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INTERNATIONAL EXPERIENCE OF PALLIATIVE CARE FOR CANCER PATIENTS: CHALLENGES, ISSUES, AND DEVELOPMENT PROSPECTS. LITERATURE REVIEW

Aigerim A. Mukusheva[1], https://orcid.org/0000-0002-7046-4375
Zaituna A. Khismetova[1], https://orcid.org/0000-0001-5937-3045
Nazym S. Iskakova[1], https://orcid.org/0000-0001-5631-5499
Dinara S. Serikova-Yessengeldina[1], https://orcid.org/0000-0002-9470-9488
Aliya K. Atabayeva[1], http://orcid.org/0000-0001-7725-2255
Bibinur K. Sydykova[2], https://orcid.org/0000-0002-7013-3461
Yernar Tursynbet[3], https://orcid.org/0000-0003-1871-1954

[1] **NCJSC «Semey Medical University», Semey, Republic of Kazakhstan;**
[2] **Kazakhstan Medical University "KSPH", Almaty, Republic of Kazakhstan;**
[3] **National Centre of Sports Medicine and Rehabilitation, Astana, Republic of Kazakhstan.**

Abstract

Background: Palliative care for cancer patients is a critical component of modern oncology, aimed at improving the quality of life for patients with terminal or advanced-stage cancer. It focuses on alleviating symptoms such as pain, nausea, fatigue, and psychological distress, while also providing emotional and spiritual support for both patients and their families. Over the past decades, palliative care has evolved from being a niche service to a fundamental aspect of cancer treatment, increasingly integrated into healthcare systems worldwide. Despite its importance, access to high-quality palliative care remains limited, particularly in low- and middle-income countries. Many countries with developed healthcare systems have made significant strides in improving the availability and quality of palliative care services, yet challenges persist, including a shortage of trained professionals, fragmented funding, and cultural stigma surrounding death and end-of-life care.

Aim. To critically analyze the international experiences in providing palliative care for cancer patients, examining the challenges, issues, and opportunities for development across different healthcare systems.

Search strategy. The following approach was used for the literature review on palliative care for cancer patients. The search was conducted in major scientific databases such as PubMed, Scopus, Web of Science, and others. The review included peer-reviewed articles published between 2015 and 2025, focusing on palliative care for adult cancer patients. Studies not related to palliative care or focused on pediatrics were excluded. The search involved a combination of keywords and filters by language and publication date (last 10 years). To expand the scope of sources, references cited in selected papers and data from experts were also considered.

Results and conclusions. The literature review highlights that palliative care for cancer patients has evolved significantly, with various models in both developed and developing countries. Challenges such as workforce shortages, fragmented funding, late referrals, and limited access to opioids persist globally. Innovations like telemedicine and interdisciplinary care teams have shown promise in improving access and quality of care, but their implementation remains inconsistent. Developed countries have more integrated systems, while middle-income nations struggle with regulatory and resource limitations.

Keywords: *palliative care, cancer patients, palliative care models, hospice care, pain management, telemedicine in palliative care.*

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Резюме

МЕЖДУНАРОДНЫЙ ОПЫТ ПАЛЛИАТИВНОЙ ПОМОЩИ ОНКОЛОГИЧЕСКИМ ПАЦИЕНТАМ: ПРОБЛЕМЫ, ВЫЗОВЫ И ПЕРСПЕКТИВЫ РАЗВИТИЯ. ОБЗОР ЛИТЕРАТУРЫ

Айгерим А. Мукушева[1], https://orcid.org/0000-0002-7046-4375
Зайтуна А. Хисметова[1], https://orcid.org/0000-0001-5937-3045

Назым С. Искакова[1], https://orcid.org/0000-0001-5631-5499
Динара С. Серикова-Есенгельдина[1], https://orcid.org/0000-0002-9470-9488
Алия К. Атабаева[1], http://orcid.org/0000-0001-7725-2255
Бибинур К. Сыдыкова[2], https://orcid.org/0000-0002-7013-3461
Ернар Турсынбет[3], https://orcid.org/0000-0003-1871-1954

[1] **НАО «Медицинский университет Семей», г. Семей, Республика Казахстан;**
[2] **Казахстанский медицинский ниверситет «ВШОЗ», г. Алматы, Республика Казахстан;**
[3] **РГП на ПХВ «Национальный центр спортивной медицины и реабилитации»,**
г. Астана, Республика Казахстан.

