Table 2 Palliative care models and innovations in the Eastern Mediterranean Region

POLICY: Recognition of palliative care as an official medical specialty in Lebanon

Problem:
Approval of palliative care as an official medical specialty, a critical step in palliative care development, has not occurred in Lebanon.

Goal:
Official recognition of palliative care as a medical specialty.

Scope:
National

Barriers / overcoming the barriers:
Obtaining official approval for a new medical specialty often is complicated. The body responsible for approval of any new medical specialty in Lebanon is the Medical Specialties Committee at the Ministry of Public Health (MoPH). The Director-General of the MoPH chairs the Medical Specialties Committee, which meets monthly. The process of establishing a new specialty is initiated when multiple individual requests are submitted to the MoPH by practicing physicians with documented clinical expertise in the requested specialty. Once several requests have been received by the MoPH, the Medical Specialties Committee must review and discuss them. If the addition of the new specialty is deemed justified, the Director-General submits a recommendation on behalf of the Committee to the Minister of Health to modify the official List of Medical Specialties, specifying the associated training requirements. Once approved, a Ministerial Decree is issued officially approving the specialty.
A nongovernmental National Committee for Pain Control and Palliative Care (NCPCPC) was established in 2010 in Lebanon with a mandate to draft a strategy for the development of palliative care. Recognition of palliative care as a medical specialty was among the goals. The Subcommittee on Practice drafted proposed licensing requirements for palliative care physicians that were published in the Lebanese Medical Journal.
The nongovernmental Lebanese Center for Palliative Care, Balsam, began actively advocating for the recognition of palliative medicine as a medical specialty after its founder and medical director obtained certification in Hospice and Palliative Medicine by the American Board of Family Medicine, a member of the American Board of Medical Specialties in 2012. No other physicians who were board certificated in hospice and palliative medicine in Lebanon at the time, but the Balsam team was able to identify a few board-certified Lebanese physicians who were living and working abroad and licensed to practice in Lebanon. The submission of requests for inclusion of palliative medicine into the list of medical specialties at the MoPH was coordinated through Balsam in collaboration with members of the NCPCPC.

Effect on the public healthcare system:
Not yet discernible.

Outcomes:
Palliative medicine was officially recognized as a medical specialty in Lebanon on 28 June 2013, 6 months after submission of the initial request and within 2 years of the establishment of the NCPCPC. The process would not have been successful without strong political support from within the MoPH and the coordinated efforts of palliative care advocates represented by the NCPCPC.

SERVICE IMPLEMENTATION/EDUCATION: Establishing home-based palliative care services in the Islamic Republic of Iran

Problem:
Patients with end-stage chronic illnesses in the Islamic Republic of Iran commonly continue to receive specialized disease treatment in hospitals and die in intensive care units (ICUs) despite a national shortage of hospital and ICU beds and the high expense of this treatment. There are no hospices in the Islamic Republic of Iran; community-based palliative care has rarely been both available and affordable; and opioid prescription for outpatients is problematic.

Goal:
To make safe and cost-effective palliative home care accessible throughout the country and thereby to increase patients' and families' satisfaction care, to reduce length of stay in hospitals, and to improve the quality of nursing care.

Scope:
National

Barriers / overcoming the barriers:
Reasons for the lack of palliative home care in the Islamic Republic of Iran include cultural values and laws that make it difficult for nurses to enter homes, a lack of clinicians trained in palliative care, and antipathy toward opioids (opiophobia).
Recognizing this problem, the Ministry of Health and Medical Education (MOHME) in July 2016 approved a new regulation (Code D/101/691, Article 22) enabling establishment of home care units within hospitals and home care and counselling centres in the community. The hospital-based homecare unit is responsible for identifying and referring patients to community homecare centres. A doctor at this centre examines the patient and creates a care plan that is executed at home by a nurse. A physician visits the patient at home as needed. Universities of medical sciences are empowered to license 1 home care centre for every 50 000 people. In addition, private homecare centres for cancer patients were established by a charitable organization in Isfahan and Tehran.
To assist with this initiative, the MOHME Nursing Deputy developed continuing nursing education courses in palliative and home care, and palliative care programmes that are now required for homecare nurses. Efforts are now underway to include required training in palliative and home care in undergraduate and graduate nursing curricula.
Remaining social and legal barriers include a persistent belief among healthcare policymakers that nurses should work in hospitals and not provide primary care or home care; a lack of clinical guidelines for palliative home care; a lack of health insurance coverage for home care; and a lack of indicators to monitor the quality of home care.

Effect on the public healthcare system:
Following World Health Organization guidance, a promising way forward would be to include palliative home care as an essential element of primary health care provided by existing public urban and rural health centres. This likely would reduce costs for the public healthcare system, help to unburden hospitals, and promote universal health coverage by assuring follow-up and end-of-life care in the community for seriously ill people.

