the terminal stage.

### **Scope of services – the program covers:**

- a) Outpatient palliative care for incurable patients who are registered in Tbilisi, Kutaisi, Telavi, Zugdidi, Ozurgeti and Gori municipalities – the program covers home care by a palliative mobile team (doctor/ nurse);
- b) Inpatient-palliative care and symptom control of incurable patients;
- c) Providing medication to incurable patients.

### **Recently, the following requirements have been added to the program:**

- Life-expectancy estimate being within 3-6 months;
- Inappropriateness of any further treatment (given the firm belief of specialists that the diagnosis is accurate);
- The service provided under Article 3 (a) shall be delivered to the beneficiary for a period not more than 6 months.

### ***Financing Methodology and Reimbursement***

Financing the components defined by the program and the reimbursement procedure are subject to the following conditions:

- a) The unit of reimbursement for the services provided according to Article 3 (a) of the Program is a visit, the cost of one visit is 11 GEL;
- b) The unit of reimbursement for the services provided according to Article 3 (b) of the Program is a bed-day. The maximum cost of the bed is 75 GEL and is covered by the program:
  - b.a) 70% of actual cost of service, the co-payment of beneficiary is 30%;
  - b.b) For the beneficiaries specified in the Article 1 (State Program on Universal Healthcare) approved by the Resolution #36 of the Government of Georgia on February 21, 2013 – 80% of actual cost of service, the co-payment of beneficiary is 20%, while the program covers 90% of the actual cost of services for people of retirement age. The co-payment of beneficiary is 10%.
- c) Within the frames of the service following service under the program does not subject to copayment:
  - c.a) For the beneficiaries specified in the Article 2 (2) (State Program on Universal Healthcare) approved by the Resolution #36 of the Government of Georgia on February 21, 2013:
    - c.a.a) For the beneficiaries specified in the sub-clause A
    - c.a.b) For the beneficiaries specified in the sub-clause B:
      - c.a.b.a) For 0-5 aged children and children with disabilities;

- c.a.b.b) For veterans with age pensions as well as the veterans with sharply expressed disability;
- c.c) For people infected with HIV/AIDS.
- d) In frames of the services provided according to the Article 3 (c) of the Program, the medicines mentioned above shall be provided to the beneficiaries of the Program free of charge (without co-payment) within the budget allocated to the Program.

The State Program on Palliative Care of Incurable Patients contradicts the existing legislation on palliative care in Georgia, namely its continuous nature and commitment to universal access. Moreover, the program, which is designed specifically for incurable patients, underlines that eligible beneficiaries of the service are only those incurable patients who have a terminal stage of the disease and need palliative care only at the end of life.

Given that the patient seeks for the inpatient care as a last resort and in an extremely severe situation, home care services are of great importance. However, the strict and vague requirements and criteria for inclusion in the home care program makes it unattainable to fully implement palliative care (only 3-4% of incurable patients receive home care). The current situation affects the quality of patient care and leads to delayed palliative care.

In addition, there are problems in terms of geographical access (the state palliative care program operates only in Tbilisi, Kutaisi and 4 municipalities of Georgia, in total 6 municipalities out of the 76 municipalities; at the present moment, Telavi is out of the palliative care program).

At the same time, due to the limited financial resources, only doctors/nurses are engaged in the state program - failing to provide full and holistic care (bio-psycho-social approach) and only managing the physical condition. And what's most important, this happens very late and at the end-of-life, regardless the duration of symptoms and their causes. Consequently, the state program fails to address the main goal of palliative care - provide holistic care and enhance quality of life as much as possible and support patient's "well-being". The existing program needs to be revised and improved.

# MAIN BARRIERS TO THE DEVELOPMENT OF PALLIATIVE CARE

## Conclusion

**Barriers to access to palliative care services** – A state palliative care program aims to improve the quality of life of incurable patients by improving financial access to palliative care. Nevertheless, there are many problems and challenges related to palliative care in Georgia. In particular, accessibility problems arise from the strict eligibility criteria for the beneficiaries, vague program management and limited financing of the provider clinics.