Введение: Паллиативная помощь онкологическим больным является важнейшим компонентом современной онкологии, направленным на улучшение качества жизни пациентов с терминальной или запущенной стадией рака. Она направлена на облегчение таких симптомов, как боль, тошнота, усталость и психологические расстройства, а также на оказание эмоциональной и духовной поддержки как пациентам, так и их семьям. За последние десятилетия паллиативная помощь превратилась из узкоспециализированной услуги в фундаментальный аспект лечения рака, который все больше интегрируется в системы здравоохранения по всему миру. Несмотря на свою важность, доступ к высококачественной паллиативной помощи остается ограниченным, особенно в странах с низким и средним уровнем дохода. Многие страны с развитыми системами здравоохранения добились значительных успехов в повышении доступности и качества услуг паллиативной помощи, однако проблемы сохраняются, включая нехватку подготовленных специалистов, фрагментарное финансирование и культурную стигматизацию, связанную со смертью и уходом в конце жизни.

Цель. Критический анализ международного опыта оказания паллиативной помощи онкологическим больным, изучение вызовов, проблем и возможностей для развития в различных системах здравоохранения.

Стратегия поиска. Для обзора литературы по паллиативной помощи онкологическим пациентам был использован следующий подход. Поиск проводился в основных научных базах данных, таких как PubMed, Scopus, Web of Science и других. В обзор были включены рецензируемые статьи, опубликованные в период с 2015 по 2025 год, с фокусом на паллиативную помощь взрослым онкологическим пациентам. Исследования, не связанные с паллиативной помощью или посвящённые педиатрии, были исключены. Поиск включал сочетание ключевых слов и фильтров по языку и дате публикации (за последние 10 лет). Для расширения охвата источников также были учтены ссылки, приведённые в отобранных статьях, и данные, полученные от экспертов.

Результаты и выводы. В обзоре литературы подчеркивается, что паллиативная помощь онкологическим больным претерпела значительные изменения благодаря использованию различных моделей как в развитых, так и в развивающихся странах. Такие проблемы, как нехватка рабочей силы, фрагментарное финансирование, несвоевременное направление к врачу и ограниченный доступ к опиоидам, сохраняются во всем мире. Такие инновации, как телемедицина и междисциплинарные медицинские бригады, показали себя многообещающими в плане улучшения доступа и качества медицинской помощи, но их внедрение остается непоследовательным. Развитые страны имеют более интегрированные системы, в то время как страны со средним уровнем дохода сталкиваются с нормативно-правовыми и ресурсными ограничениями.

Ключевые слова: *паллиативная помощь, онкологические больные, модели паллиативной помощи, хосписная помощь, обезболивание, телемедицина в паллиативной помощи.*

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Түйіндеме

ОНКОЛОГИЯЛЫҚ НАУҚАСТАРҒА ПАЛЛИАТИВТІК КӨМЕК КӨРСЕТУ БОЙЫНША ХАЛЫҚАРАЛЫҚ ТӘЖІРИБЕ: МӘСЕЛЕЛЕР, ҚИЫНДЫҚТАР ЖӘНЕ ДАМУ БОЛАШАҒЫ. ӘДЕБИЕТТІК ШОЛУ

Айгерим А. Мукушева[1], https://orcid.org/0000-0002-7046-4375
Зайтуна А. Хисметова[1], https://orcid.org/0000-0001-5937-3045
Назым С. Искакова[1], https://orcid.org/0000-0001-5631-5499
Динара С. Серикова-Есенгельдина[1], https://orcid.org/0000-0002-9470-9488
Алия К. Атабаева[1], http://orcid.org/0000-0001-7725-2255
Бибинур К. Сыдыкова[2], https://orcid.org/0000-0002-7013-3461
Ернар Тұрсынбет[3], https://orcid.org/0000-0003-1871-1954

[1] **«Семей медицина университеті» КеАҚ, Семей қ., Қазақстан Республикасы;**
[2] **Қазақстандық медицина университеті «ҚДСЖМ» Алматы қ., Қазақстан Республикасы;**
[3] **«Ұлттық спорттық медицина және оңалту орталығы» ШЖҚ РМК, Астана қ., Қазақстан Республикасы.**

Кіріспе: Онкологиялық науқастарға паллиативті көмек-қатерлі ісіктің соңғы немесе дамыған сатысы бар науқастардың өмір сүру сапасын жақсартуға бағытталған қазіргі онкологияның маңызды құрамдас бөлігі. Ол ауырсыну, жүрек айну, шаршау және психологиялық бұзылулар сияқты белгілерді жеңілдетуге және пациенттерге де, олардың отбасыларына да эмоционалды және рухани қолдау көрсетуге бағытталған. Соңғы онжылдықтарда паллиативтік көмек жоғары мамандандырылған қызметтен бүкіл әлем бойынша денсаулық сақтау жүйелеріне көбірек енетін қатерлі ісік ауруларын емдеудің негізгі аспектісіне айналды. Маңыздылығына қарамастан, жоғары сапалы паллиативті көмекке қол жетімділік шектеулі болып қалады, әсіресе табысы төмен және орташа елдерде. Денсаулық сақтау жүйесі дамыған көптеген елдер паллиативтік көмек қызметтерінің қолжетімділігі мен сапасын арттыруда айтарлықтай жетістіктерге жетті, бірақ проблемалар, соның ішінде дайындалған мамандардың жетіспеушілігі, фрагментті қаржыландыру және өлім мен өмірдің соңына байланысты мәдени стигматизация сақталады.

Мақсаты: Онкологиялық науқастарға паллиативтік көмек көрсетудің халықаралық тәжірибесін сыни талдау, денсаулық сақтаудың әртүрлі жүйелерінде даму үшін сын-қатерлерді, проблемалар мен мүмкіндіктерді зерттеу болып табылады.

Іздеу стратегиясы: Онкологиялық науқастарға паллиативті көмек туралы әдебиеттерді шолу үшін келесі тәсіл қолданылады. Іздеу PubMed, Scopus, Web of Science және басқалары сияқты негізгі ғылыми дерекқорларда жүргізілді. Шолуға 2015-2025 жылдар аралығында жарияланған және онкологиялық науқастарға ересектерге паллиативтік көмек көрсетуге арналған рецензияланған мақалалар кірді. Паллиативтік көмекке қатысы жоқ немесе педиатрияға байланысты зерттеулер алынып тасталды. Іздеу тіл мен жарияланған күні бойынша (соңғы 10 жыл ішінде) кілт сөздер мен сүзгілердің тіркесімін қамтиды. Дереккөздердің ауқымын кеңейту үшін жеке мақалалардағы сілтемелер мен сарапшылардың деректері қарастырылды.

Нәтижелер мен қорытындылар: Әдебиеттерге шолу онкологиялық науқастарға паллиативтік көмек дамыған елдерде де, дамушы елдерде де әртүрлі модельдерді қолдану арқылы айтарлықтай өзгерістерге ұшырағанын көрсетеді. Жұмыс күшінің жетіспеушілігі, фрагментті қаржыландыру, дәрігерге уақтылы жолдама бермеу және опиоидтарға қол жетімділіктің шектелуі сияқты мәселелер бүкіл әлемде жалғасуда. Телемедицина және пәнаралық денсаулық сақтау топтары сияқты инновациялар медициналық көмектің қолжетімділігі мен сапасын жақсарту тұрғысынан перспективалы болды, бірақ оларды енгізу сәйкес келмейді. Дамыған елдердің интеграцияланған жүйелері бар, ал орташа табысы бар елдер нормативтік-құқықтық және ресурстық шектеулерге тап болуда.

Түйінді сөздер: *паллиативтік көмек, онкологиялық науқастар, паллиативтік көмек үлгілері, хоспистік көмек, ауырсынуды басу, паллиативтік көмектегі телемедицина.*

Дәйексөз үшін:
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Introduction

International experiences of palliative care for cancer patients reveal a diverse landscape shaped by varying healthcare systems, cultural contexts, and resource availability. Palliative care aims to improve the quality of life for patients with life-threatening illnesses, yet its implementation and integration differ significantly across regions [55]. This overview highlights key aspects of palliative care practices and challenges faced globally.

Palliative sedation is a critical component of end-of-life care for cancer patients, particularly in Europe. An international study involving Belgium, Germany, Italy, Spain, and the Netherlands focuses on monitoring discomfort and sedation levels to optimize patient comfort during palliative sedation [52].

The study underscores the need for standardized monitoring protocols to ensure effective sedation management and improve patient outcomes [52].

The Middle East Cancer Consortium emphasizes the importance of training and education for both formal and informal caregivers to enhance palliative care services. This approach aims to empower caregivers and improve decision-making processes for patients with advanced cancer [56].

Recommendations include national strategies to establish comprehensive palliative care services across all healthcare levels [56].

Integrated palliative care (IPC) models are being explored in Europe to address fragmentation in service delivery. These models aim to provide continuous and coordinated care, improving the quality of life for patients and their families.

The study of IPC initiatives in several European countries seeks to identify successful integration mechanisms and enhance palliative care practices [6].

While these studies highlight advancements in palliative care, challenges remain, particularly in regions with limited resources and infrastructure. The disparity in service availability and integration underscores the need for global efforts to expand and improve palliative care access, ensuring that all cancer patients receive compassionate and effective end-of-life care.

Aim. To critically analyze the international experiences in providing palliative care for cancer patients, examining the challenges, issues, and opportunities for development across different healthcare systems.

Search strategy. The following approach will be used for the literature review on palliative care for cancer patients. The search conducted in major scientific databases such as PubMed, Scopus, Web of Science, and others. The review include peer-reviewed articles published between 2015 and 2025, focusing on palliative care for adult cancer patients. Studies not related to palliative care or focused on pediatrics excluded. The search involve a combination of keywords and filters by language and publication date (last 10 years). To expand the scope of sources, references cited in selected papers and data from experts considered.

