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Description

“Imagination at scale is our only recourse.” Jonathan Ledgard [1]. The majority of global deaths are characterized by misery and limited palliation and occur in low- and middle-income countries (LMICs) [2, 3]. Two thirds of patients with cancers in these countries die of these malignancies; 70-80% of these deaths are accompanied by severe pain [4]. Pain is also a major symptom in patients dying of other common non-communicable diseases [5]. As an example, in Nepal estimates for 2012 based on mortality data, are that pain at the end of life was an issue for 84% of 13,724 patients dying of cancer, 67% of 31,714 patients dying of cardiovascular disease (CVD), and 67% of 17,049 patients dying of chronic obstructive pulmonary disease (COPD), and experts opined that these figures may be low [6]. While the pain syndromes associated with malignancies are usually directly related to the pathophysiology of the disease processes, those associated with CVD and COPD often appear more associated with general functional disability. In Globocan, cancer estimates for 2018, among many data items for examples, some striking numbers are that of all cancer deaths 57.3% were in Asia; China has the highest age-specific death rate for lung cancer; South Central Asia (meaning India and Pakistan) with 26% of the global population, has the highest global incidence rates for oral cancer in men, and mortality incidence ratios of 63% for cervical cancer and 53% for breast cancer, compared with ratios of 30% and 15% respectively for North America [7]. These data for cancer suggest what the most frequent diseases needing palliation are in Asia, where the majority of the underserved case burden occurs.

Strategies for addressing the growing challenges of end-of-life palliative care, particularly in LMICs, have been defined based on high-income country models of health care services and research, and despite efforts to apply these in resource-constrained settings; the assumptions inherent in recommendations of even multi-national groups are astonishingly insensitive to the realities of health systems' operations in many LMICs. For example, the ASCO Resource-Stratified

Practice Guideline starts with a discussion of palliative care models in which “needs of patients and families are identified and met at all levels, in collaboration with the team providing oncology care” [8]. The basic care recommendation which follows states that “Palliative care needs should be addressed in the community or at the primary health care level. Their emphasis is on community engagement models, which in the case of Kerala, India have been enormously impressive, with an astonishing breadth of critical and needed activities [9-11]. What is not commented on in detail in these reviews is any rigorous evidence that patient symptom management efforts are observably impactful. Further, as

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the Kerala authors themselves comment, the efforts there are markedly different than those which characterize palliative care elsewhere in that country [10].

In summary, for most patients in the world needing end-of-life symptom-addressing palliative care, providers are not available, health systems are weak, and the quality of the interventions received, if any, is likely to be low. An applicable general framework for addressing this abyss however, is now apparent, grounded in emerging favourable data about three components: new kinds of health paraprofessionals; information technology tools; and innovative health system approaches.

Palliative care para-professional specialists

Because the chokepoint for provision of palliative care to the majority of global citizens-in-need is lack of access to providers, the creation of new types of palliative care specialist providers is essential [2,12,13]. As an example, routinizing components of specialty care which can be carried out by paraprofessionals has been dramatically successful for cataract treatment. The specific steps in evaluating patients, preparing for and doing cataract surgery were broken down,

and replaced by effective automated, patient-tailored, artificial intelligence-facilitated decision-making systems for patient symptom management are increasingly available [18-23]. Such systems can bring Paraprofessionals into front line roles in patient care [24].

Innovative health systems

To address the gap between population needs and available services in palliative care we need, world-wide, major scaled-up changes in operational efficiencies and productivity [12, 19]. We need what Christensen calls disruptive innovation [12]. The foregoing two sections of this communication identify how these efficiency and productivity challenges can be successfully and economically addressed. Markman and the late Jonathan Mann have pointed to a central issue applicable to how we approach the global palliative care challenges: the critical matter is how we define the problems [25]. We have been talking about how we train more palliative care physician specialists and primary care providers, when we might better be asking how we can describe the specific work tasks for rapidly trainable paraprofessional palliative care specialists, transforming or increasing the activity portfolios for example of primary care nursing professionals and linking these practitioners to palliative care centres using information technology tools We have been talking about increasing provision of face-to-face provider encounters, when we have the means to, and should be striving to offer tele-palliative care. We have been struggling to develop palliative care treatment guidelines and get providers to use these, when we have the skills to create automated patient-tailored intervention recommendations. We have the opportunity now to scale up effective palliative care systems. Developing local experiments implementation research exploring these alternative approaches to do this is the way forward [26].

The broad framework for addressing global end-of-life palliative care dictates a need for disruptive local approaches characterized by more imagination about defining the central issues and how to address them. We need more of Jonathan Ledgard’s spirit [1].

Conclusion

The global health community has the responsibility and the opportunity to close the access abyss in the relief of pain and other types of suffering at end-of-life and throughout the life course, caused by life-limiting and life-threatening health conditions

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