

Putting palliative care on the global health agenda

Palliative care—defined by WHO as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering”¹—has been largely absent from the global health dialogue and consequently a low priority for donor investment.

However, an important window of opportunity has opened to push palliative care up the global health agenda: the publication of an initial draft of the United Nations (UN) Sustainable Development Goals (SDGs), a set of targets that will define global health priorities from 2015 to 2030.² The SDGs will replace the eight Millennium Development Goals adopted by 193 countries in 2000. Those goals had minimal mention of improvement of quality of life or palliation of symptoms, and cancers, heart disease, and other non-communicable diseases often requiring palliative interventions were totally absent.

Despite the lack of attention and investment, positive developments have occurred in promotion of palliative care in the past 15 years.³ In 2011, 136 (58%) of the world's 234 countries had at least one palliative care service—an increase of 21 (9%) from 2006, with the most substantial gains made in Africa.⁴ At the global policy level, three important advances have been made. First, in 2000, palliative care was included in the UN's International Covenant on Economic, Social and Cultural Rights, which says: “States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons...to preventive, curative and palliative health services”.⁵ Second, essential medicines for palliative care were included in the 18th WHO Essential Medicines List in 2013. Third, in May, 2014, the World Health Assembly (WHA) passed a landmark resolution urging member states to support access to essential medicines, and to strengthen palliative care as an integrated component of universal health coverage throughout the life course, stating that palliative care is an ethical responsibility of health systems.⁶

However, poor access to effective palliative care remains a global public health failing, with almost 20 million people requiring end-of-life palliative care services globally every year. A similar number also need such care in the year before their death. About 80% of these people live in low-income and middle-income

nations and 1.2 million of them are children. Most of the demand for palliative care services is associated with the ever-increasing burden of chronic and non-communicable disease. HIV/AIDS, diabetes, and neurodegenerative diseases present an enormous need for palliative care, especially in low-income countries and populations. Cancer is a leading cause of morbidity and mortality worldwide, with an estimated 14.1 million new cases and 8.2 million deaths in 2012.⁷ It is projected that by 2030, mortalities from cancer worldwide will rise to 13.2 million.⁸ Furthermore, pain control is essential but largely unavailable even in cases of severe injury, acute infections, and epidemics (eg, Ebola) and the fallout of natural disasters, in which cases often end in death. Despite this widespread need, only 20 countries (8.5%) have integrated palliative care adequately into their health-care system.

The first draft of the SDGs has 17 goals and 164 targets. The health goal, SDG3, which is to “ensure healthy lives and promote wellbeing for all at all ages”, has 13 subtargets (panel). At present, the draft makes no mention of palliative care. In 2015, however, this draft will undergo revision through a process of intergovernmental negotiations. These negotiations present a historic opportunity for palliative care to become an integral part of this era-defining agenda, central to the subsequent global health discourse.

Palliative care is particularly relevant to two specific subtargets of SDG3 in the current draft. First, it is relevant to sub-target 3.8, the target of achievement of universal health coverage, “including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all”. Universal health care is premised on the following factors: a strong, efficient, well-run health system; a system for financing health services; access to essential medicines and technologies; and sufficient capacity of well-trained, motivated health workers to provide the services to meet patients' needs based on the best available evidence. Second, palliative care is relevant to target 3.9b, which aims to “support research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines”.

Panel: 13 subtargets included in the first draft of the health SDG (SDG3): Ensure healthy lives and promote wellbeing for all at all ages

- 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 livebirths.
- 3.2 By 2030, end preventable deaths of newborns and under-5 children.
- 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.
- 3.4 By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and wellbeing.
- 3.5 Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- 3.6 By 2020, halve global deaths and injuries from road traffic accidents.
- 3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.
- 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination.
- 3.9a Strengthen implementation of the Framework Convention on Tobacco Control in all countries as appropriate.
- 3.9b Support research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration which affirms the right of developing countries to use to the full the provisions in the TRIPS [Trade-Related Aspects of Intellectual Property Rights] agreement regarding flexibilities to protect public health and, in particular, provide access to medicines for all.
- 3.9c Increase substantially health financing and the recruitment, development and training and retention of the health workforce in developing countries, especially in the least developed countries and small island developing states.
- 3.9d Strengthen the capacity of all countries, particularly developing countries, for early warning, risk reduction, and management of national and global health risks.