Search results and their discussion.

Clinical models of palliative care

Modern palliative care in oncology employs several complementary models of care, designed to address the diverse needs of patients. Specialized palliative care is developed through outpatient, inpatient consultative, inpatient specialized, home-based (home care), and hospice models. Each model is focused on a specific stage and condition of the patient [29]. For example, outpatient palliative care clinics serve as a key point for early access, enabling long-term patient support, symptom management, education, and future treatment planning. Inpatient consultative teams work in hospitals, providing expert management of acute symptoms in hospitalized patients and assisting with discharge planning and continued care. In cases of severe symptoms and complex situations, specialized palliative care units (or palliative care beds) in hospitals offer intensive, comprehensive care [50]. Home-based palliative care services (home team care) focus on patients with limited mobility and moderate symptoms, allowing assistance in the comfort of the home setting. Finally, hospices (including day hospitals and hospice-type hospitals) are primarily for patients in the final stage of the disease with an unfavorable prognosis, providing comprehensive care and support at the end of life. These five models complement each other and together form a continuous support system throughout the disease [27]. According to literature reviews, the optimal approach is a combined model: early integration of outpatient palliative care alongside oncological treatment, with enhanced support in the hospital or at home as the disease progresses. This approach, applied in countries like the UK, Australia, and others, is associated with reduced unnecessary hospitalizations, improved quality of life, and even some extension of patients' life expectancy [9]. Overall, accumulated international experience shows that flexible organization of palliative care – from hospitals to home – enables a wide range of needs of cancer patients to be met and ensures continuity of care [21].

Role of Multidisciplinary Teams

One of the cornerstone principles of palliative care is the multidisciplinary, or interdisciplinary, approach. Palliative care teams typically include physicians (specialized in palliative care or related fields), nurses, pain management specialists, psychologists, social workers, and often chaplains, volunteers, and other professionals [7]. Team-based palliative care allows specialists from various disciplines to jointly and comprehensively address the multidimensional needs of patients and their families—ranging from physical symptoms to psychological, social, and spiritual support [26]. Numerous studies confirm that the involvement of such a team can significantly improve pain and symptom control, reduce levels of anxiety and depression in patients, increase satisfaction with care, and enhance the overall quality of life [32]. For example, a meta-analysis showed that multidisciplinary palliative care significantly improves the quality of life of cancer patients and reduces their levels of depression and anxiety compared to standard approaches [37]. In clinical practice in developed countries, the team-based approach has become the standard: for instance, the American Society of Clinical Oncology (ASCO) officially recommends the involvement of a specialized interdisciplinary palliative care team for all patients with advanced cancers and high symptom management needs [53]. Similarly, in the United Kingdom, palliative care has historically been built on the collaboration between general practitioners, hospice specialists, and social services, ensuring a holistic approach to alleviating patient suffering. Multidisciplinary teams not only address diverse issues (pain, shortness of breath, nausea, emotional distress, family and spiritual matters) but also assist in making complex decisions, planning the next stages of care, and connecting patients with necessary resources [54]. Ultimately, the interdisciplinary approach enhances the effectiveness of palliative care and its ability to adapt to the unique needs of each patient. This approach is recognized globally as a key factor in the success of palliative programs [26].

Legislative Regulation and Healthcare Strategies

Legislative and regulatory measures over the past decade have played a crucial role in the development of palliative care, solidifying it as an integral part of healthcare systems. An international benchmark was set by the WHO Resolution 67.19, adopted in 2014, which called for all countries to strengthen palliative care as part of universal health coverage throughout life [43]. The resolution included recommendations for developing national policies, funding, workforce training, improving access to opioid analgesics, and integrating palliative care at all levels of healthcare delivery [23].

In response to this call, many countries have taken steps toward institutionalizing palliative care. In developed healthcare systems, palliative care was already largely integrated, but the last 10 years have seen new legislative initiatives and strategies. In the UK, the first national End-of-Life Care Strategy was adopted in 2008, outlining goals to expand hospice and palliative care within the NHS. Subsequent programs like "Ambitions for Palliative and End-of-Life Care" (2015–2020) have aimed to ensure equal access to end-of-life care. Although there is no separate law specifically for palliative care in the UK, regulatory support is provided through its inclusion in the guaranteed NHS package and government support for hospices. At the institutional level, the National Council for Palliative Care oversees policy, and clinical guidelines are developed by entities such as the National Institute for Health and Care Excellence (NICE) [57].

In Germany, a significant step was the adoption of the Federal Hospice and Palliative Care Act (HPG) in December 2015. This legislation officially included palliative care as part of standard services covered by mandatory health insurance, strengthening support for hospices and home care services. The law requires insurance funds to cover 95% of hospice costs (previously around 90%) and introduced mechanisms for quicker contract agreements between funds and home-based palliative care providers. Additionally, nursing homes are now required to collaborate with hospice services, and inpatient palliative care units are entitled to special reimbursement rates for treatment [40].

In Canada, the passage of the "Framework on Palliative Care in Canada Act" (2017) led to the publication of a comprehensive National Palliative Care Framework in 2018. This framework defined palliative care, established workforce training commitments, and addressed service development across settings (hospital, hospice, home, long-term care) [1]. In subsequent years, Canada's government implemented the Palliative Care Action Plan (2019), investing in hospice expansion, workforce education through Pallium Canada, and access monitoring systems [1].

In Australia, the government developed the National Palliative Care Strategy 2018, a unified plan coordinated between the federal government and states aimed at ensuring all Australians have access to quality palliative care for life-limiting illnesses. This strategy enshrines palliative care as a fundamental part of universal healthcare and sets goals for the next five years, including a monitoring system for implementation [20].

In the United States, although there is no single law guaranteeing palliative care for all citizens, regulatory measures have been introduced to promote its development. A key component is the Medicare hospice benefit, introduced in the 1980s, which covers hospice care for terminal patients over 65. In the last decade, several versions of the PCHETA (Palliative Care and Hospice Education and Training Act) have been presented to Congress, advocating for funding specialist training and research in palliative care. Furthermore, many states have enacted regulations requiring hospitals to inform patients about palliative care options or establish palliative care consultative services in large hospitals [53]. As a result of these policies, by 2019, 72% of U.S. hospitals with 50 or more beds had their own palliative care teams, a significant increase from approximately 53% in 2008 [63].

Overall, the experience of developed countries shows that governmental support and clear policies significantly accelerate the integration of palliative care into healthcare systems. National strategies or legislation (such as those in Germany and Canada) ensure funding, coordination of efforts, and the removal of barriers (e.g., access to opioid analgesics) [34]. However, even wealthy countries continue to face challenges—such as the mismatch between high end-of-life treatment costs and the average quality of palliative care in the U.S.—which highlights the importance of not only funding but also focusing the system on the needs of dying patients [63].

Funding of Palliative Care

The financial and economic models of palliative care organization significantly impact the accessibility and quality of services. International comparative analysis shows that in most countries, palliative care funding is mixed, combining resources from public (or insurance) systems, charitable organizations, and personal funds from patients [62]. Non-governmental sources continue to play a significant role – historically, hospices and palliative care services in many countries originated as initiatives by non-profit organizations and philanthropists and are still partially supported by charitable funds in many places. Meanwhile, government funding is gradually expanding but is rarely strictly tied to objective epidemiological needs, resulting in unevenness and gaps in the financing system [19].

For example, in the UK, considered one of the leaders in palliative care, the state covers about 83% of the costs for palliative consultations in hospitals, approximately 59% of the costs for home-based (domiciliary) care, around 30% of the expenses related to inpatient stays, and only about 23% of the costs for day hospice services. The rest of the financial burden is covered by charitable funds and donations, reflecting the historically established partnership between the NHS and the non-governmental sector in this field [21] .

In Germany, following the 2015 law, almost all basic hospice and palliative care services are financed by mandatory health insurance (statutory Krankenkassen). Insurance funds now reimburse 95% of the costs of inpatient hospices for adults (previously about 90%); additionally, they are required to cover not only personnel costs but also medications and materials for home hospice services. Special palliative care (SAPV) services at home are billed separately, encouraging outpatient providers to enter into contracts with insurance funds [40].

In Canada, funding for palliative care is a shared responsibility between provincial authorities and the federal government, with services for patients generally being free of charge under the universal healthcare system. However, until recently, the volume and quality of services varied significantly across provinces. The implementation of the 2018 National Palliative Care Framework implies federal funding for the development of home care services, training, and research initiatives [1].

In the United States, the funding model differs: hospice care for elderly patients is funded by the government through the Medicare program (fixed daily rates for patients with a life expectancy of six months or less), while palliative care teams for non-terminal patients are funded through regular sources such as insurance companies or directly by hospitals [42] . This has led to the wide development of hospices in the U.S. (in 2018, about 1.55 million patients received hospice services), while outpatient palliative care clinics and hospital-based consultative teams are funded differently, often through hospital budgets, charitable grants, or consultation fees [24]. Recently, new payment models have been developed in the U.S., aimed at promoting early palliative care – for example, pilot projects for simultaneous (concurrent) provision of palliative support alongside oncology treatment with separate payments. However, funding remains fragmented [60].

Australia and New Zealand primarily finance palliative care from public sources within their public health systems, but private charitable organizations (e.g., the Silver Chain Foundation in Australia) also contribute, particularly in the development of home services and hospices [25]. Overall, a common feature of palliative care funding in developed countries is the combination of government guarantees with support from the third sector. Experts note that payment mechanisms often do not reflect the actual workload of care and patients' needs. For example, funding may be based on fixed rates (per diem in hospices or DRG in hospitals) that do not differentiate patients by the complexity of their cases [49]. Modern studies call for improvements in funding models – introducing payment for the volume of care provided (e.g., by team activity or by needs indicators), avoiding incentives that lead to patient segregation or undesirable administrative decisions [19].

Innovative Technologies and Approaches

In recent years, there has been active implementation of technological and organizational innovations in palliative care, partially accelerated by the COVID-19 pandemic. One of the key trends has been the use of telemedicine in palliative care [4]. The emergence and widespread adoption of modern telecommunications have opened new opportunities for supporting patients who are at home or in remote areas [59]. Studies show that telehealth applications help expand the reach and effectiveness of palliative services, providing consultations and monitoring from a distance [28]. Telemedicine is used for video consultations between patients and palliative care doctors and nurses, remote symptom assessments, psychological support, as well as organizing teleconsultations among specialists (e.g., between oncologists and palliative care experts) [22]. A separate development is telepharmacy, which involves remote monitoring of prescription management and medication intake, particularly relevant for pain management and symptom therapy [39].

A comprehensive 2024 review notes several advantages of telepalliative care: it increases patient access to experts (especially in rural and hard-to-reach areas), reduces the need for exhausting trips for seriously ill patients to clinics, and allows for prompt responses to changes in the patient's condition [35]. At the same time, challenges arise, including the need to train elderly patients in using video communication, ensuring confidentiality and quality of communication, and maintaining the "human" aspect of care when contact is mediated remotely [28].

The COVID-19 pandemic in 2020–2021 dramatically accelerated the adoption of telemedicine: in many hospitals and hospices around the world, the forced shift to remote consultations (due to lockdowns and the risk of infection) proved the viability of this format. After the pandemic, many elements of telecare remained part of routine practice, becoming an important complement to in-person visits [38]. For instance, in the UK and Canada, protocols for remote symptom monitoring for cancer patients receiving palliative care have been developed, while in the USA, the Palliative Care Quality Collaborative (CAPC) issued recommendations on organizing telepalliative visits [15].

In addition to telemedicine, other innovations are emerging in palliative care. The use of mobile applications and wearable devices to track symptoms and medication intake is growing, providing real-time data on patient condition [36]. Some centers (e.g., in Australia) have introduced electronic alert systems to notify palliative care teams about patients admitted to the hospital with an exacerbation of cancer, allowing timely consultation. Automated prescribing systems (triggers) based on electronic health records are being used for the timely referral of patients to palliative care services when certain criteria are met (e.g., repeated hospitalizations, tumor progression) [41]. It is also worth mentioning the development of online educational platforms and resources for caregivers – in recent years, numerous websites and courses have emerged, teaching caregivers palliative care skills at home, psychological support, and legal aspects (such as guardianship, wills, etc.) [44]. These resources are actively developing in Canada and Australia with government support. Finally, experiments with artificial intelligence technologies are beginning to penetrate the field of palliative care, such as using AI for predicting patient needs or identifying hidden symptoms based on voice and video data, although this is still in the research phase [58].

Thus, innovative technologies complement traditional palliative care models, enhancing accessibility, flexibility, and personalization. The key task for the coming years is to develop an evidence base and standards for the application of these technologies (especially telemedicine) in palliative care to maximize their benefits and minimize potential risks. The development of policies and protocols in this area will determine the further trajectory of innovation implementation in palliative care practices [28].

Features of Developed and Developing Countries: Comparison and Trends

Countries with highly developed healthcare systems have accumulated extensive experience in organizing palliative care, which can serve as a benchmark for the rest of the world. For example, the United Kingdom is traditionally recognized as one of the leaders: in 1967, the first modern hospice (St. Christopher's Hospice) opened there, and today the UK ranks first in the world in terms of quality end-of-life care. The British model is characterized by a wide network of hospices (many of which are charitable but receive significant support from the National Health Service), as well as the integration of palliative care teams into hospitals and clinics nationwide. High standards of training, the presence of clinical guidelines (such as those by NICE), and public support for the hospice movement have helped the UK secure its leadership position [16].

Australia and New Zealand are also consistently among the countries with the best palliative care; in the 2021 global ranking, Australia received the highest grade (Grade A), ranking 4th out of 81 countries evaluated. This reflects the success of national strategies, a strong primary care system (where general practitioners participate in palliative care), and attention to rural regions through telemedicine and home care services [10].

Germany has significantly expanded access to palliative care over the past decade. Legislation guarantees funding, and the country has dozens of hospices and specialized units within hospitals. The SAPV (Specialized Outpatient Palliative Care) system ensures the management of seriously ill patients at home across all federal states.

The United States demonstrates a combination of advanced experience and certain shortcomings: on the one hand, many large cancer centers (e.g., MD Anderson, Memorial Sloan Kettering) have exemplary palliative care integration programs, and numerous studies and innovations come from the U.S.; on the other hand, access to services across the country is uneven, and due to funding peculiarities, there is often an emphasis on expensive treatment until the very end, which impacts the average quality of dying (the U.S. ranks in the middle of global rankings) [12].

Canada's approach is similar to that of the UK, although regional differences exist due to its geographical and federal structure. Overall, all of the mentioned developed countries have national policies, specialized training for doctors and nurses, a wide range of care models (hospital, outpatient, home, hospice), and a focus on early palliative care for cancer patients. Their experience confirms the effectiveness of integrated palliative care: for example, in the UK, there has been a decrease in the proportion of cancer patients dying in hospitals, with an increase in the number of those who can spend their final days at home or in a hospice, which aligns with many patients' preferences. In Germany, the 2015 legislative changes led to an increase in home care services and better coordination between hospitals and hospices [51].

In the U.S., from 2015 to 2019, the coverage of hospitals with palliative care teams increased from 67% to 72%, and the number of hospitalizations accompanied by palliative consultations also increased significantly, linked to efforts by associations to implement quality standards. In Canada, after the launch of the national framework in 2018, there has been increased access to hospices and expanded home care programs, particularly in Indigenous communities and remote areas [31].

Australia reports the implementation of national palliative care standards and the development of outcome measurement systems (e.g., national palliative care indicators monitored by the Australian Institute of Health and Welfare). Thus, developed countries demonstrate that political will and investment in palliative care lead to tangible improvements in clinical practice and patient satisfaction [64].

Progress in palliative care also exists in middle-income countries, but it is more fragmented. According to estimates by WHO and the World Hospice Alliance, 80% of the global need for palliative care is in low- and middle-income countries, but only about 4% of that need is met there. In other words, the overwhelming majority of patients in these countries still do not receive adequate pain relief and other symptom management. While affluent countries meet about half of the needs of the seriously ill (50% of the need), in less wealthy regions, palliative care is often still in its infancy [61].

In countries such as Iran, India, and some African states, palliative care is not yet systematically integrated: services are provided sporadically, covering a narrow circle of patients, and are not effectively incorporated into national healthcare systems [48]. National programs or policies in this area are often absent, access to opioid analgesics is limited due to regulatory barriers, and the training of medical staff is sparse [8], [18].

Nevertheless, the last decade has seen positive shifts. Several middle-income countries have become pioneers at the regional level. For example, Malaysia has incorporated palliative care into its healthcare strategy, developing it at oncology centers, which has enabled services to be provided in some areas of the country. South Africa, one of the leading African countries, has established several hospice care centers, partially relying on NGOs and international support [47]. In Eastern Europe, countries such as Poland, Romania, and Russia have increased the number of hospices and home care teams in recent years, largely due to the enthusiasm of individual organizations and support from churches or philanthropists.

Latin America is also showing progress: in Chile, palliative care for cancer patients was recognized as a patient right in 2020 and included in the guaranteed health coverage package, while Colombia and Argentina are developing national training programs for palliative medicine doctors [14]. Many middle-income countries are adopting WHO's 2014 recommendations, adapting the public health model in the development of palliative care, which includes six key components: political support, funding, workforce training, access to medications, service delivery systems, and monitoring/research [2].

However, significant challenges remain. According to international estimates, there is a shortage of at least 2 million trained specialists globally, with this shortage most acutely felt in middle- and low-income countries [17]. The issue of access to opioid analgesics also remains problematic: despite the easing of some international regulations, in several countries, strict control and concerns over prescribing morphine have led to a decrease in average morphine consumption – from 6 mg per person in 2014 to about 4.5 mg in 2021 (per capita in the hypothetical patient). This indicates insufficient removal of barriers to pain relief [46].

Nonetheless, there is a growing understanding that palliative care is an essential component of the healthcare system, even with limited resources. WHO urges countries to include palliative care in universal health coverage programs and train primary care physicians in basic palliative care skills (the concept of primary palliative care in clinics) [5].

In middle-income countries, the most realistic and sustainable strategy is to develop palliative care at the primary care level – trained general practitioners and nurses can provide basic care, bringing in specialists for more complex cases. This model has been successfully tested in certain provinces of South Africa and India (Kerala state) [45], [11]. On a global scale, ten years after the WHO resolution, experts express disappointment at the pace of progress: according to the World Hospice Alliance, only about 14% of the estimated 60 million people who need palliative care annually receive it [30].

Nonetheless, positive shifts are undeniable – palliative care has firmly entered the global health agenda as a crucial area related to human rights and the right to a dignified life until the end. Accelerating the development of palliative care in middle- and low-income countries is possible with the activation of political will, international support, and the removal of key barriers (regulatory, educational, financial) [13].

Promising trends include expanding social and volunteer support, involving communities and family members in care, creating national palliative care plans (as Kenya and Bangladesh have done in recent years), and integrating palliative care into existing structures, such as oncology clinics and chronic disease services [3].

Conclusion

The international experience of the last decade convincingly demonstrates that palliative care for adult cancer patients is an essential component of modern oncology and healthcare in general. Developed countries have formed comprehensive clinical models that cover patients at all stages – from outpatient management right after the diagnosis of terminal cancer to home and hospice care in the final stages. Multidisciplinary teams have become the gold standard, providing a holistic approach to patients and their families, improving symptom control, and reducing the burden on the system (more rational use of hospitalizations, preventing crisis situations) [33].

The development of palliative care heavily depends on effective government policies and funding: where palliative care is recognized as a priority (either legislatively or strategically) and is adequately funded, there is a significant increase in services and improved end-of-life quality indicators. On the other hand, gaps in funding and policy absence lead to fragmentation and inequity in access.

Innovations – from telemedicine to new organizational approaches – open new horizons, making palliative care more accessible and convenient for patients, especially in the era of digitization and the lessons learned from the pandemic. The main challenge of the new decade is to spread the successes of palliative care worldwide, overcoming the gap between rich and poor countries. Despite serious challenges (workforce, financial, infrastructure), there is a clear understanding of the way forward: integrating palliative care into healthcare systems, training every doctor in the basics of palliative care, ensuring access to key medications (morphine must stop being a luxury), and engaging society in supporting vulnerable patients. Palliative care, which originated as a humanitarian initiative, has today become an integral part of evidence-based medicine and human rights. The international review shows that with political will, proper planning, and compassion, the suffering of millions of cancer patients can be significantly alleviated, giving them and their families dignity, comfort, and support during the most difficult time of life.

Conflicts of interest

There are no conflicts of interest.

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Ethical Standards

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Information about the authors:

Aigerim Mukusheva, PhD student in the 2nd year the Department of Public Health, NCJSC “Semey Medical University,” Semey, Republic of Kazakhstan; e-mail: aigerim.mukusheva@smu.edu.kz; Cell phone: +77076087273; https://orcid.org/0000-0002-7046-4375

Zaituna Khismetova – Candidate of Medical Sciences, Professor, Head of the Department of Public Health, NCJSC “Semey Medical University,” Semey, Republic of Kazakhstan; e-mail: zaituna.khismetova@smu.edu.kz; Cell phone: +77772582681; ORCID: https://orcid.org/0000-0001-5937-3045.

Nazym Iskakova – PhD, Lecturer at the Department of Public Health, NCJSC “Semey Medical University,” Semey, Republic of Kazakhstan; e-mail: nazym.iskakova@smu.edu.kz; Cell phone: +77751030454; ORCID: https://orcid.org/0000-0001-5631-5499;

Dinara Serikova-Esengeldina – PhD, Lecturer at the Department of Public Health, NCJSC “Semey Medical University,” Semey, Republic of Kazakhstan; e-mail: dinara.esengeldina@smu.edu.kz; Cell phone: +77785886986; ORCID: https://orcid.org/0000-0002-9470-9488;

Aliya Atabayeva – PhD, Lecturer at the Department of Public Health, NCJSC “Semey Medical University,” Semey, Republic of Kazakhstan; e-mail: aliya.atabayeva@smu.edu.kz; Cell phone: +77753900269; ORCID: https://orcid.org/0000-0001-7725-2255;

Bibinur Sydykova, PhD, Head of the Department of Epidemiology, Evidence-Based Medicine and Biostatistics
Kazakhstan Medical University "KSPH", Almaty, Republic of Kazakhstan e-mail: bibinursk@gmail.com; Cell phone: +77751760441; https://orcid.org/0000-0002-7013-3461

Yernar Tursynbet, PhD, Deputy General Director, National Centre of Sports Medicine and Rehabilitation, Astana, Republic of Kazakhstan, e-mail: yernartursynbet@gmail.com., Cell phone: +77012185298; https://orcid.org/0000-0003-1871-1954

Corresponding Author:

Aigerim A. Mukusheva - PhD student in the 2nd year the Department of Public Health, NCJSC “Semey Medical University” Semey, Republic of Kazakhstan

Postal Address: Republic of Kazakhstan, 071400, Semey, Abay St., 103.

E-mail: aigerim.mukusheva@smu.edu.kz

Phone: +7 7076087273