- ✓ Funding for the palliative care program or service has not increased since 2004; If we take into consideration the devaluation of the national currency and inflation, it will appear that the funding has been halved. The reimbursement limitations of palliative care services diminishes the whole idea of palliative and hospice care – a multidisciplinary approach (physical, social, psychological, spiritual, etc.). In addition to a medical professional (doctor, nurse, pharmacist, etc.) this field requires engagement of other specialists, like: psychologists, social workers, caregivers and others. Therefore, in order to solve the existing problems or to make the necessary steps for the development of the field, it is necessary to join the efforts of people of different professions and support from various institutions. Lack of funding, not to speak of the quality and volume of services, also affects the quantity of services. As the present study showed, due to the scarcity of state program funding, service providers are discontinuing the provision of palliative care services, instead of expanding them.
- ✓ Lack of services is one of the most challenging problems. There are limited number of beds and the majority is concentrated in Tbilisi (hospice, palliative care center), while in some regions there are only several wards or beds. Based on experience, a recommended range is between 80 and 100 inpatient beds per million people (EAPC, 2009) This also includes the needs of non-oncology patients. Based on the population of Georgia, the required number of beds will be 300-370. At this stage,

## MAIN BARRIERS TO THE DEVELOPMENT OF PALLIATIVE CARE

there are 148 beds in Georgia in different forms (bed, ward, department or hospice); However, due to Covid-19 pandemics, only part of them continue operations.

- ✓ Home care services are available in only 6 municipalities out of 76 in Georgia (Tbilisi, Kutaisi, Ozurgeti, Zugdidi, Gori and Telavi municipalities, although the latter, at present, is out of the palliative care program) and this service is not available at all in 70 municipalities.
- ✓ Palliative care counseling service is not available in the general profile Level 2 and 3 clinics, which affects both the management of patients and, if necessary, their referral to appropriate centers. This leads to lack of awareness about palliative care and relevant services and/or delayed referrals.

Education - Most palliative care service providers do not have the necessary self-evaluation methods to assess the patient with holistic care or conduct quality monitoring. Service providers rarely use relevant protocols and palliative care services are mostly bio-medical in nature. Their knowledge is also mostly limited to medical aspects only.

- ✓ Shortage of doctors and nurses with relevant education.
- ✓ Practical absence of other palliative care professionals of non-medical profile (psychologist, social worker, nanny, caregiver, etc.). Low awareness and lack of volunteers due to this factor.

Regulation of opioid usage - essential medicines in palliative care - limit doctors from prescribing and administering opioids in outpatient settings, thus not avoiding unnecessary suffering and pain.

- ✓ Severe lack of access to essential opioid medication - opioids. Only 25% of outpatient service providers are able to prescribe opioids and therefore, treat pain at home. This leads to incorrect, irrational and inefficient development of the sector (low share of home care services in 2020 - 3%). All of this indicates that terminally ill patients in need of palliative care services are suffering and failing to receive adequate care.



## RECOMMENDATIONS

- **Increase funding for the state palliative care program to better meet the program's goal**, namely improving the quality of life for patients with incurable illnesses. It should be pointed out, that the quality will only improve with better access to palliative care services, increased financial support and efficient policies. This requires holistic care and continuous service delivery to the beneficiaries. It is important to increase the financial support for both inpatient and outpatient services to ensure multidisciplinary, holistic care “where it is most comfortable for the patient and their carers” (implies physical access, a place of residence, or mostly a patient's home. Home care services should be increased, which also requires state policy design and implementation);
- **Increase access to services and equal geographical distribution of palliative care services**. It is important to focus on home care and the outpatient component while delivering services. Both of these components need to be developed, especially in the regions of Georgia;
- **Improving inpatient services**. Effective steps need to be taken in this direction. In particular, where there is a shortage of palliative care beds, increase the number or set up a certain number, to ensure geographical accessibility to hospital palliative care services throughout Georgia.
- For the development of outpatient services and their effective operation, it is important to **retrain the primary care unit** and/or develop and strengthen skills in palliative/inpatient care; Also, development/update of training curricula in palliative medicine, where not only clinical skills will be developed, but attention will be paid also bio-ethics, communication, psychology, etc. (Planning and implementing palliative care services: a guide for program managers).
- **Mandatory inclusion of palliative care training courses in medical and nursing education curricula** (undergraduate). It is recommended to design a minimum standard of palliative care curriculum for medical and nursing schools;

- The palliative care **module should be included in residency programs of all specialties;**
- **Multidisciplinary palliative care teams should be established** - with the involvement of at least one doctor, a nurse, a social worker, a psychologist and a chaplain. It is recommended to develop a basic palliative care training program in accordance with the profession of each member of the multidisciplinary team.
- It is critically important to **improve access to essential palliative care medicines**, particularly opioids, both in injectable and tablet forms.
- **Maximum integration of palliative care into the healthcare system.** Basic palliative care should be available in all types of care facilities (outpatient clinics, first aid services, long-term care facilities, hospitals, etc.). However, special attention should be paid to the development and integration of palliative care service in community and primary health care networks (Integrating palliative care and symptom relief into primary health care: a WHO guide for planners, implementers and managers ISBN 978-92-4-151447-7) to make palliative care services as accessible as possible - to exclude no one in need.