SDG=Sustainable Development Goal.

Inclusion of palliative care within SDG3 has been advocated by Human Rights Watch, which called for a specific target for universal access to palliative care and pain medicine, consistent with the 2014 WHA resolution and the need to ensure adequate availability of narcotic analgesics for medical and scientific purposes.⁹ The next phase of the SDG process will involve intense intergovernmental debate on the draft, and on the mechanisms of financing the goals, particularly at the development financing conference that is due to take place in July, 2015, in Addis Ababa, Ethiopia. Assuming that room exists to reflect on the targets and their wording, we agree with Human Rights Watch and contend that the public health importance

of palliative care is such that it should be explicitly cited as a component part of the “essential health care services” (SDG3.8), and be accompanied by a dedicated globally relevant indicator, one that has applicability to SDG3.8 and SDG3.9b, for example as a proxy for access to essential medicines generally.

The recent report of *The Lancet* Commission on investing in health,¹⁰ which laid out a 20 year health investment framework for all low-income and lower-middle income countries, argued that the non-communicable disease package should include oral morphine. This drug is an effective analgesic for moderate-to-severe pain that is increasingly available in developing nations. We support the Commission’s call to ensure that all countries of all income statuses have access to oral morphine and propose an indicator that is a specific and feasible measure of SDG3.8 and SDG3.9b’s achievement in the palliative care context. This indicator builds on the WHO’s global monitoring indicator in its non-communicable disease framework that measured palliative care access by oral morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.¹¹ Specifically, an improved SDG target indicator would be morphine-equivalent consumption per person. The International Narcotics Control Board already requires national governments to report this information, thereby ensuring mechanisms exist to enable the proposal to happen. Although such an indicator does not capture the holistic nature of palliative care, it does ensure that, as an essential aspect of a functioning health system, palliative care is represented.

In September, 2014, at the 20th International Congress on Palliative Care in Canada, seven international and national organisations issued the Montreal Declaration, calling for the inclusion of hospice and palliative care in the SDGs.¹² The declaration, which has further focused global palliative care attention on the importance of the SDGs’ epoch-defining health agenda, will be supported by the recently inaugurated Harvard Global Equity Initiative-*Lancet* Commission on global access to pain control and palliative care.¹³

In the next year, increased global attention about the need for palliative care needs to be translated into active engagement with the SDG revisions process. By combination of evidence, advocacy and policy making, a solid base can be made for implementation of effective, equitable, and universal access to palliative care.

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Towards a global cancer fund

The annual death toll from cancer has risen by almost 40% since 1990,¹ and this increase is set to continue. Deaths from cancer are projected to increase from the present level of around 8 million a year to more than 13 million by 2030, with most of the burden being in poorer countries.² Once a problem almost exclusive to rich countries, cancer is rapidly becoming a leading cause of death and disability in poor countries, where cancer survival is much lower than in the affluent parts of the world—eg, breast cancer survival in the Gambia is below 15%.³ Yet, low-income countries have just 5% of the resources to deal with 80% of the global cancer burden.⁴

The unacceptable asymmetry between the cancer burden and financial resources in low-income countries prompted the European School of Oncology to convene the World Oncology Forum (WOF) in 2012, bringing together 100 cancer researchers, clinicians, policy makers, industry representatives, patient advocates, and scientific journalists to debate the question “Are

we winning the war against cancer?”⁵ Having concluded that current global strategies to control cancer are largely insufficient, the participants issued a ten-point call to action—“stop cancer now!”⁶—formulated within the framework of the international commitment to reduce preventable deaths from non-communicable diseases by 25% by 2025 (“25 by 25”).⁷ The call to action not only asks for a major improvement in prevention, early diagnosis, and treatment, but also requests new models of research focused on patients’ benefit.

To reach the 25 by 25 target, at least 1.5 million deaths from cancer will need to be prevented per year. In 2014, leading international experts met at the WOF to promote sustainable new models of public-private partnership to find new cancer therapies that could make a real difference in patients worldwide. This was followed by the 2014 World Cancer Leaders’ Summit, organised by the Union for International Cancer Control, when the economic case for cancer control was discussed. The loss of output from



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