Sustainability / scalability:
Currently, home care is not covered by major health insurance companies (Iranian health insurance, and social security insurance) and families must pay out of pocket. The Nursing Deputy of the MOHME has submitted to the Iranian High Council of Insurance a proposal for a basic package of palliative home care to be covered by insurance coverage that could be funded by increasing the cost of some other services.

Outcomes:
Today, there are approximately 700 active home care centres throughout the country. Better indicators of home care outcomes are needed such as pain control, quality of life, patient and family satisfaction, rehospitalization rates, emergency department visits, and costs.

Table 2 Palliative care models and innovations in the Eastern Mediterranean Region *(concluded)*

SERVICE IMPLEMENTATION / EDUCATION: Integration of palliative care into primary health care in Saudi Arabia

Problem:
Although palliative care was available in some tertiary and secondary level hospitals in Saudi Arabia, it was not available at the primary care level.
Goal:
To create a sustainable and reproducible model of palliative care integration into primary health care (PHC).
Scope:
The model created at a single PHC centre (PHCC) is designed to be reproducible at all 46 PHCCs in the King Fahad Medical City (KFMC) system in Riyadh and throughout the country.
Barriers / overcoming of barriers:
There were no models of palliative care at the primary care level in Saudi Arabia.
However, palliative care for patients with serious illnesses was included by the government in its "Vision 2030, Model of Care" initiative to improve health care. On the basis of this policy, the existing inpatient palliative care team at KFMC began integration of palliative care into primary care at one PHCC in 2018. Family physicians working at the PHCC were trained for 3 months in basic palliative care and then began providing services with support from specialists at KFMC. After 1 year, they felt confident to run the weekly palliative care clinic independently.
Costs / savings:
There is no cost to the patient for palliative care at the PHCC, and it is easily accessible for those living in that community. By contrast, a visit to the private clinic at a tertiary hospital costs about US$ 100 without medications and investigations, and more travel is required. Thus, providing palliative care at PHCCs appears to provide financial risk protection and convenience for patients and families. It also may reduce admissions and length of stay in hospitals and thereby reduce cost for the healthcare system, but no comparative study of costs has been performed as yet.
Effect on the public health care system:
This model will likely strengthen the healthcare system by unburdening the inpatient and outpatient services at hospitals and thereby reducing costs and facilitating access to hospitals by patients whose needs cannot be met in the community.
Sustainability / scalability:
Planning is underway to replicate this model in all PHCCs in Saudi Arabia.
Outcomes:
As of January 2020, 110 patients and 200 caregivers were seen in the PHCC palliative care clinic; 20% were receiving active oncology treatment; no-show rate was 45%; and overall satisfaction score was 90% .
Next steps:
Creation of multidisciplinary palliative care teams at primary care level.

SERVICE IMPLEMENTATION / EDUCATION: paediatric palliative care in Egypt

Problem:
Paediatric palliative care did not exist in Egypt, and seriously ill children suffered due to lack of appropriate care.
Goal:
To establish paediatric palliative care services at the Children's Cancer Hospital – Egypt (CCHE), the national referral centre for paediatrics.
Scope:
National
Barriers / overcoming of barriers:
Major barriers in Egypt to palliative care in general and paediatric palliative care in particular include lack of government policies on palliative care, inaccessibility of opioid analgesics, inadequate education, and negative attitudes among physicians toward opioids, delivering bad news, and comfort-oriented care.
In 2010, CCHE launched the first paediatric palliative care (PPC) programme in the Eastern Mediterranean Region. The multidisciplinary PPC team provides care in the emergency room, an outpatient clinic, and inpatient units, and home care is provided 5 days per week within metropolitan Cairo by nurses and social workers. Consultation is provided by telephone for patients outside of Cairo. Oral morphine is available for the PPC team's patients, and a 15-day supply can be dispensed. The PPC team offers training in palliative care to residents and oncology fellows, nurses, nurse aids, psychologists, and social workers from Egypt and other countries.
Costs / savings:
Data on costs and possible savings from palliative care or hospice services are not available.
Effect on the public health care system:
No data
Outcomes:
Approximately 50 children per month receive PPC from the CCHE palliative care team. They represent 20% of the children treated in the hospital.

an example of how determined and skilful advocacy can achieve this goal.

Two cases describe the inaccessibility of opioid analgesics due to overly restrictive regulations, lack of training in opioid therapy, or unjustified fear of opioids. While no cases specifically addressed strategies to overcome these barriers to palliative care, multiple case reports have been published by participants in the International Pain Policy Fellowship (*20–25*). Unfortunately, no countries from the EMR participated in this Fellowship. We propose creation of a similar 2-year fellowship to assist EMR countries to develop balanced national opioid policies using the International Pain Policy Fellowship as a model.

Three of the cases address the inseparability of palliative care service implementation and training in palliative care (*26–28*). Integration of sustainable, high-quality palliative care services into healthcare systems requires an enabling foundation in government policy as well as coordination of opioid accessibility and training, and establishment of clinical services (*9*). If opioids are made accessible before appropriate prescribing regulations and training, they may either expire on the shelf or be prescribed injudiciously. If training is