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## ANNEX 1

Nº	Name	Service	# of beds	Cost of a bed-day in GEL	Nosology	Funding source	# of staff	Region	Address	Manager	Telephone number
1	New Vision University Hospital	Inpatient	16	75	Chronic, incurable	State	Total: 15 (5 doctors, 5 nurses, 4 nursing assistants, 1 administrator)	Tbilisi	#13 Lubliana Str./#6 Mikheil Chikauri Str.	Ms. Eka Sesiasvili	599531743 / 514024114
2	Georgian Patriarchate's Therapy Clinic	Inpatient	19	75	Chronic, incurable	State	Total: 22 (12 doctors, 5 nurses, 4 nursing assistants, 1 administrator)	Tbilisi	#9 Tsindali Str.	Mr. Revaz Tabukashvili	599532173 / 595596410
3	JSC Universal Medical Center	Hospice/ Inpatient	18	75	Chronic, incurable	State	Total: 14 (8 doctors, 5 nurses, 1 administrator)	Tbilisi	Lisi Lake Surrounding, 4	Mr. Ioseb Abesadze	599900319
4	LLC Zurab Shakarashvili Onco-haematological Clinic Lifemed	Inpatient	23	75	Chronic, incurable	State	Total: 20 8 physicians, 6 nurses 5, assistant doctor, 1 chaplain	Tbilisi	#6 Nino Javakhishvili Str.	Mr. Zakaria Shakarashvili	577100828
5	LLC Clinic Rediti - Academician Zaal Kakhiani Multi-profile Clinic	Inpatient	20	75	Chronic, incurable	State	Total: 13 (4 doctors, 4 nurses, 4 assistant doctors, 1 administrator)	Tbilisi	#80 Guramishvili Ave.	Mr. Revaz Shalamberidze	599914993 / 557630253
6	LLC Malkhaz Katsiasvili Multiprofile Emergency Medicine Center	Inpatient	6	75	Chronic, incurable	State	Total: 15 (3 doctors, 8 nurses, 3 assistant doctors, 1 administrator)	Tbilisi	#10 Al. Geronidze Str.	Ms. Lali Petashvili	593319685
7	Transfiguration Convent Mercy Center	Hospice, Home Care, School	6	Free of charge	Chronic, incurable	Donations	Total: 24 (1 doctors, 12 nurses, 5 assistant doctors, 5 administrators, 1 chaplain)	Tbilisi	#7 Urbnisi Str.	Ms. Mariam Palavandishvili	577224464 / 577224423

## ASSESSMENT OF PALLIATIVE CARE SERVICES

8	LLC Family Medicine National Center	Outpatient / Home Care	11	Chronic, incurable	State	Total: 57 (22 doctors, 15 nurses, 9 psychologists, 3 social workers, 3 administrators, 5 psychiatrists)	Tbilisi	#43 Javakhi ishvili Str. (#57 Tsinam- dzgvrishvili Str.)	Ms. Irine Karosan- idze	577445010/ 599559553
9	LLC Family Medicine Centre Dioskuria	Outpatient / Home Care	11	Chronic, incurable	State	Total: 3 (1 doctor, 1 nurse, 1 administrator)	Tbilisi	#14 Ilori Str.	Ms. Nana Gerge- dava	595599462
10	LLC Family Medicine Centre Abkhazeti	Outpatient / Home Care	11	Chronic, incurable	State	Total: 5 (2 doctors, 2 nurses, 1 administrator)	Tbilisi	#8 Lagidze Str.	Ms. Lamzira Zodelava	599149288
11	LLC Clinic Rustavi	Inpatient	13	Chronic, incurable	State	Total: 12 (3 doctors, 4 nurses, 4 assistant doctors, 1 administrator)	Kvemo Kartli	Rustavi, 7 m/d	Mr. Vladimir Pants- kava	571769553
12	LLC Gormedi - Medical Network					Total: 10 (2 doctors, 4 nurses, 1 junior doctor, 1 psychologist, 1 chaplain, 1 administrator)	Shida Kartli	Gori, 14a Tskhinvali Highway		595566507
13	LLC Hospital Service	Inpatient	75	Chronic, incurable	State	Total: 7 (1 doctor, 4 nurses, 1 assistant doctor, 1 administrator)	Imereti	Kutaisi, #16 Chkhobadze Str.	Ms. Maia Dol- mazash- vili	577100360
14	LLC Beau Monde Clinic	Inpatient	75	Chronic, incurable	State	Total: 13 (5 doctors, 5 nurses, 1 occupational therapist)	Imereti	Kutaisi, #15 Z. Gam- sakhurdia, Lane 1	Mr. Mamuka Mikadze	599555770

15	LLC Kutaisi Rehabilitation Hospital	Outpatient / Home Care	11	Chronic, incurable	State	Total: 7 (3 doctors, 2 nurses, 1 assistant doctor, 1 administrator)	Imereti	Kutaisi, #13 m. Dvallyshvili Str.	Mr. Soso Kachakhidze	599535424
16	LLC Imereti Regional Medical Centre (Terjola-med)	Inpatient	75	Chronic, incurable	State	Total: 12 (1 doctors, 4 nurses, 4 assistant doctor and nurse, 1 psychologist, 1 social worker, 1 administrator)	Imereti	Terjola, #82 Rustaveli Str.	Mr. Vladimir Kekuladze	598244400
17	LLC High Technology Medical Centre	Inpatient	75	Chronic, incurable	State	Total: 11 (2 doctors, 6 nurses, 1 psychologist, 1 administrator, 1 assistant doctor)	Adjara	Batumi, #118/120 Pushkini Str.	M.s. Medea Kajaja	577140505
18	LLC Samegrelo-Zemo Svaneti Oncological Centre	Outpatient	11	Chronic, incurable	State	Total: 2 (1 doctor, 1 nurse)	Samegrelo-Zemo Svaneti	Zugdidi, #7 Titia Str.	M.s. Nona Pipia	599789558
19	Evex Hospitals - Poti Medical Centre						Samegrelo	Poti, #6 K. Gamsakhurdia Str.		



## ANNEX 2

### *Questionnaire*

*Questionnaire will take approximately 20 minutes to complete. Participation in this study is completely voluntary. Completing the questionnaire confirms your consent to participate and you can complete it fully, partially or not at all. Your individual answers will be anonymous. We know how busy you are but would like to ask you to complete the following questionnaire. The answers you provide will help us gather information about palliative care services and needs. Thank you in advance for your cooperation!*

### Types of Service:

#### 1. Description of services: (check all correct answers)

- Inpatient (ward or hospital beds) services
- Palliative Care Unit
- Hospice
- Outpatient services
- Home care program
- Other – please describe \_\_\_\_\_

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#### 2. How does your organisation define palliative care?

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#### 3. What is the main goal of palliative care? (check all correct answers)

- Provide relief from pain
- Provide care at the end of life

- Provide care to alleviate patient suffering
- Provide comfort and support to patients and their families
- All of the above-mentioned
- Other \_\_\_\_\_

4. Does your organization use/have service standards/protocols or guidelines? If yes, please name.

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5. What services are included in your palliative care program?

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6. Out of each type of below listed positions which and how many personnel work for you?

- Doctor
- Nurse
- Assistant Doctor
- Social Worker
- Psychologist
- Spiritual Consultant (Chaplain/Spiritual Leader)
- Volunteer
- Other \_\_\_\_\_

**Access to Services - structure and process**  
(e.g. continuity, communication)

1. What is the average number of patients per month you provide palliative care to?

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2. What is the geographic service area of your program according to population and district/region?

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3. Do you have any connection with other district/regional healthcare services?

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4. Should it be necessary, do you have a referral system of a patient or his/her family member to other services (e.g. social social assistance, legal issues ...)?

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5. Do you have a system to access patient's medical records (from the place s/he was discharged)?

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6. Do you provide legal services to the patients?

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7. Are there any barriers in access to your services?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please name \_\_\_\_\_

8. Do you have access to opioid analgesics (for patients)? If yes, how are they obtained?

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9. Who is responsible for opioid

- prescription? \_\_\_\_\_

- stocking? \_\_\_\_\_

- dispensing? \_\_\_\_\_

- administration? \_\_\_\_\_

10. Do you face any barriers around opioid use? (purchase, storage prescription, etc.)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please name the challenges \_\_\_\_\_

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11. Is morphine in tablet form available at your workplace?

Yes \_\_\_\_\_ No \_\_\_\_\_

Is morphine injection available at your workplace?

Yes \_\_\_\_\_ No \_\_\_\_\_

## Education and Training

1. Have you undergone training in the palliative care? (name the course)?

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2. How many days/weeks/months did the training last?

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3. What were the main topics of the training?

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4. Do you have information about further capacity building opportunities in palliative care for your staff?

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5. Do you see the need of additional training? If yes, on what topic?

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## Data Collection and Information Management

1. What are the issues covered during the initial patient assessment (physical, social, psychological, spiritual, other)?

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2. Do you have standard assessment templates/scales to collect information?

Yes \_\_\_\_\_ No \_\_\_\_\_

3. Do you have any system in place to control treatment quality?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe.