

EAPC Atlas of Palliative Care in the European Region 2025

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Fernanda Bastos, Laura Monzón, Daniela Suárez, Juan José Pons and Carlos Centeno.



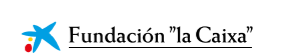
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DESIGN AND PRODUCTION

Errea (www.somoserrea.es)

COVER ILLUSTRATION

María Expósito

EDITORIAL

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SUBJECTS

Palliative Care | Hospice Care | Atlas European Region, EURO

SUGGESTED CITATION

APA style: Garralda, E., Tripodoro, V. A., Ling, J.; Brennan, J., Montero, Á., Bastos, F., Monzón, L., Suárez, D., Pons, J. J., & Centeno, C. (2025). *EAPC Atlas of Palliative Care in the European Region 2025*. Pamplona: EUNSA.

Vancouver style: Garralda, E., Tripodoro, V. A., Ling, J.; Brennan, J., Montero, Á., Bastos, F., Monzón, L., Suárez, D., Pons, J. J., & Centeno, C. (2025). *EAPC Atlas of Palliative Care in the European Region 2025*. Pamplona: EUNSA.

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The study included 56 countries and territories from the European region (EURO) according to the World Health Organization: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kosovo, Kyrgyzstan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Monaco, Montenegro, The Netherlands, North Macedonia, Norway, Poland, Portugal, Republic of Moldova, Romania, the Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Türkiye, Turkmenistan, Ukraine, United Kingdom, Uzbekistan and Vatican City.

DL NA 1029-2025 | ISBN 978-84-313-4034-6

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Introduction

Palliative care (PC) is integral to universal health coverage (UHC) as it alleviates suffering and enhances the quality of life. However, its accessibility and integration into European healthcare systems remain inconsistent even when its need is estimated to be approximately affecting 4,279,278 people every year (66,114 children). Evaluating PC development based on the new WHO conceptual framework offers critical insights into health system capacities, especially in addressing serious health-related suffering.

Objectives

This study aimed to depict the current situation of PC health policies, services, emphasising integration into health systems, including paediatric care, professional training programs, access to opioids and essential medicines, research and community empowerment. The ultimate goal was to identify gaps, foster advocacy, and support the inclusion of PC within UHC frameworks and benefits packages.

Methodology

The methodology for this project was refined from previous editions and followed several steps. First, **Building Networks of National Informants** involved forming a network of consultants from key organisations like national PC associations and experienced in-country informants. Consultants were selected based on expertise in PC and validated the data gathered. Second, the **set of WHO indicators were adapted to the European context** through an international workshop held in Barcelona. Third, **data Collection through the E-Course** utilised a free online course accredited by the University of Navarra, where consultants completed modules that introduced PC development dimensions and indicators, providing figures and narrative justifications and supporting documents for their responses. The fourth step, **analy-**

sis involved conciliation (compiling and harmonising in ATLANTES the diverse data from consultants with available literature to create country reports), **validation** (incorporating quantitative and qualitative data validated by the consultants in one single country report per country), and **endorsement** of validated reports by the national PC associations (when existing). Finally, the fifth step was the **comparative analysis** of indicators and resulting country reports presented in this EAPC Atlas of Palliative Care in Europe 2025.

Results

A potential network of European informants was built with around 791 in-country informants, most of which (n=524), had participated in a variety of EAPC publications including previous Atlases. In total, 200 in-country experts participated in the study (105 completed the accredited online e-course and 95 completed the e-survey), from 52 countries (3.57 participants per country on average, min 1-max 13). Only four countries failed to report data and were built based on AI tools and available literature: Azerbaijan, Vatican City, Tajikistan and Turkmenistan. Country reports were validated by the vast majority of participants for 49/56 countries (88%), and, furthermore, out of the 39 countries with a national PC Associations, 35 (91%) were endorsed.

This study identified 7,119 specialised PC services (median=24), corresponding to a median of 0.96 services per 100,000 inhabitants; and 524 paediatric services available in 41 countries (median=2.5) across the region. The consumption of opioids per million inhabitants per day ranged between less than 500 S-DDD in Central Asia to over 5,000 Statistically Defined Daily Dose (S-DDD) in Western Europe; being the regional median 2,983 S-DDD, and the average 4,959 S-DDD. The list of the WHO essential medicines is readily available in primary care at over 60% of

European countries, while Immediate Release (IR) oral morphine fully available in primary care in 50% of the countries. Thirty countries reported some sort of official accreditation of palliative medicine for physicians, 21 of which recognised PC as a specialty or sub-specialty. Nineteen countries and 21, respectively, reported mandatory teaching of PC in the majority of the country's medical and nursing schools, and the region accounts for 121 full PC professors distributed in 23 countries (35 in the UK, 15 in the Netherlands and 14 in Germany). Regarding policies, 43/56 countries (76%) have included PC in the list of health services provided at the primary care level: 31 through the General Health Law, some more 12 through a government decree or law. There is a stand-alone national strategy in 21 countries, while in 12 additional countries it is included within other national plans, such as cancer, NCD, or general health plans, through a dedicated section. Just 13 countries report a well-defined and structured (scientific & technical) coordinating entity for PC within the Ministry of Health and only nine have developed a national PC law.

Nearly a 60% of European countries (n=33) documented at least one national conference specifically dedicated to PC every year, with multidisciplinary attendance, accessible for professionals from remote areas, and paediatric topics included. Estimations pointed out a high PC research production in 19 countries, 8 of which reporting very high rates and, coincidentally, existing PC-specific national research calls. There is a generalised and strong national and sub-national presence of PC advocacy and promoting patient rights in 33 countries (60%), and 16 countries report the existence of guidelines or policies on Advance Care Planning, while some eight report living wills and another eight, surrogate decisionmakers.



Conclusion

This fourth edition of the EAPC Atlas of Palliative Care in Europe 2025 highlights a situation where, despite noticeable progress since the last Atlas, limited provision of services, and limitations to essential medicines and PC education persists. Likewise, sub-regional patterns are still strongly correlated to countries' income levels and geographic distribution.

Way forward

The Atlas findings highlight key priorities and opportunities to strengthen PC across the European region, emphasising health policies, service provision, access to medicines, research, education, and community empowerment. Utilising WHO indicators to establish continuous monitoring mechanisms and involving more countries is deemed critical for advancing PC development.

Recommendations for successful implementation include creating national PC strategies, incorporating PC into UHC packages, and expanding service availability with a focus on home-based and primary healthcare programs. Ensuring access to essential PC medications, enhancing PC education in medical training, fostering research, promoting peer learning, and empowering communities to advocate for PC services are essential steps toward progress. ●

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Presentation

EU Foreword



Jeroen Hasselaar

President of the European Association
for Palliative Care

EAPC Atlas of Palliative Care in the European Region 2025

The world needs palliative care more than ever as increasing numbers of people require such care. The European region is home to about 750 million people. The World Health Assembly resolution 67.19, 'Strengthening palliative care as a component of comprehensive care throughout the life course' was passed in 2014. This called on nations to improve access to all that need it. Over a decade later the vast majority of those who need palliative care predominantly in low- and middle-income countries, still do not have access to it. The EAPC believes and advocates for access to palliative care to be a fundamental human right.

The EAPC supports member states in their efforts to achieve the best palliative care. Using the WHO regional classification, about 17,9% of adults are in need of palliative care in the European Region (EURO). This need relates to malignant neoplasms (cancers) (40%), cerebrovascular diseases (14,9%), dementia (18%), and lung diseases (11,3%), amongst others. Nations in the region are at different stages of developing palliative care to be included as universal health care within their health systems.

In 2021, the WHO published *Assessing the development of palliative care worldwide: a set of actionable indicators* coordinated by the ATLANTES Global Palliative Care Observatory. The indicators build on previous work to identify key components that form the provision and implementation of a public health policy approach and allow a mechanism to identify strengths and challenges of a national approach to developing and implementing a national palliative care strategy.

The EAPC welcomes this new Atlas on palliative care in Europe. It aligns closely with our strategic objectives and our vision for equitable and accessible palliative care for all. We hope that it will find its way to professionals, policymakers, researchers and the broader public to improve palliative care across Europe. ●



“The EAPC welcomes this new Atlas on palliative care in Europe. It aligns closely with our strategic objectives and our vision for equitable and accessible palliative care for all”

EU Foreword



Julie Ling

Technical Officer, Health Workforce and Service Delivery Unit, World Health Organization, European Regional Office, Copenhagen, Denmark

The WHO European region

The ATLANTES team at the Global Observatory of Palliative Care at the University of Navarra is a World Health Organization (WHO) Collaborating Centre. Their work with WHO focuses on the mapping of palliative care development globally, with specific attention to each region. This collaboration has contributed to the production of this fourth edition of the European Association for Palliative Care (EAPC) Atlas of Palliative Care in Europe.

The World Health Organization Regional Office for Europe (WHO/Europe), based in Copenhagen, is one of six WHO regional offices. It supports 53 Member States across Europe and Central Asia in improving public health and achieving better health outcomes for all. It is estimated that each year, 9 million people in the European Region require palliative care—yet access remains a significant challenge. Palliative care is a vital component of Universal Health Coverage (UHC) and of human rights-based health systems.

In the WHO European Region, with a population of approximately 750 million people, the provision of palliative care is marked by significant diversity in access, quality, and integration into national health systems. The data presented in this latest edition of the EAPC Atlas includes original data from 49 countries, supplemented by relevant literature for the remaining countries and territories. It offers a comprehensive, comparative, and evolving picture of the state of palliative care in Europe.

As the Technical Officer for Palliative Care at the WHO Regional Office for Europe, I recognise the important role of the Atlas as both a reference document and an advocacy tool. The ATLANTES team has introduced a new meth-

odology, utilising established WHO palliative care indicators, enhanced data collection techniques, and multiple stages of validation. This process increases the reliability of the data and enables comparisons with previous editions (2007, 2013, 2019). Together, these editions offer a unique longitudinal overview of palliative care development in the region.

The Atlas provides detailed information on key dimensions of palliative care systems, as defined by WHO indicators: the empowerment of people and communities, the development of health policies, access to essential medicines (including morphine), the expansion of research and education, and the provision of specialised services. The inclusion of country-level profiles enables policymakers, researchers, and advocates to identify both areas of progress and critical gaps across the region.

Finally, I would like to thank the ATLANTES team for their work on this important resource. It will serve as a valuable tool to inform and support Member States in their efforts to integrate palliative care into all levels of health care, ensuring that no one in Europe is left behind in the face of serious illness. ●



“In the WHO European Region, with a population of approximately 750 million people, the provision of palliative care is marked by significant diversity in access, quality, and integration into national health systems”

EU Note from the authors

Evaluating the development of PC in countries provides a vital lens through which to assess the capacity of health systems to address the multifaceted needs of individuals experiencing Serious Health-Related Suffering (SHS). PC represents a cornerstone of UHC by focusing on alleviating suffering and improving quality of life, yet its integration and accessibility remain uneven across regions.

To accomplish a thorough evaluation, it was imperative to identify reliable indicators and methodologies capable of monitoring the breadth and impact of health policies on PC service provision. This includes measuring the integration of these services into broader health systems, the availability of paediatric palliative care (PPC), the development of undergraduate professional training programs, the accessibility and appropriate use of opioids and essential palliative medicines, and the empowerment of individuals and communities who benefit from these resources. These indicators serve as tools for analysis and reflect health systems' commitment to equity and inclusivity in care delivery.

This publication is the fourth edition of the EAPC Atlas, an achievement that sheds light on the current state and historic trends of PC in these countries and territories. The project was coordinated under the leadership of the EAPC with valuable collaboration from various stakeholders. The extensive data collection process aimed to compile actionable insights and define evidence-based strategies to enhance the study's impact, fostering advocacy efforts for the comprehensive inclusion of PC services in UHC frameworks and health benefits packages across the region.

The ATLANTES Global Observatory of Palliative Care, based at the University of Navarra, played a pivotal role in designing the evaluation process and compiling this report. This Atlas offers a unique and indispensable tool for understanding PC development in the European Region by systematically assessing resources, strengths, and opportunities. The insights from the selected indicators provide decision-makers with essential information to prioritise healthcare needs, address policy gaps, allocate resources effectively, and strengthen healthcare activities.

Beyond supporting decision-making, measurement also drives improvement. By standardising and tracking indicators, we can elevate the quality of PC services, raise awareness about its importance, mobilise essential resources, and foster greater transparency. All these efforts align with global UHC objectives, significantly reducing health inequities and improving access to care for vulnerable populations. The indicators proposed in this report not only serve as benchmarks for progress but also hold the potential to align with global Primary Health Care (PHC) measurement frameworks, enriching national and regional health planning efforts.

The report is structured to provide a detailed analysis and practical tools for action. The first section offers a comprehensive overview of each PC component, presenting comparative data to highlight existing gaps and opportunities for improvement in the short term. Country comparisons facilitate benchmarking, helping policymakers and stakeholders draw meaningful conclusions to guide future initiatives. In the second section, infographics are featured for each country and area, serving as visually engaging tools to support decision-making, promote innovative approaches, and strengthen advocacy for PC integration.



“Beyond supporting decision-making, measurement also drives improvement. By standardising and tracking indicators, we can elevate the quality of PC services, raise awareness about its importance, mobilise essential resources, and foster greater transparency”

EU Note from the authors

The work encapsulated in this Atlas reflects a collaborative and multidisciplinary effort. It establishes a baseline for developing a regional PC monitoring system, enabling periodic evaluations to track progress. The country-specific data in this publication result from meticulous data collection, drawing from available liter-

ature, contributions from national leaders and consultants, and consultations with WHO country offices and International, Regional and National Associations of Palliative Care. These efforts ensured depth and contextual accuracy, with findings reviewed and endorsed by key stakeholders. ●



ATLANTES Global Observatory of Palliative Care, from left to right: Juan José Pons, Álvaro Montero, Fernanda Bastos, Daniela Suárez, Vilma Tripodoro, Laura Monzón, Carlos Centeno, Eduardo Garralda and Jesús López Fidalgo.

EU Network of collaborators

On behalf of the project team and their supporting institutions, we express our gratitude to the organisations, institutions, associations, and professionals who made this project possible by contributing valuable time to provide information, feedback, and support. The following individuals participated in the training process and completed the survey as consultants or as reviewers, providing essential information on the development of PC in their respective countries and territories.

A potential network of European informants was built with around 791 in-country informants, most of which (n=524), had participated in a variety of EAPC publications including previous Atlases. In total, despite failing to find informants in four countries (where reports were built based on Artificial Intelligence tools and available literature), 200 in-country experts participated in the study: 105 completed the accredited online e-course and 95 completed the e-survey or thoroughly reviewed the reports. ●

TABLE 1. Collaborators who participated as key informants for their respective countries/territories and country's representatives

Country	Name	Organisation
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	Sophie Aupet	National end-of-life platform
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	Caroline Tete	French Society for Palliative Care Support
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	Ana Carvalho	Compassionate Community
	Marília Dourado	University of Coimbra
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	Ana Ramos	Nursing School of Lisbon
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	Vadim Pogonet	Institute of Oncology, Republic of Moldova
Republic of North Macedonia	Lazo Jordanovski	Specialised hospital for geriatric and palliative medicine 13 November
	Lidija Veterovska Miljkovic	Macedonian gerontology institute
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	Căruntu Adriana	National Palliative Care Association (ANIP)
	Malina Dumitrescu	National Palliative Care Association (ANIP)
	Flavia Hurducas	Hospice Casa Sperantei
	Nicoleta Mitrea	Hospice Casa Sperantei
	Ancuta Camelia	Hospice Casa Sperantei
Russia	Diana Nevzorova	Hospice Care Professionals Association
	Veronika Andreyevna Belova	Hospice Care Professionals Association
San Marino	Daniele Battelli	Ospedale de Stato
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Serbia	Tomi Kovacevic	Institute For Pulmonary Diseases of Vojvodina Sremska Kamenic
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	Mateja Lopuh	General Hospital Jesenice
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	Erika Zelko	Public Health Care Centre, Ljubljana
	Andrej Žist	Slovenian Palliative Care Society
	Marjana Bernot	Slovenian Palliative Care Society
	Petra Gornik	Slovenian Palliative Care Society
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	Katja Kusek	Slovenian Palliative Care Society
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	Javier Resa	Hospital Hestia-Madrid
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	Confidential	Members of the Association for Palliative Medicine of Great Britain and Ireland
Uzbekistan	Norbaev Rustambek	Children Hospice Taskin

EU The Atlas project

The EAPC Atlas of Palliative Care in Europe 2025 is an initiative led by the European Association for Palliative Care (EAPC) and implemented by the ATLANTES Global Observatory of Palliative Care at the Institute for Culture and Society, University of Navarra (Spain). In 2022, ATLANTES was designated as a WHO Collaborating Centre for the Global Monitoring of Palliative Care Development, and the Atlas project forms part of its official work plan as a Collaborating Centre.

Since 2022, ATLANTES—under the leadership and coordination of international palliative care associations—has conducted the Global Study on the Development of Palliative Care in every country of the world, using the methodology based on the WHO's 2021 technical report *Assessing the Development of Palliative Care Worldwide: A Set of Actionable Indicators*.

The project benefits from the collaboration and scientific guidance of the International Association for Hospice and Palliative Care (IAHPC), the Worldwide Hospice Palliative Care Alliance (WHPCA), and the World Health Organization, particularly through its Regional Offices for Europe (EURO).

The ATLANTES Global Observatory of Palliative Care at the University of Navarra coordinated the development of this project, with Eduardo Garralda, Laura Monzón and Vilma Tripodoro serving as project leads. The core technical team was composed of Álvaro Montero, Fernanda Bastos, Daniela Suárez, Eduardo Garralda, Juan José Pons and Carlos Centeno. We also counted on the essential support of Julie Ling, former CEO of the European Association for Palliative Care (EAPC), and Joanne Brennan, current CEO.

The project was carried out under the supervision and guidance of key collaborators from the World Health Organization, including Julie Ling (WHO Europe), and Megan Doherty (WHO Headquarters, Geneva, Department of Service Delivery and Safety).

We are deeply grateful to the members of our Advisory Board for their invaluable guidance throughout the development of this Atlas. Their expertise and insight were instrumental in shaping this project. Our sincere thanks go to:

- Megan Doherty and Marie-Charlotte Bouésseau (WHO Geneva)
- Julie Ling (WHO EURO)
- Issimouha Dille Mahamadou (WHO AFRO)
- Lamia Mahmoud and Nahla Gafer (WHO EMRO)
- Mark Stoltenberg (Massachusetts General Hospital)
- Liliana De Lima, Katherine Pettus, and Hibah Osman (IAHPC)
- Emmanuel Luyirika and Eve Namisango (APCA)
- Stephen Connor (WHPCA)
- Joanne Brennan and Christine Harvey (EAPC)
- Julia Downing (ICPCN)
- José Luis Pereira (ICS–University of Navarra)
- Daniel Cobos Muñoz (Swiss Tropical and Public Health Institute Basel, Switzerland)

EU The institutions involved

THE EUROPEAN ASSOCIATION FOR PALLIATIVE CARE (EAPC)

Joanne Brennan



Established in 1988, the EAPC is a membership organisation committed to supporting the promotion and development of palliative care throughout Europe and beyond. Recognised by the Council of Europe, the EAPC aims to speak with 'one voice and one vision' on matters that are important in palliative care. To do so, we recognise the definition of palliative care set out by the World Health Organisation.

Respectful of the cultural and political diversity of our members, the EAPC provides a forum for all of those either working or with an interest in palliative care. The EAPC works in close collaboration with our members, research partners and other European and international agencies. Through our significant networks, we advocate, anticipate and proactively shape EU health and research policies on palliative care issues. We raise awareness about palliative care and the value and benefits it can have for individuals, healthcare services and communities.

The EAPC represents and is open to members from associations and individuals in Europe and throughout the world. Members are engaged in palliative care across the lifespan and trajectories from a range of perspectives: specialist and generalist clinical practice, professional groups and public, education, advocacy, and research.

Strategic Objectives

Organisational

Be an effective, multiprofessional and sustainable membership organisation, based in Europe.

Education

- Contribute to the development and progression of PC competence and education.
- Increase PC awareness, knowledge and literacy for professionals, volunteers and society in general.

Research

- Build research and development capacity in PC.
- Facilitate and support palliative care research.
- Promote evidence informed PC practice.
- Disseminate palliative research findings.

Advocacy

- Facilitate and encourage palliative care leadership nationally and internationally.
- Lobby for the growth and integration of palliative care within health and social care systems.
- Champion equitable, appropriate and timely access to palliative care.
- Promote the integration of the patients and those close to them as well as public perspectives in palliative care practice, research and policy developments.
- Be actively involved in discussions with partners, shaping the definition of what palliative care is now and should be in the future.
- Support global advocacy organisations and other initiatives seeking to develop palliative care.
- Promote capacity building in palliative care through strong international partnerships.
- Collaborate with affiliated organisations and seek opportunities to foster new partnerships.

ATLANTES GLOBAL OBSERVATORY OF PALLIATIVE CARE

WHO Collaborating Centre for the Global Monitoring of Palliative Care Development
Prof. Carlos Centeno, Director



The ATLANTES Global Observatory of Palliative Care is committed to promoting the global development of palliative care (PC) with the aim of improving the quality of life of individuals facing serious and life-limiting illnesses. Through a combination of scientific research, international collaboration, and knowledge dissemination, ATLANTES seeks to integrate palliative care into health systems worldwide, ensuring its accessibility and sustainability.

As part of the Institute for Culture and Society at the University of Navarra (Spain), ATLANTES brings together a multidisciplinary team of researchers and professionals specialising in medicine, social sciences, public health, bioethics, and policy analysis. The observatory works closely with international experts, professional organisations, and policymakers to generate and translate evidence into actionable strategies.

EU The institutions involved

A central aspect of ATLANTES' work is fostering a positive perception of palliative care in both society and the medical profession. The observatory promotes a patient-centred approach based on the principles of human dignity, holistic support, and respect for the natural course of life. This includes not only medical care but also the psychosocial, emotional, and spiritual dimensions of well-being.

Since 2022, ATLANTES has been designated as a WHO Collaborating Centre for the Global Monitoring of Palliative Care Development, taking on specific commitments aligned with the World Health Organization's mission. These responsibilities include:

1. Evaluating and monitoring the development of palliative care services globally, using evidence-based methodologies to track progress and identify gaps in access and quality. This is carried out through regional and global Atlases, offering a comprehensive analysis of palliative care integration in different health systems.
2. Disseminating key findings and data to inform policymakers, health authorities, and stakeholders, ensuring that palliative care becomes an integral part of national and international health planning.
3. Providing strategic guidance for the advancement of palliative care, by assessing trends, challenges, and policy frameworks that influence its implementation and sustainability.

As part of these efforts, ATLANTES collaborates closely with leading global institutions, including the World Health Organization (WHO), the International Association for Hospice and Palliative Care (IAHPC), the Worldwide Hospice Palliative Care Alliance (WHPCA), and regional palliative care networks.

By fulfilling these commitments, ATLANTES contributes to WHO's overarching goal of ensuring that palliative care is recognised as a fundamental component of health services worldwide. A particular focus is placed on low- and middle-income countries where palliative care remains scarce, and on fostering capacity-building initiatives that empower local healthcare providers.

Through its continued research, advocacy, and collaboration, the ATLANTES Global Observatory of Palliative Care remains dedicated to advancing the field, shaping global policy, and reinforcing the importance of compassionate, high-quality care for all individuals facing serious illnesses.

THE INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE (IAHPC)

Katherine Pettus



The International Association for Hospice and Palliative Care (IAHPC) is a global membership organisation officially chartered in the US since 2000. It is a non-state actor in official relations with the World Health Organization (WHO) and a civil society organisation in consultative status with the UN Economic and Social Council (ECOSOC). These official accreditations entitle the IAHPC to participate, by invitation, in official meetings of the multilateral organisations and specialised agencies of the UN, and in technical consultations on specific projects executed by Secretariat staff.

The IAHPC's vision is "a world free from health-related suffering," and its mission is to "serve as a global platform to inspire, inform, and empower individuals, governments, and organisations to increase access to, and optimise the practice of, palliative care." The global board of directors supervises the organisation's four pillars of work: education, advocacy, research, and communications.

The IAHPC has collaborated closely with regional palliative care organisations and has recently focused on strengthening national associations and partnering with academic institutions to advance global palliative care integration and quality care provision at the national level.

IAHPC members are regularly invited to participate in research projects such as the GAP Project to develop Essential and Expanded Palliative Care Packages and a Manual on the Use of Essential Medicines. Forthcoming projects will be associated with work plans agreed under its accreditation relationships with WHO and UN ECOSOC organisations, as well as the International Narcotics Control Board.

Pallipedia, the IAHPC Calendar of Events, and the Directory of Services—regularly updated by IAHPC staff—provide palliative care workers, professional associations, and the global public with valuable resources at no charge. This includes information published by institutional partners, including the dissemination of the ATLANTES Atlases through institutional websites, social and traditional media, and regularly scheduled webinars, courses, or conferences.

EU The institutions involved

The IAHPC has played a key role in building the network of contributors who made the Global Survey possible by:

- Refining the indicators and consulting on the ATLANTES survey methodology.
- Sharing membership lists by region to facilitate member participation in ATLANTES surveys.
- Extending membership benefits to all individuals who participated in the ATLANTES surveys.

The IAHPC collaborates with ATLANTES by supporting national-level palliative care planning based on the GAP Essential and Expanded Palliative Care Packages and the ATLANTES Global Survey indicators and baseline assessment. The ATLANTES Regional Atlases will serve as a key resource for individual and academic researchers, advocates, and national palliative care organisations whose members will take the forthcoming six-module IAHPC/PROESA course on the GAP Essential Packages.

THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE (WHPCA)

Dr. Stephen R. Connor, Executive Director



The Worldwide Hospice Palliative Care Alliance (WHPCA) is an international non-governmental organisation focusing exclusively on hospice and palliative care development worldwide. We are a network of national and regional hospice and palliative care associations and affiliate organisations.

The WHPCA was formed in 2008 as a global voice for palliative care provider organisations through a series of global summits at regional conferences starting in 2005. The WHPCA is in official relations with the World Health Organization (WHO) and holds consultative status with the United Nations through its Economic and Social Council (ECOSOC). This enables us to influence global health policy at WHO and UN meetings.

Our primary advocacy focus is on ensuring the inclusion of palliative care within the UN Sustainable Development Goals, particularly Goal 3: Improving Health and Well-Being, specifically under target 3.8, achieving Universal Health Coverage (UHC). WHPCA played a key role in ensuring palliative care was recognised as an essential compo-

nent of the UHC continuum (Promotion–Prevention–Treatment–Rehabilitation–Palliative Care).

Today, the WHPCA has over 500 organisational members across 103 countries. Organisational membership is free, and all WHPCA resources are accessible on our website: <https://thewhpc.org>.

Mission

To improve access to timely, quality palliative care globally and reduce serious health-related suffering through impactful collaboration with the global health community. We believe that no one with a life-limiting condition, such as cancer, organ failure, or HIV, should endure unnecessary pain and distress.

Vision

A world with universal access to hospice and palliative care.

Key Facts

- The WHPCA is a registered charity in the UK, where our secretariat is based.
- Over 70 million people require palliative care annually, including more than 27 million at the end of life. Over 20 million of these individuals die in avoidable pain and distress.
- Pain management is fundamental to hospice and palliative care. The WHPCA actively works to improve access to essential medications. Currently, about 80% of the world's population lacks adequate access to the medications required to manage pain and other symptoms.
- The WHPCA upholds a patient-centred approach, addressing the physical, psychological, social, practical, legal, and spiritual needs of patients and their families.
- The WHPCA advocates for the integration of hospice and palliative care into national and regional health systems and supports organisations in achieving this goal.
- We collaborate with partner organisations to support patients, families, and caregivers in alleviating pain and distress while promoting quality of life.

Strategic Plan Goals 2024-2025

- **Strategic Goal 1:** Advocate for the inclusion of palliative care services under universal health coverage at all levels, including primary care.
- **Strategic Goal 2:** Work with member organisations to build leadership and management capacity, enhance evidence-based advocacy and policy skills, provide technical assistance, and strengthen communication capabilities. ●

EU Aim and objectives

For the fourth time in Europe, this work aimed to implement a set of actionable indicators for evaluating PC development in the European Region. The goal was to consolidate the monitoring of the development of palliative care in the Member States.

The objectives were to:

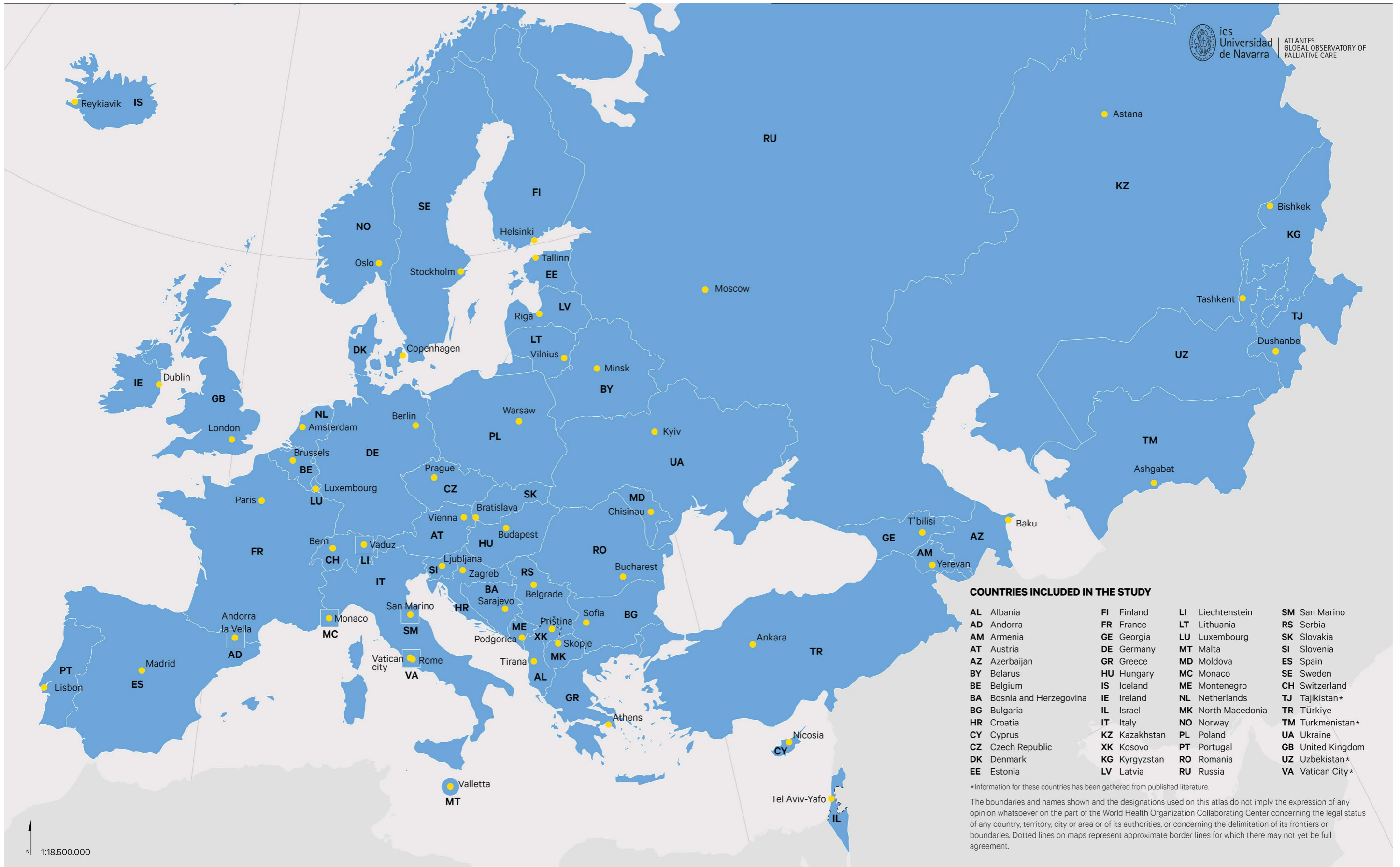
- Implement a set of WHO quantitative and qualitative indicators to monitor PC development in the WHO-EURO.
- Identify areas for improvement in the development of PC in the regions.
- Present updated, reliable, evidence-based information and comprehensive analysis on PC development regionally.
- Provide open-access data on PC development in each country of the WHO-EURO to facilitate discussion and benchmarking. ●



This Atlas presents the most relevant information to palliative care development in a way that is clear, accessible, and easy to interpret for professionals, policymakers, and the general public.

Population and methods

EU Geopolitical context



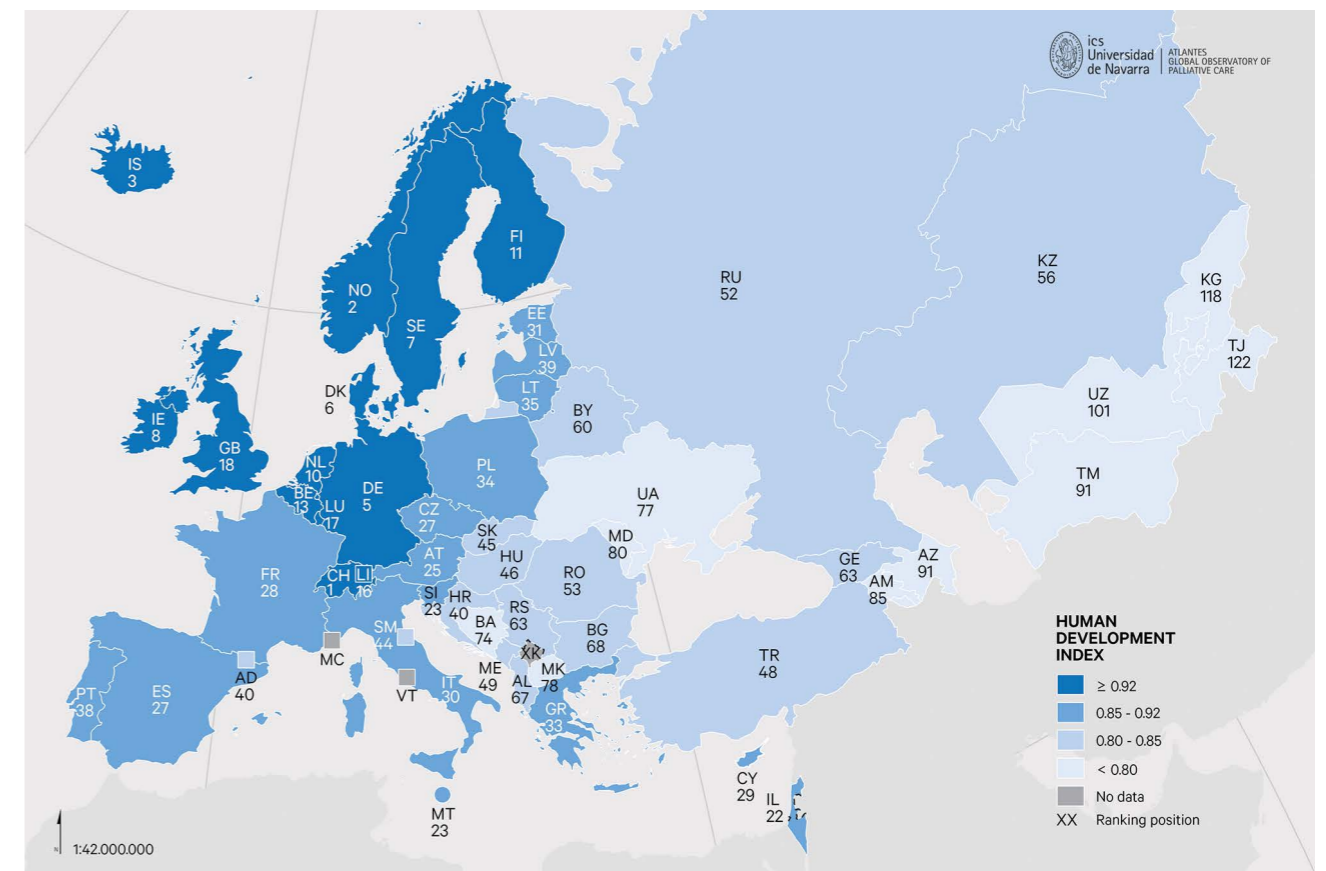
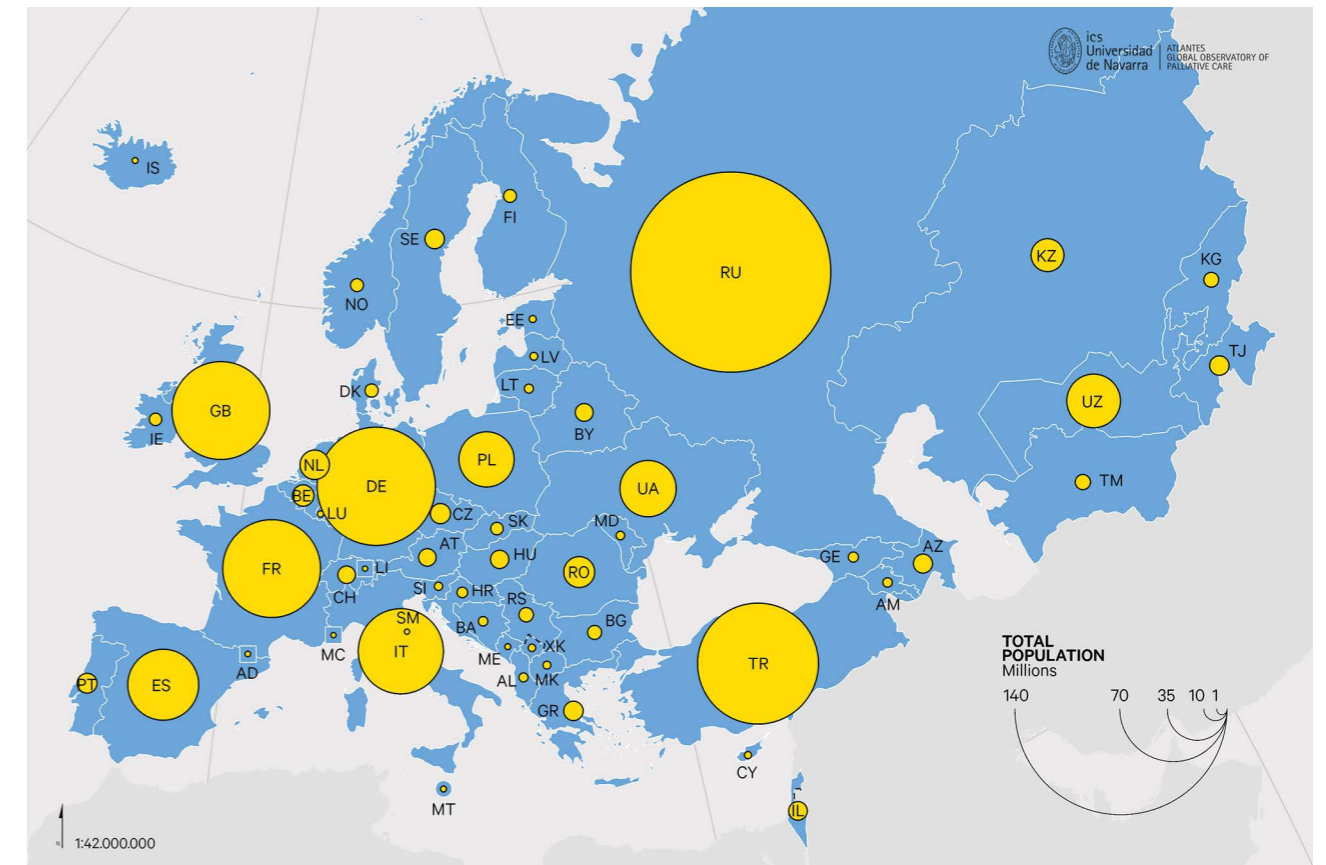
EU Geopolitical context

EU Socioeconomic context

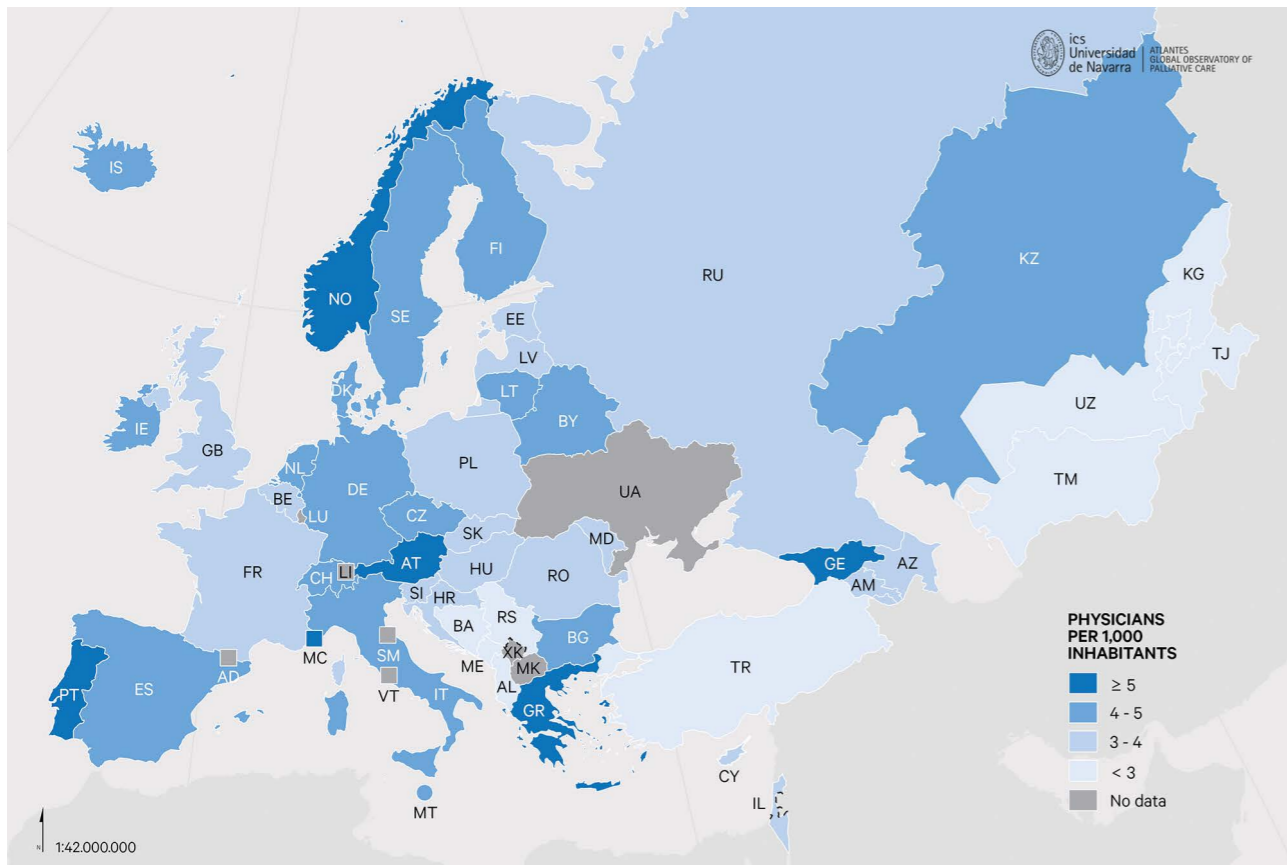
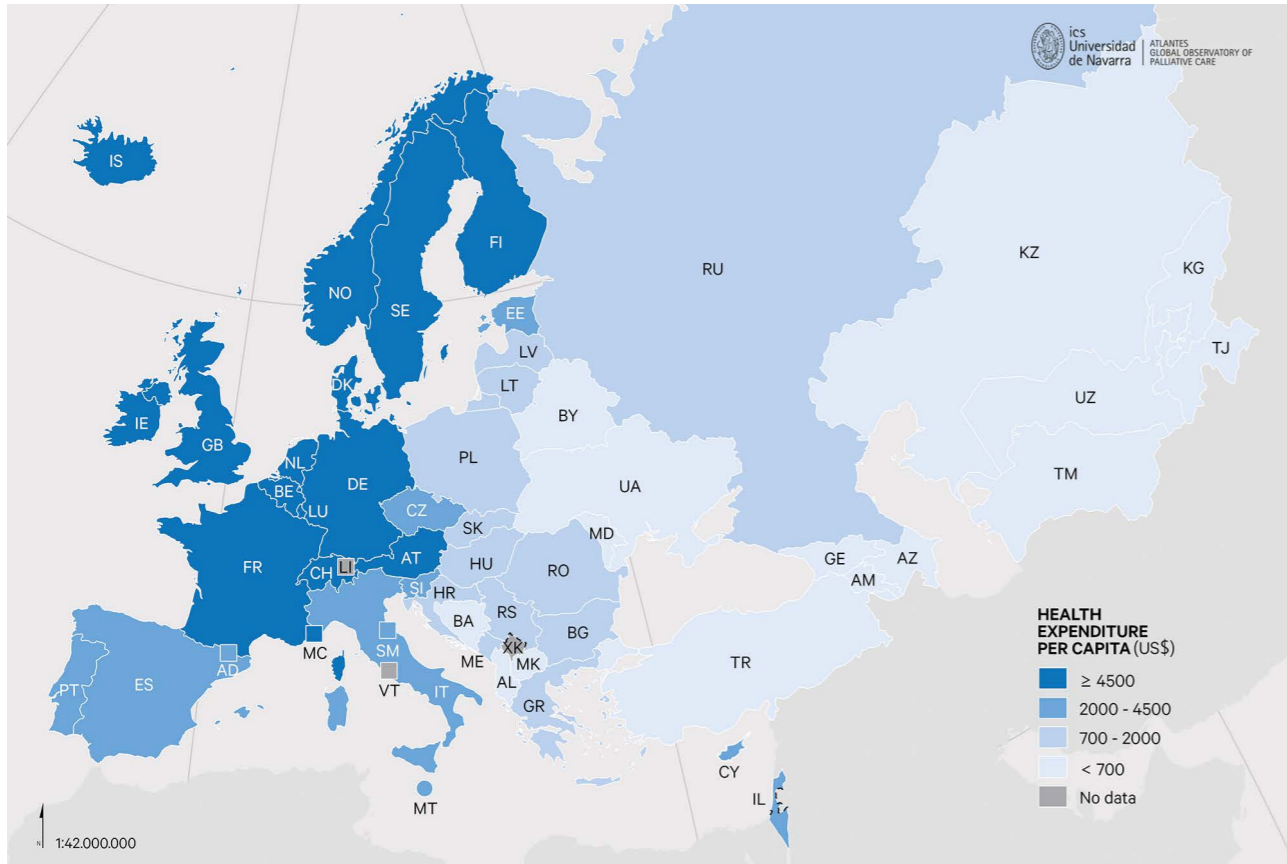
TABLE 2. Demographic and economic overview of the European Region

Country or Area	Population total 2023	Health expenditure total (Per capita, US\$), 2021	Income Levels 2022	Human development index rank	Physicians per 1000 Inhabitants
Albania	2,745,972	464.74	Upper middle income	67	—
Andorra	80,856	3,505.99	High income	40	—
Armenia	2,990,900	613	Upper middle income	85	—
Austria	9,131,761	6,505	High income	25	5.43
Azerbaijan	10,153,958	249	Upper middle income	91	—
Belarus	9,178,298	468	Upper middle income	60	—
Belgium	11,787,423	5,680.231	High income	13	3.24
Bosnia-Herzegovina	3,185,073	692	Upper middle income	74	—
Bulgaria	6,446,596	1,040	High income	68	4.29
Croatia	3,859,686	1,384	High income	40	3.61
Cyprus	1,344,976	2,990	High income	29	3.55
Czech Republic	10,864,042	2,498.52	High income	32	4.25
Denmark	5,946,952	7,382	High income	6	—
Estonia	1,370,286	2,094.50	High income	31	3.44
Finland	5,583,911	5,488	High income	11	4.38
France	68,287,487	5,380.88	High income	28	3.34
Georgia	3,715,483	417	Upper middle income	63	5.33
Germany	83,280,000	6,626.00	High income	9	4.52
Greece	10,405,588	1,845.78	High income	33	6.37
Vatican City	—	—	—	—	—
Hungary	9,592,186	1,382	High income	46	3.30
Iceland	393,349	6,716	High income	3	4.41
Ireland	5,307,600	6,764.26	High income	8	4.06
Israel	9,756,600	4,339	High income	22	3.65
Italy	58,993,475	3,350	High income	30	4.10
Kazakhstan	20,330,104	403	Upper middle income	56	—
Kosovo	1,756,366	—	Upper middle income	—	—
Kyrgyzstan	7,099,750	73	Lower middle income	118	2.15
Latvia	1,877,445	1,898	High income	39	3.38
Liechtenstein	39,850	—	High income	16	—
Lithuania	2,871,585	1,859	High income	35	4.50
Luxembourg	666,430	7,636	High income	17	—
Malta	552,747	3,642	High income	23	4.28
Monaco	38,956	8,634.26	High income	—	—
Montenegro	616,177	985	Upper middle income	49	2.77
Netherlands	17,877,117	6,539	High income	10	3.91
North Macedonia	1,827,816	560	Upper middle income	78	—
Norway	5,519,594	9,163	High income	2	5.17
Poland	36,687,353	1,159	High income	34	3.39
Portugal	10,578,174	2,747	High income	38	5.77
Republic of Moldova	2,457,783	410	Upper middle income	80	3.25
Romania	19,059,479	963	High income	53	3.47
Russian Federation	143,826,130	936	High income	52	—
San Marino	33,860	4,131.94	High income	44	—
Serbia	6,623,183	919.17	Upper middle income	63	2.84
Slovakia	5,426,740	1,685	High income	45	3.68
Slovenia	2,120,461	2,775	High income	23	3.33
Spain	48,347,910	3,234.29	High income	27	4.48
Sweden	10,536,632	6901	High income	7	—
Switzerland	8,888,093	10,897.45	High income	1	4.44
Tajikistan	10,389,799	73	Lower middle income	122	2.13
Türkiye	85,325,965	441	Upper middle income	48	2.17
Turkmenistan	7,364,438	565.26	Upper middle income	—	2.14
Ukraine	37,732,836	368	Upper middle income	77	—
United Kingdom	68,350,000	5,738.48	High income	18	3.17
Uzbekistan	35,652,307	157	Lower middle income	101	2.81

EU Socioeconomic context



EU Socioeconomic context



EU Palliative care needs across the WHO EURO

As the global population continues to age, there is a corresponding rise in non-communicable diseases (NCDs) alongside the continued presence of chronic and infectious diseases. This trend is contributing to a growing need for palliative care (PC) worldwide, and Europe is no exception.

For this edition of the ATLAS, we estimate the number of people in Europe –and in each individual country– who experience serious health-related suffering (SHS) each year. To do this, we focus on individuals who die from life-threatening or life-limiting conditions.

Our estimates are based on data from 2015, drawn from the International Association for Hospice and Palliative Care (IAHPC) Global Data Platform. This year was selected because it offers the most complete and recent dataset available for this analysis. We apply the methodology

developed by the Lancet Commission on Palliative Care and Pain Relief (Knaul et al., 2018), which defines SHS as suffering linked to a need for palliative care.

The Commission's approach uses global mortality data across 20 key health conditions. It adjusts for the prevalence of physical and psychosocial symptoms known to cause significant suffering. For each condition, a specific multiplier was developed to estimate the proportion of people likely to benefit from palliative care. These multipliers form the basis for estimating the overall need for palliative care in the population. The need for PC for the total population and for children in a given year is presented by country and broken down by disease group. The ATLAS estimates that in 2015, 4,279,278 million people in Europe experienced SHS (66,114 of them being children under the age of 15). ●

FIGURE 1. Main health conditions requiring palliative care

Main health conditions requiring PC ¹	TOTAL SHS (people died in 2015 needing PC across participating countries, in millions)
	0 250,000 500,000 750,000 1,000,000 1,500,000 2,000,000
Cancer	1,818,424 (42.5%)
Cerebrovascular diseases	738,226 (17.3%)
Dementia	333,755 (7.8%)
Lung diseases	311,535 (7.3%)
Non-ischemic heart disease	183,778 (4.3%)
Injury	158,498 (3.7%)
Liver disease	134,003 (3.1%)
Chronic ischemic heart disease	121,129 (2.8%)
Atherosclerosis	113,743 (2.7%)
CNS Degenerative disease	78,617 (1.8%)
Leukemia	61,486 (1.4%)
HIV	57,460 (1.3%)
Renal Failure	45,595 (1.1%)
Tuberculosis	40,503 (0.9%)
Low birth weight & prematurity	26,944 (0.6%)
Congenital malformations	24,901 (0.6%)
Musculoskeletal disorders	17,393 (0.4%)
Malnutrition	6,652 (0.2%)
Inflammatory disease of the CNS	4,643 (0.1%)
Heart Failure	1,994 (0.0%)
TOTAL	4,279,278 (100%)

¹ Source: The Lancet Commission on Global Access to Palliative Care and Pain Relief. Serious health-related suffering database, 2015.

 Palliative care needs across the WHO EURO

TABLE 3. Palliative care needs of people who die each year with serious health-related suffering (SHS) in selected countries of the WHO European region (in thousands)

Country	Heart Failure	Tuberculosis	HIV	Cancer	Leukemia	Dementia	Inflammatory disease of the CNS	CNS degenerative diseases	Cerebro-vascular diseases	Non-ischemic heart disease
Albania	0.00	0.01	0.03	4.46	0.13	0.73	0.02	0.11	3.04	0.35
Armenia	0.00	0.09	0.12	7.11	0.12	0.77	0.01	0.04	2.25	0.54
Austria	0.01	0.07	0.05	18.10	0.78	1.89	0.02	1.14	3.33	2.38
Azerbaijan	0.00	0.04	0.34	8.64	0.24	1.25	0.13	0.18	5.73	0.72
Belarus	0.00	0.87	1.20	17.29	0.59	3.17	0.03	0.29	12.80	1.68
Belgium	0.05	0.11	0.05	25.27	1.00	6.59	0.03	1.81	4.65	1.02
Bosnia&Herzegovina	0.00	0.12	0.00	6.29	0.10	1.54	0.01	0.24	4.69	1.87
Bulgaria	0.00	0.09	0.10	16.03	0.36	3.04	0.03	0.42	14.12	5.06
Croatia	0.01	0.04	0.01	12.27	0.39	0.97	0.01	0.61	4.88	1.03
Cyprus	0.00	0.01	0.00	1.67	0.09	0.21	0.00	0.09	0.38	0.16
Czech Republic	0.07	0.13	0.01	23.66	0.82	2.38	0.03	0.90	6.31	1.66
Denmark	0.02	0.04	0.02	14.20	0.49	3.00	0.01	0.76	2.14	0.51
Estonia	0.00	0.03	0.05	3.29	0.13	0.11	0.00	0.12	0.68	0.50
Finland	0.01	0.05	0.00	10.69	0.33	7.11	0.01	0.92	2.81	0.80
France	0.23	0.84	0.45	148.48	6.33	39.39	0.16	9.62	22.24	6.87
Georgia	0.00	0.15	0.20	6.44	0.14	1.38	0.02	0.08	6.73	2.12
Germany	0.33	0.70	0.41	202.11	7.85	32.83	0.16	14.04	37.08	19.59
Greece	0.00	0.09	0.26	25.43	1.41	7.86	0.03	0.70	12.44	2.29
Hungary	0.01	0.11	0.01	28.54	0.84	2.72	0.03	0.68	8.00	3.23
Iceland	0.00	0.00	0.00	0.50	0.01	0.17	0.00	0.04	0.09	0.02
Ireland	0.01	0.02	0.01	7.70	0.26	1.72	0.01	0.55	1.24	0.25
Italy	0.39	0.96	0.93	150.44	6.15	28.80	0.21	8.53	40.58	14.92
Kazakhstan	0.02	2.27	0.28	27.75	1.15	2.69	0.19	0.46	9.67	1.76
Kyrgyzstan	0.01	0.66	0.16	3.46	0.14	0.03	0.07	0.23	3.26	0.51
Latvia	0.00	0.08	0.09	5.42	0.19	0.21	0.01	0.14	3.30	0.74
Lithuania	0.02	0.22	0.01	7.58	0.26	0.27	0.02	0.23	3.78	0.51
Luxembourg	0.00	0.00	0.00	0.90	0.04	0.18	0.00	0.07	0.17	0.05
Montenegro	0.00	0.00	0.01	1.23	0.03	0.21	0.00	0.01	1.12	0.12
Netherlands	0.09	0.12	0.03	39.95	1.34	12.05	0.03	2.53	6.51	1.30
Norway	0.02	0.04	0.01	9.92	0.33	2.70	0.01	0.69	1.84	0.31
Poland	0.01	0.55	1.11	84.13	2.39	13.84	0.10	1.97	29.09	8.61
Portugal	0.04	0.27	0.51	24.36	0.88	4.06	0.03	1.43	8.28	1.35
Republic of Moldova	0.00	0.29	0.09	5.63	0.14	0.13	0.02	0.10	4.31	1.06
Romania	0.06	1.15	0.21	45.15	1.29	1.62	0.06	1.02	28.96	7.87
Russian Federation	0.03	18.07	38.22	309.93	7.49	13.42	1.00	1.68	262.33	40.18
Serbia	0.02	0.12	0.03	20.97	0.60	1.40	0.03	0.94	9.05	7.88
Slovakia	0.01	0.04	0.00	12.38	0.37	1.54	0.01	0.36	3.13	0.78
Slovenia	0.01	0.02	0.00	5.53	0.18	0.15	0.00	0.16	1.31	0.48
Spain	0.15	0.45	0.78	95.52	3.44	27.61	0.10	5.54	18.32	7.47
Sweden	0.05	0.07	0.01	20.07	0.76	7.15	0.01	1.19	4.17	1.33
Switzerland	0.01	0.04	0.04	15.27	0.58	5.71	0.01	1.23	2.38	1.58
Tajikistan	0.01	0.24	0.81	3.65	0.11	0.52	0.42	0.29	3.48	0.72
North Macedonia	0.00	0.03	0.00	3.59	0.09	0.05	0.00	0.12	2.64	1.65
Türkiye	0.06	0.79	0.36	90.13	3.21	30.00	0.46	3.78	28.53	9.42
Turkmenistan	0.01	0.47	0.00	3.81	0.13	0.44	0.11	0.15	3.73	0.67
Ukraine	0.02	6.66	9.82	86.22	2.19	1.97	0.27	0.65	67.32	7.88
United Kingdom	0.16	0.51	0.21	144.61	4.88	57.90	0.15	10.22	24.52	4.17
Uzbekistan	0.05	2.74	0.39	12.66	0.71	0.29	0.55	1.59	10.82	7.83
Totals	1,994	40,503	57,460	1,818,424	61,486	333,755	4,643	78,617	738,226	183,778

Source: <https://iahcp.org/what-we-do/research/global-data-platform-to-calculate-shs-and-palliative-care-need/database/>

 Palliative care needs across the WHO EURO

Chronic ischemic heart disease	Lung diseases	Liver disease	Renal Failure	Low birth weight & prematurity	Congenital malformations	Injury	Atherosclerosis	Musculo-skeletal disorders	Mal-nutrition	SHS total	SHS children
0.28	0.47	0.23	0.10	0.11	0.11	0.26	0.26	0.01	0.00	10,710	308
0.46	0.88	0.73	0.12	0.12	0.11	0.33	0.17	0.01	0.00	13,982	300
0.97	2.82	1.86	0.50	0.06	0.16	1.34	1.49	0.15	0.00	37,112	181
1.25	1.54	2.67	0.48	1.72	0.64	0.92	0.24	0.01	0.02	26,753	2,936
3.02	1.24	0.16	0.23	0.10	0.22	3.27	0.45	0.00	0.00	46,605	359
0.76	6.29	2.05	0.61	0.08	0.18	2.14	2.19	0.37	0.23	55,469	284
0.43	1.10	0.57	0.22	0.05	0.05	0.52	0.42	0.03	0.00	18,251	112
1.70	2.73	1.78	0.49	0.15	0.14	0.95	1.30	0.03	0.01	48,509	347
0.72	1.74	1.10	0.23	0.02	0.06	0.84	0.69	0.09	0.00	25,717	92
0.08	0.40	0.10	0.07	0.01	0.02	0.11	0.14	0.03	0.00	3,577	21
1.68	3.72	2.21	0.46	0.08	0.11	1.61	1.66	0.13	0.23	47,844	190
0.27	3.45	0.95	0.17	0.06	0.09	0.59	0.92	0.23	0.01	27,937	121
0.28	0.23	0.29	0.14	0.00	0.02	0.22	0.17	0.03	0.00	6,283	22
0.55	1.22	1.32	0.12	0.02	0.11	0.90	0.84	0.14	0.00	27,966	89
3.14	20.90	10.54	2.48	0.58	1.15	10.72	12.20	2.60	3.42	302,357	1,683
0.82	1.43	1.12	0.27	0.16	0.13	0.54	0.32	0.02	0.00	22,077	358
9.22	39.50	18.16	5.53	0.60	1.09	10.43	19.64	2.00	0.22	421,489	1,556
1.52	5.08	1.30	0.86	0.14	0.17	0.98	1.22	0.07	0.00	61,866	339
1.91	4.74	3.32	0.50	0.17	0.18	1.68	1.50	0.24	0.02	58,430	329
0.02	0.10	0.02	0.01	0.00	0.00	0.03	0.02	0.01	0.00	1,065	6
0.26	1.89	0.46	0.14	0.05	0.11	0.41	0.48	0.14	0.00	15,710	155
5.45	27.98	12.49	5.46	0.38	0.87	7.14	9.41	1.95	0.54	323,567	1,095
1.49	15.18	0.47	2.33	0.99	0.87	4.91	0.66	0.00	0.13	73,270	2,549
0.67	1.11	1.89	0.21	0.69	0.44	0.93	0.13	0.06	0.01	14,652	1,549
0.48	0.31	0.48	0.13	0.03	0.04	0.46	0.20	0.04	0.00	12,358	71
0.81	0.64	0.90	0.11	0.03	0.05	0.78	0.36	0.05	0.00	16,636	97
0.03	0.19	0.09	0.02	0.00	0.00	0.08	0.09	0.01	0.01	1,931	6
0.08	0.15	0.05	0.04	0.01	0.00	0.07	0.08	0.00	0.00	3,211	20
0.93	8.38	1.56	0.53	0.15	0.30	2.17	2.64	0.55	0.02	81,177	400
0.31	2.28	0.37	0.17	0.03	0.09	0.69	0.81	0.15	0.10	20,855	98
5.27	9.85	8.86	1.19	0.53	0.65	6.78	4.32	0.44	0.10	179,786	1,272
0.61	4.63	1.98	0.39	0.06	0.11	1.31	1.48	0.26	0.07	52,111	206
0.88	0.79	2.98	0.17	0.12	0.15	0.70	0.15	0.02	0.00	17,730	331
4.28	6.82	9.16	2.50	0.37	0.31	2.62	2.56	0.03	0.10	116,133	935
34.86	28.13	0.47	3.86	3.90	4.31	47.78	13.05	0.01	0.01	828,722	10,364
1.00	3.66	1.17	1.11	0.23	0.11	1.03	1.60	0.13	0.01	51,080	424
0.71	0.94	1.63	0.26	0.10	0.11	0.91	0.44	0.05	0.03	23,814	241
0.20	0.52	0.48	0.10	0.02	0.02	0.41	0.37	0.05	0.00	10,016	36
2.66	24.24	7.60	2.61	0.34	0.58	4.22	6.85	2.54	0.17	211,194	927
0.86	3.65	1.06	0.34	0.06	0.15	1.39	2.18	0.28	0.09	44,862	193
0.57	2.52	1.03	0.33	0.08	0.17	1.20	1.00	0.29	0.06	34,115	211
0.52	1.17	1.33	0.27	2.04	0.78	1.31	0.09	0.01	0.19	17,948	4,282
0.19	0.63	0.20	0.14	0.05	0.02	0.19	0.21	0.00	0.00	9,798	89
4.05	22.24	5.62	4.22	4.10	4.82	8.90	4.19	1.02	0.70	226,595	13,503
0.66	0.50	2.23	0.30	1.07	0.49	0.93	0.09	0.01	0.02	15,821	2,315
17.31	7.48	0.45	1.10	0.93	1.11	12.98	2.36	0.02	0.01	226,764	2,479
3.77	34.20	10.53	1.52	0.95	1.19	5.86	9.18	2.93	0.09	317,550	2,012
3.16	1.88	8.01	2.45	5.39	2.31	3.95	2.93	0.15	0.03	67,874	10,618
121,129	311,535	134,003	45,595	26,944	24,901	158,498	113,743	17,393	6,652	4,279,278	66,114

Knaul FM, Farmer PE, Krakauer EL, et al. Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: The Lancet Commission report. Lancet 2018; 391(10128): 1391-454 <http://www.thelancet.com/commissions/palliative-care>

Knaul FM, Farmer PE, Krakauer EL, De Lima L, Bhadelia A, Jiang Kwete X, Arreola-Ornelas H, et al. Technical Note and Data Appendix for "Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: The Lancet Commission report". Background Document. Miami: University of Miami Institute for Advanced Study of the Americas. Available at: <https://miami.edu/lancet>

EU Methods of the project

In 2021, a consensus-building process led by ATLANTES and coordinated by WHO was conducted to identify a refined set of indicators to monitor the development of PC programs in different contexts, especially in countries where PC is at an initial stage of development. The straight set was chosen from a long list of validated indicators used in different settings worldwide. The consensus was reached by a panel of international experts representing all WHO regions through a series of meetings, group work, and a two-round Delphi process. The group agreed upon a working concept of PC development and fed it into an updated conceptual model. The technical report titled *Assessing the Development of Palliative Care Worldwide: A Set of Actionable Indicators* presents a set of palliative care indicators that Member States can universally apply to monitor and evaluate the provision of PC services¹.

The proposed model highlights six essential components required to provide optimal PC for those people with severe health-related suffering (Figure 2):

1. Empowerment of people and communities.
2. Robust health policies related to PC.
3. PC-related research.
4. Use of essential PC medicines.
5. Education and training for health workers and volunteers providing PC.
6. Provision of PC within integrated health services.

The WHO established a set of 14 PC indicators using the updated PC development conceptual model (Table 4). These indicators were applied to each country by gathering information from participants known as experts. The project for each country involved a national cross-sectional observational study. Each country was profiled individually and presented in this final report. The data included quantitative outcomes along with supplementary qualitative information. Each country produced and validated its national report.

The set of 14 indicators for assessing palliative care (PC) in the European region was reviewed through a structured discussion and rating process, focusing on both relevance and feasibility within the regional context.

This process took place during a pre-congress workshop held in Barcelona in 2024, involving 27 participants from 18 countries. The majority of attendees represented national palliative care associations, ensuring a wide range of perspectives from across Europe.

As a result of these discussions: The wording of several indicators was revised for clarity and alignment with national contexts. Additional attributes were added to strengthen the indicators' specificity and applicability. Two new indicators were introduced for inclusion in the final evaluation list:

- Inclusion of palliative care topics in national research funding calls.
- General availability of various opioids, in different formulations, at the primary care level.

A full report of the workshop discussions and outcomes is available here:



Figure 2. The WHO's new framework for Palliative care Development: The House of Palliative Care.

EU Methods of the project

TABLE 4. WHO indicators

	Core	Strategic
Empowerment of people and communities		
1 Existence of groups dedicated to promote the rights of patients in need of palliative care, their families, their caregivers and disease survivors	✓	✓
2 Existence of national policy or guideline addressing advance care planning of medical decisions for use of life-sustaining treatment or end-of-life care		✓
Health policies		
3 Existence of a current national palliative care plan, programme, policy or strategy with defined implementation framework	✓	✓
4 Inclusion of palliative care in the list of health services provided at the primary care level in the national health system		✓
5 Existence of national coordinating authority for palliative care (labelled as unit, branch, department) in the Ministry of Health (or equivalent) responsible for palliative care		✓
Research		
6 Existence of congresses or scientific meetings at the national level specifically related to palliative care	✓	
7.1 Palliative care research on the country estimated by peer reviewed articles		✓
7.2 Inclusion of palliative care topics in national research calls	✓	
Use of essential medicines		
8 Reported annual opioid consumption —excluding methadone— in Defined Daily dose for statistical purposes (S-DDD)	✓	✓
9 Availability of essential medicines for pain and palliative care at all levels of care		✓
10.1 General availability of immediate-release oral morphine (liquid or tablet) at the primary care level		✓
10.2 General availability of different opioids and in different formulations at the primary care level	✓	
Education and training		
11 Proportion of medical and nursing schools with palliative care formal education in undergraduate curricula	✓	✓
12 Specialisation in palliative medicine for physicians	✓	
Integrated palliative care services		
13 Number of specialised palliative care programmes in the country per population	✓	✓
14 Number of specialised palliative care programmes for paediatric population in the country	✓	

Source: Assessing the development of palliative care worldwide: a set of actionable indicators. WHO, 2021.

EU Methods of the project

ATLANTES structured the research process in four steps (Figure 2):

1. Building an informant network
2. Data collection through the E-Course
3. Analysis: conciliation, validation and endorsement of National associations
4. Results dissemination

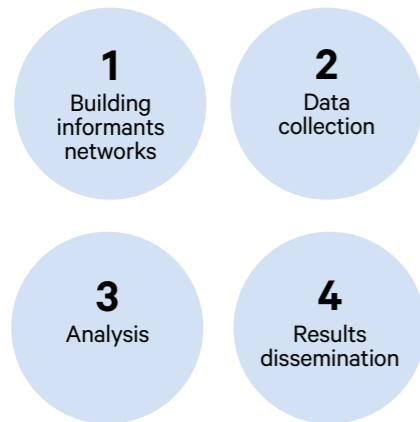


Figure 2. Methodology scheme in four steps

1. BUILDING NETWORKS OF NATIONAL INFORMANTS

Since January 2024, ATLANTES has built a network of consultants among the following organisations: WHO Regional Office EURO, the IAHP, the WHPCA, the EAPC, and the National PC associations. In each country, data were agreed upon by at least two consultants who met two or more of the selection criteria:

1. More than 5 years of PC professional experience
2. Identified as PC National Champion for an International or National Association
3. Participation in previous Atlas studies
4. Publications on PC development
5. Member of a PC organisation
6. High interest in PC development

Experts were asked whether they consented to having their data made public in upcoming publications.

2. DATA COLLECTION THROUGH THE E-COURSE

A free, asynchronous, tutored online course accredited by the University of Navarra was created. This e-course carries one European Credit Transfer and Accumulation System (ECTS) credit (25 hours) and comprises seven units. The first unit includes a didactic guide with general information such as overall objectives, course modules, methodology, resources, and critical dates. The second unit gathers the socio-demographic information of the participants necessary for granting official certification. Units three to six feature short videos introducing PC development dimensions, a measurement framework, supporting PDF documents, and a questionnaire. Each question corresponds to a WHO indicator within its dimension and includes a multiple-choice option to determine the country's level of development in that indicator. After selecting the level, participants were prompted to provide a narrative justification and uploaded supporting documents to validate their responses. The final unit contains Benin's country report, the outcome of the first pilot project validating the WHO conceptual framework. The course was available in English.

PC experts were invited through official emails, following specific selection criteria. By October 2024, invitations were shared via social media and international PC association websites to expand the reach and capacity-building potential. Additional incentives, like free International IAHP membership, were offered upon course completion (Figure 3).

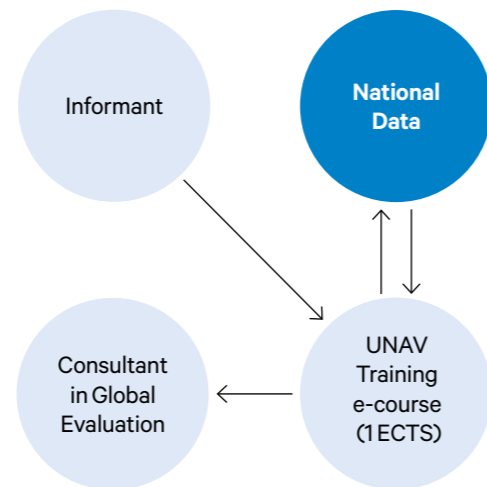


Figure 3. Data Collection through the E-Course with experts from each country.

EU Methods of the project

A total of 791 key informants were contacted, of whom 105 participated in the online course, 92 through e-surveys or reviewing thoroughly the reports (64.1% female). Initially, the study included 56 countries and areas within the WHO-EU region. In most territories, two or more key informants contributed to the study. The network of key informants comprised professionals from diverse scopes and fields of action in PC, ensuring a comprehensive and multidisciplinary perspective that underpins the thoroughness and validity of the study.

Each country included at least 2 informants who met two or more of the following selection criteria:

1. Over 5 years of professional experience in PC,
2. Identified as a National PC Champion by international or national associations,
3. Participant in previous studies,
4. Member of a National or Regional Association,
5. Publications on national development and
6. Engagement of national PC development.

Experts' Palliative Care Expertise Profile

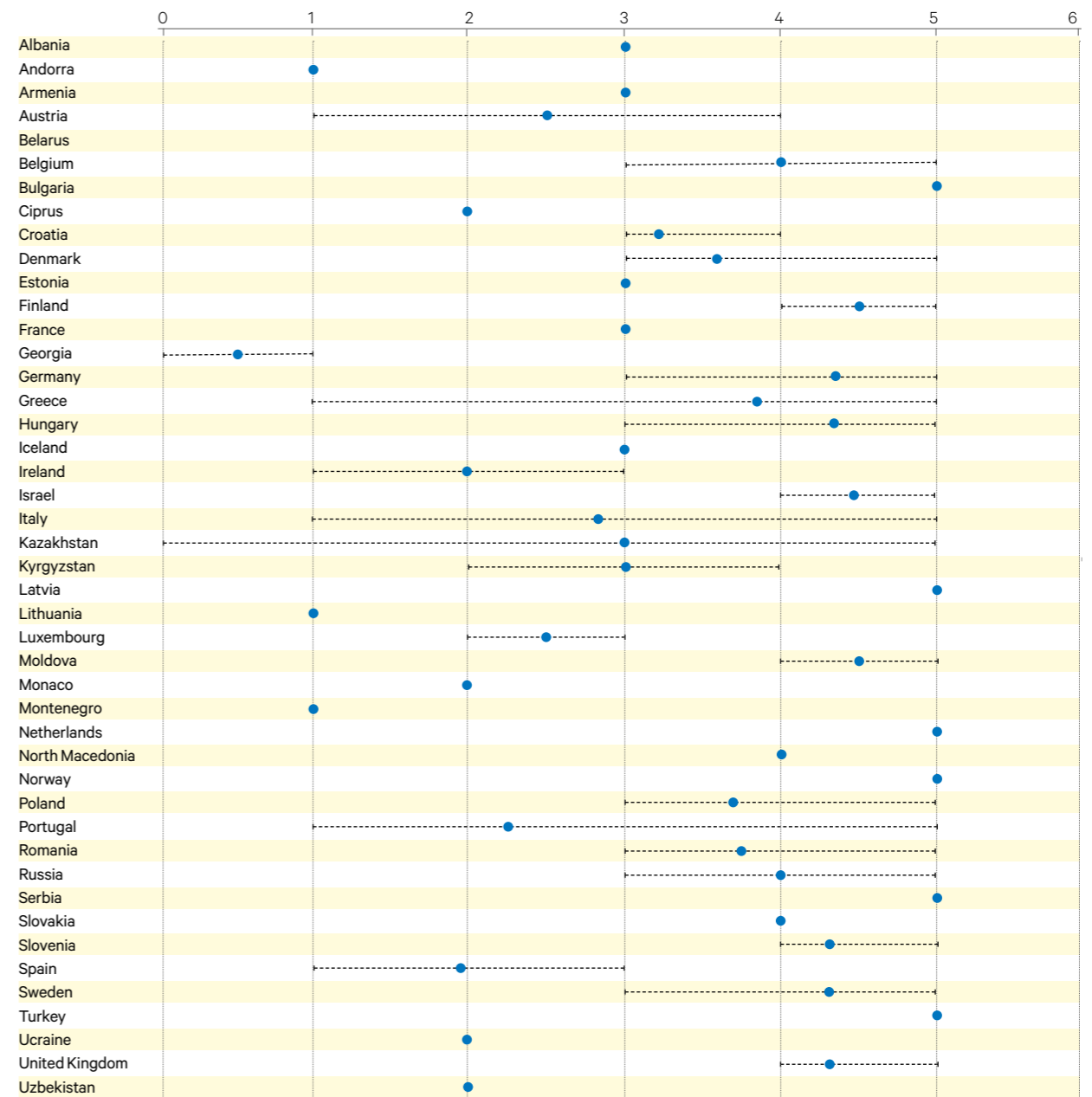
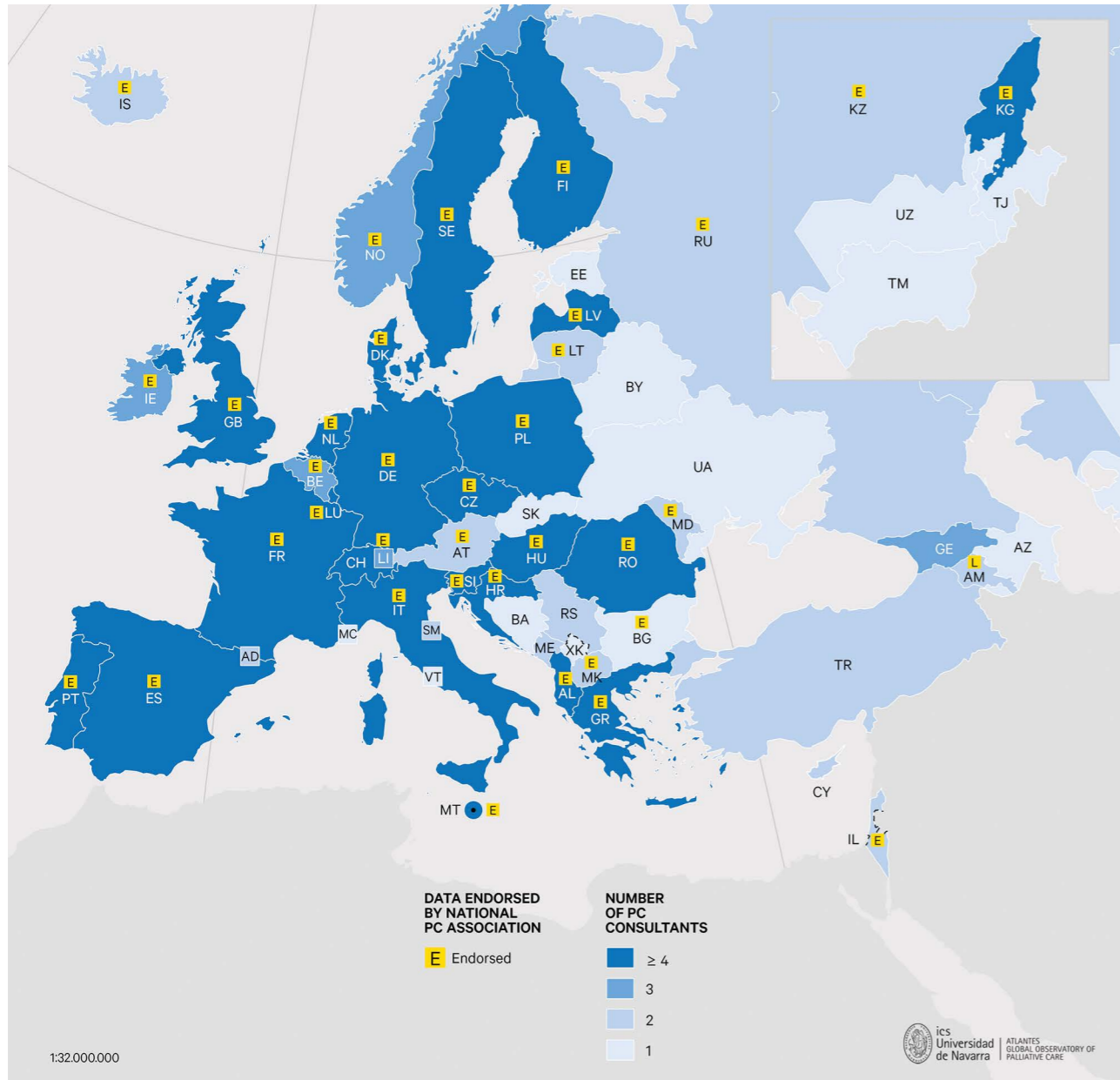


Figure 4. Experts' palliative care expertise profile according to selection criteria (Average score, Max.Score, Min.Score).

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Network of collaborators.

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3. ANALYSIS: CONCILIATION, VALIDATION AND ENDORSEMENT OF NATIONAL ASSOCIATIONS

Data has been collected through online questionnaires and compiled into a structured country-wise database. A total of 56 country reports have been produced, including 52 reports with conciliated information from key informants and four reports based on a literature review (specifically for the, Vatican City, Tajikistan and Turkmenistan). The path of the collected data is shown in Figure 5.

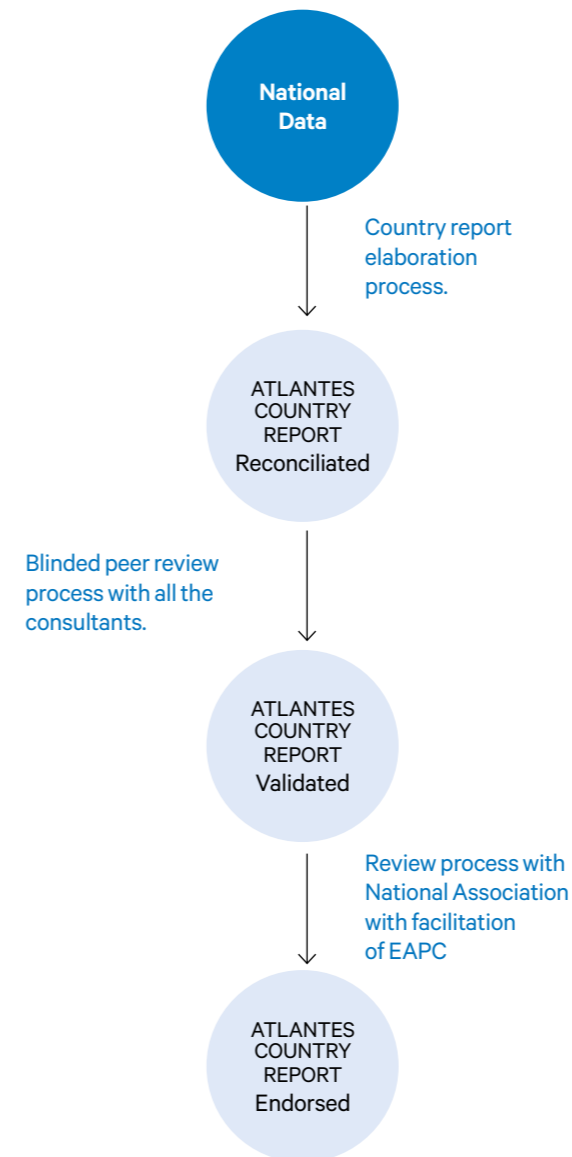


Figure 5. The path of the collected data.

Initially, all consultant inputs have been conciliated for each indicator to ensure consistency. Subsequently, the gathered information has been supplemented with available literature, with a level assigned to each indicator and a valid justification for the assignment. As a result, structured Country Reports have been developed, incorporating assigned levels of PC development and a narrative contextualisation for each assessed indicator. Key informants have validated these reports (originals, and further experts based on each reports' needs) and, when possible, they have been endorsed by National PC Associations. Each report lists the validation level, the consultants' names and the national associations' involvement.

The 16 indicators used to assess palliative care development across European countries were based on a range of data sources and scoring methods, adapted to the context of each country. The collection and calculation methods varied depending on the nature of the indicator.

Scored on a 1–4 Integer Scale

The following indicators were assessed using a single integer score ranging from 1 (lowest level of development) to 4 (highest level):

1. Groups promoting the rights of patients
2. Policies related to advance care planning
4. Inclusion of palliative care in the basic health package at the primary care level
6. Existence of palliative care congresses or scientific meetings
7. Number of palliative care-related research articles
- 7.1 Inclusion of palliative care in national research funding calls
- 7.2 Recognition of palliative care as a medical specialty

Scored as Median Values

The following indicators were calculated as median scores, potentially resulting in decimal values between 1 and 4. This approach was used when more than one data point informed the score:

3. Existence of a national palliative care plan or strategy
5. Presence of a responsible authority for palliative care within the Ministry of Health
9. Overall availability of essential medicines for pain and palliative care at the primary care level
10. Availability of immediate-release oral morphine at the primary care level
- 10.1 General availability of different opioids in multiple formulations
13. Provision of palliative care via specialised services

Based on Quantitative Consumption Data

Indicator 8, which focuses on opioid consumption, was derived from statistical data rather than qualitative scoring. It measures Defined Daily Doses for Statistical Purposes (S-DDD) per million inhabitants per day, based on

EU Methods of the project

the average consumption of narcotic drugs (excluding methadone) during the years 2020–2022. This method provides a standardised measure to compare opioid availability and use across countries.

Source: Narcotic Drugs 2022: Estimated World Requirements for 2023 – Statistics for 2021 International Narcotics Control Board https://digitallibrary.un.org/record/4061663/files/E_INCB_2023_2-EN.pdf

Cartography

Alvaro Montero developed the cartography under the supervision of Professor Juan José Pons from the Department of History, History of Art and Geography of the University of Navarra. The software used for map construction is ArcGIS Pro 3.3.2. The digital coverages used for the country boundaries is adapted to a small scale and one was obtained from ESRI ArcGISOnline repository and other one from WHO ArcGIS Hub repository; on the other hand, the disputed borders and areas were obtained from WHO ArcGIS Hub repository. For the cities, a point map was used from Esri ArcGIS Online. The projection used for all the maps is ETRS 1989 LAEA, with the central meridian at 10°.

The scale is 1:18 500 000 for the Geopolitical Map, 1:42 000 000 for the smaller context maps and 1:32.000.000 for the several types of maps utilised for thematic representation. Choropleth and symbol maps are used for categorical and quantitative variables. Proportional symbol maps and chart maps are used for quantitative data. In terms of stylistic representation, ‘ranges’ of constant colours have been adopted and used throughout this publication: ‘blue’ for choropleths and ‘yellow’ for symbols and charts.

Boundaries and geopolitical designations

The boundaries, names, and designations used in this EAPC Atlas of Palliative Care in the European Region follow the cartographic guidelines of the World Health Organization (WHO). Their inclusion does not imply any judgment on the part of the authors or editors concerning the legal status of any country, territory, city, or area, or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. This Atlas is intended solely to provide information on palliative care in the European region and does not aim to make statements on geopolitical matters.

Commercial mentions and responsibility

The mention of specific companies or certain manufacturers’ products does not imply that they are endorsed or recommended in preference to others of a similar nature that are not mentioned.

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4. RESULTS DISSEMINATION

The upcoming release of the new EAPC Atlas of Palliative Care in the European Region 2025 marks a new milestone in advancing PC across the region. This comprehensive Atlas, to be launched at the 19th World Congress in Helsinki, Finland (29–31 May 2025), is the result of a collaborative effort by healthcare professionals, policymakers, and other stakeholders. It provides critical insights and data to support us all in improving PC services. By disseminating this valuable resource, the Atlas seeks to enhance awareness, inform policy development, and foster collaboration among countries to ensure accessible, high-quality PC for all who need it. The presentation at the EAPC Congress will serve as a platform to engage the global PC community and highlight the ongoing efforts to address challenges in the WHO Europe.

Limitations and constraints

The Atlas includes comprehensive data from 52 European countries and territories. However, four countries—**Azerbaijan, Vatican City, Tajikistan, and Turkmenistan**—are not fully represented due to limited data availability. For most countries, information was gathered through a combination of:

- Input from key informants
- Review of available literature
- Validation and amendment by at least one in-country expert

In only four cases was the data based solely on published literature, without direct input from national experts. This limited engagement has been linked to two main factors:

- The criteria used to select key informants
- The limited or non-existent palliative care activity in some of these countries

This study is based on official documents, perspectives and knowledge from national experts, WHO’s regional PC key persons and trained consultants. Although this methodology is widely accepted for data collection, the data are still considered estimates. Consequently, the accuracy and precision of the data can be challenging to verify on occasion. However, it remains the best and most up-to-date information available in the region.

Based in Spain, the ATLANTES Global Observatory of Palliative Care contributed their experience and knowledge from previous international Atlas studies (overall

EU Methods of the project

previous editions of the EAPC Atlas of Palliative Care in Europe). Nevertheless, the implementation of WHO’s new indicators and the limited evidence regarding exploring PC activity within national health systems should be considered.

Source:

1. Assessing the development of palliative care worldwide: a set of actionable indicators. Geneva: World Health Organization, 2021. <https://www.who.int/publications/i/item/9789240033351>
2. Tripodoro VA, Ray A, Garralda E, Bastos F, Montero Á, Béjar AC, Pons JJ, Bouésseau MC, Centeno C. Implementing the WHO Indicators for Assessing Palliative Care Development in Three Countries: A Do-It-Yourself Approach. *J Pain Symptom Manage*. 2025 Jan;69(1):e61-e69.
3. Report for the Pre-congress workshop on the Application of the WHO methodology for the Assessment of palliative care development worldwide: a set of practical indicators

INTEGRATING PC INTO RESPONSES TO HEALTH EMERGENCIES IN THE WHO EURO REGION

Following lessons learned from the COVID-19 pandemic, the WHO’s Fourteenth General Programme of Work, 2025–2028 (GPW 14), establishes a bold agenda to realign the world towards achieving health-related Sustainable Development Goals while promoting health equity and building resilience in health systems within our increasingly turbulent world¹. Grounded in WHO’s mission to promote, provide, and protect health and well-being for all, along with its commitment to gender equality, universality, and human rights, the new strategy outlines six strategic objectives that address the pressing health challenges and crises of our time: tackling health risks linked to our rapidly changing climate; preventing disease through collective action on health determinants; advancing PHC and essential health system capacities to enhance efforts aimed at common goals and progress towards (Universal Health Coverage (UHC); improving health service coverage and financial protection; and fortifying prevention, preparedness, and response to health emergencies.

Achieving these objectives will necessitate that PC, focused on preventing and relieving pain, other physical and psychological symptoms, and social and spiritual suffering, is regarded as a vital component of health emergency responses and meaningfully integrated into all such efforts². The WHO EURO Region has experienced significant humanitarian crises, including disease outbreaks, natural disasters, and conflicts. Such crises have resulted in widespread displacement, physical and psychological trauma, and heightened vulnerability among women, children, the impoverished, and those who are chronically ill. The severity and intensity of suffering emphasises the urgent need for humanitarian response organisations to incorporate PC into their initia-

tives and interventions. At the same time, governments in increasingly at-risk areas must build resilient healthcare systems that integrate PC at all levels of service provision, ensuring adaptability to their local needs.

Across countries and territories in this Region, Ministries of Health (MoH), public and private healthcare institutions, and humanitarian response organisations must take coordinated action to ensure that palliative care (PC) is integrated into responses to humanitarian crises and health emergencies. The following actions are essential to achieve this goal:

Ensure that national policies:

- Include access to PC for everyone as part of basic, essential, and universally accessible health care;
- Require both foreign and domestic humanitarian response organisations to incorporate PC as one of the key interventions;
- Enable foreign humanitarian response organisations to provide controlled medicines in the WHO Essential Package of Palliative Care for Humanitarian Emergencies and Crises for use in such instances.

Ensure that all domestic humanitarian response programmes and teams:

- receive training in PC and the importance not only of saving lives but also of preventing and relieving physical, psychological, social and spiritual suffering;
- are equipped with all items in the WHO Essential Package of Palliative Care for Humanitarian Emergencies and Crises;
- are enabled to recruit local mental health care providers to provide culturally and linguistically appropriate acute psychosocial care, long-term psychosocial support for survivors and bereaved family members, and culturally appropriate care counselling for foreign humanitarian responders.

In summary, the WHO Essential Package of Palliative Care for Humanitarian Emergencies and Crises provides a structured approach to delivering essential PC services in challenging environments, ensuring that patients receive the necessary care to manage their symptoms and improve their quality of life. ●

Source:

1. *A Global Health Strategy for 2025-2028 - advancing equity and resilience in a turbulent world: fourteenth General Programme of Work A Global Health Strategy for 2025-2028*
2. Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises: a WHO guide. Geneva: World Health Organization; 2018. <https://iris.who.int/bitstream/handle/10665/274565/9789241514460-eng.pdf?sequence=1>

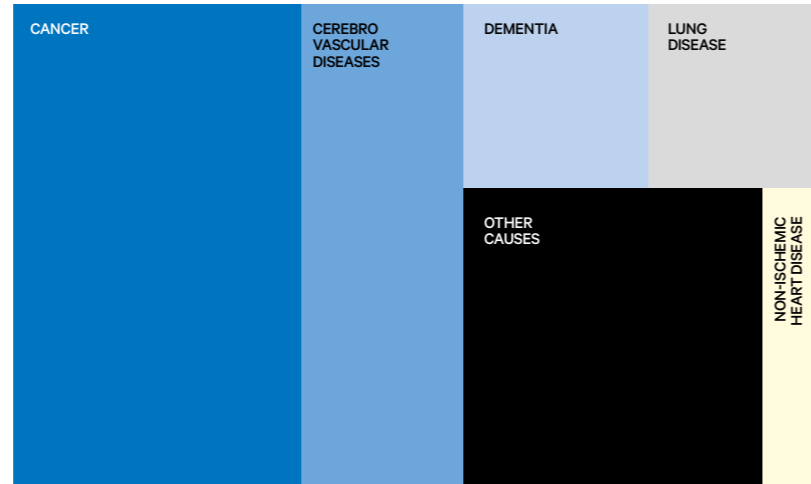
EU Abbreviations

ACP	Advance Care Planning
AD	Advance Directives
EAPC	European Association for Palliative Care
EML	Essential Medicines List
ArcGIS	Geographic Information System software
HIS	Health System Information
IAHPC	International Association for Hospice and Palliative Care
ICS	Institute for Culture and Society (Universidad de Navarra)
LMICs	Low- and Middle-Income Countries
MoH	Ministry of Health
NGOs	Nongovernmental Associations
NCDs	Non-Communicable Diseases
NLM	National Library of Medicine
OPD	Outpatient Department
PHC	Primary health care
PC	Palliative care
PPC	Paediatric palliative care
SAR	Special Administrative Region
S-DDD	Defined daily doses for statistical purposes per million inhabitants per day
SDGs	Sustainable Development Goals
SHS	Serious Health-related Suffering
UHC	Universal health coverage
UN	United Nations
WHO	World Health Organisation
WHPCA	Worldwide Hospice Palliative Care Alliance

Palliative Care in the European Region 2025: At a Glance

Over 4 million people faced SHS in the European region

CONDITION	SHS IN THOUSANDS
Cancer	1,818,424
Cerebrovascular diseases	738,226
Dementia	333,755
Lung disease	311,535
Non-ischemic heart disease	183,778
Other causes	893,560
Total	4,279,278



¹ Source: The Lancet Commission on Global Access to Palliative Care and Pain Relief. Serious health-related suffering database, 2015.

Education and Training

21/56

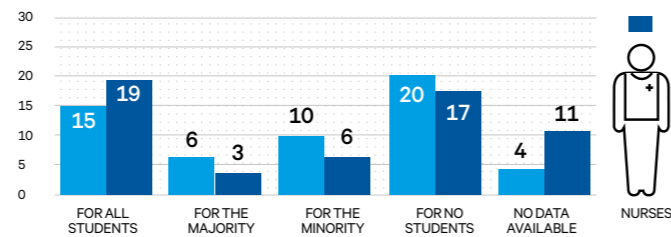
countries officially recognise PC as a medical specialty or subspecialty through national regulatory authorities.

DIPLOMAS

9/56 have other kind of diplomas with official recognition (i.e., certification of the professional category or of the job position).



PALLIATIVE CARE EDUCATION FOR FUTURE DOCTORS AND NURSES: NUMBER OF COUNTRIES TEACHING MANDATORY PALLIATIVE CARE



Research

33/56

countries host national PC conferences every year.

8/56

countries have advanced level of peer reviewed articles focusing on PC research: Belgium, Denmark, Germany, Ireland, Netherlands, Spain, Sweden and United Kingdom.

Health Policies

LEVEL	CONTENT	COUNTRIES
4	Actualised, evaluated or audited in last 5 years	15
3	Actualised but not evaluated or audited in last 5 years	9
2	Developed over 5 years ago	11
1	Not known or does not exist	12

PALLIATIVE CARE LAWS

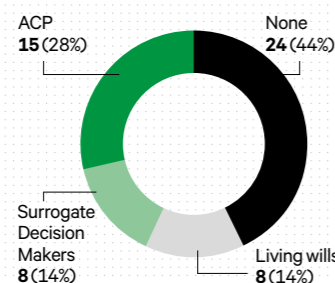
COUNTRY	YEAR	NAME
France	1999	Loi n° 99-477 du 9 juin 1999 visant à garantir le droit à l'accès aux soins palliatifs.
Belgium	2002	Wet van 14 juni 2002 betreffende de palliatieve zorg (& Amendement 2016 Pal Zorg)
Luxembourg	2009	Loi du 16 mars 2009 relative aux soins palliatifs, à la directive anticipée et à l'accompagnement en fin de vie et modifiant.
Italy	2010	Legge 38/2010 - Disposizioni per garantire l'accesso alle cure palliative e alla terapia del dolore.
Portugal	2012	Lei n.º 52/2012 de 5 de setembro - Lei de Bases dos Cuidados Paliativos.
Germany	2015	Gesetz zur Verbesserung der Hospiz- und Palliativversorgung in Deutschland (HPG) vom 1. Dezember 2015.
Armenia	2020	Law of the Republic of Armenia on Palliative Care.
Albania	2021	Ligji Nr. 156/2014 - Për Kujdesin Paliativ në Republikën e Shqipërisë.
Austria	2022	Bundesgesetz über die Einrichtung eines Hospiz- und Palliativfonds- Hospiz- und Palliativfondsgesetz.

Empowerment people and communities

33/56

have a strong national and sub-national presence of PC advocacy and promoting patient rights.

NATIONAL POLICY OR GUIDELINE ON ADVANCE CARE PLANNING (ACP) OR ADVANCE DIRECTIVES



Specialised services

7119

specialised PC services.

0,96 services per 100,000 inh on average.

524

paediatric services present in 41 countries.

TOTAL SPECIALISED SERVICES

7119 specialised PC services (0.96 services per 100,000 inh.).

Ukraine	0.23	Malta	0.72	United Kingdom	1.27	Austria	3.68
Estonia	0.22	Slovakia	0.64	Andorra	1.24	Lithuania	2.51
Kazakhstan	0.18	Georgia	0.62	Israel	1.16	Switzerland	2.10
Belarus	0.15	Romania	0.56	Germany	1.13	Sweden	1.90
Bosnia-Herzegovina	0.09	Armenia	0.53	Croatia	1.06	Netherlands	1.85
Tajikistan	0.09	Moldova	0.49	Denmark	1.06	Norway	1.83
Kyrgyzstan	0.07	Turkiye	0.49	Iceland	1.02	Czech Rep	1.68
Greece	0.04	Slovenia	0.47	Italy	1.00	Ireland	1.64
Turkmenistan	0.01	Bulgaria	0.39	Cyprus	0.97	Belgium	1.54
Azerbaijan	0.01	North Macedonia	0.38	Hungary	0.96	Finland	1.52
Uzbekistan	0.01	Serbia	0.26	Latvia	0.96	Luxembourg	1.50
Kosovo	0.00	Albania	0.25	Spain	0.96	Poland	1.42
				France	0.90	Portugal	1.42

Monaco, Liechtenstein and San Marino reported 7.70, 7.53, and 5.91, respectively.

Use of Medicines

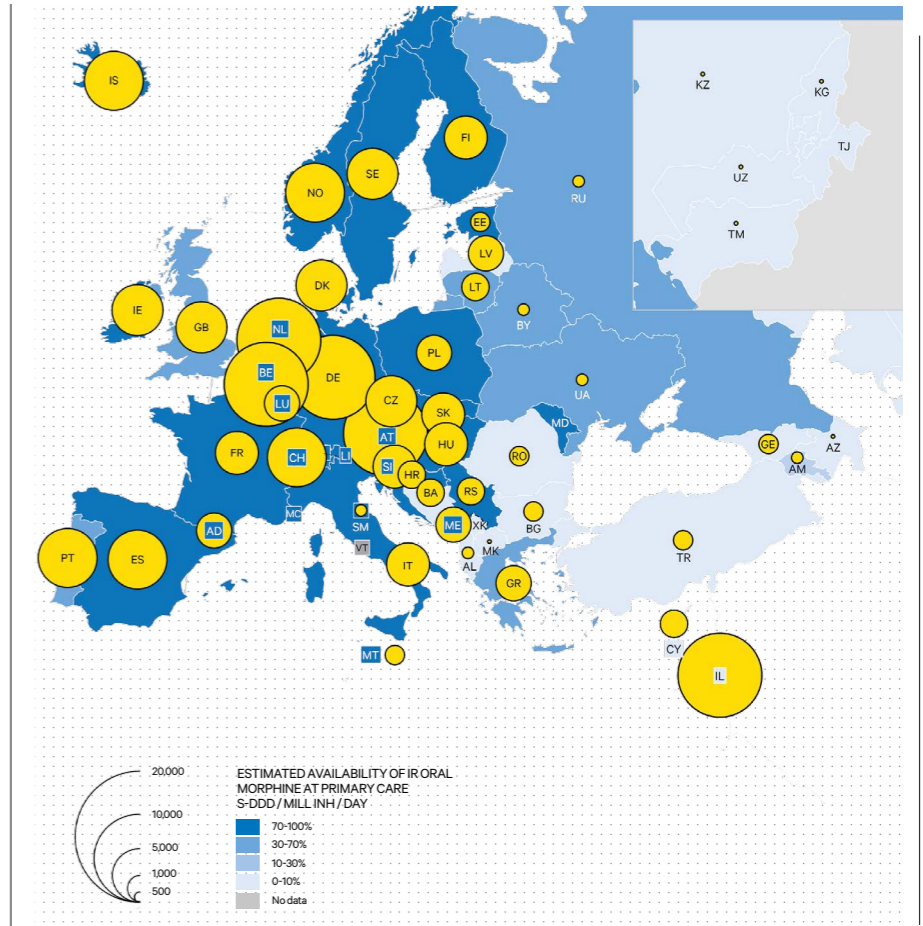
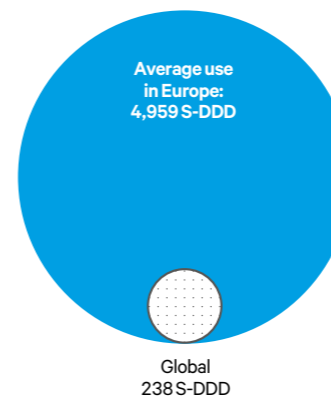
18/56

countries report available Immediate Release Oral Morphine in less than 30% of health facilities at the primary care level.



26/56 report very good availability of different opioids and in different formulations.

USE OF OPIOIDS



GLOBAL FRAMEWORK FOR THE DEVELOPMENT OF PALLIATIVE CARE IN COUNTRIES AND AREAS (WHO, 2021)



- (A) EMPOWERMENT OF PEOPLE AND COMMUNITIES
- (B) POLICIES
- (C) RESEARCH
- (D) USE OF ESSENTIAL MEDICINES
- (E) EDUCATION AND TRAINING
- (F) PROVISION OF PC

LEVEL OF DEVELOPMENT

- (1) EMERGING
- (2) PROGRESSING
- (3) ESTABLISHED
- (4) ADVANCED

Thematic maps

EU Map 1: Empower people and communities

The empowerment of people and communities relates to the capacity of a country to empower individuals, families and communities as partners in the development of health and social services as well as in the engagement in shared decision-making about their own health. This entails the availability of advocacy resources to protect and enhance the participation of patients and caregivers in the development of palliative care programmes.

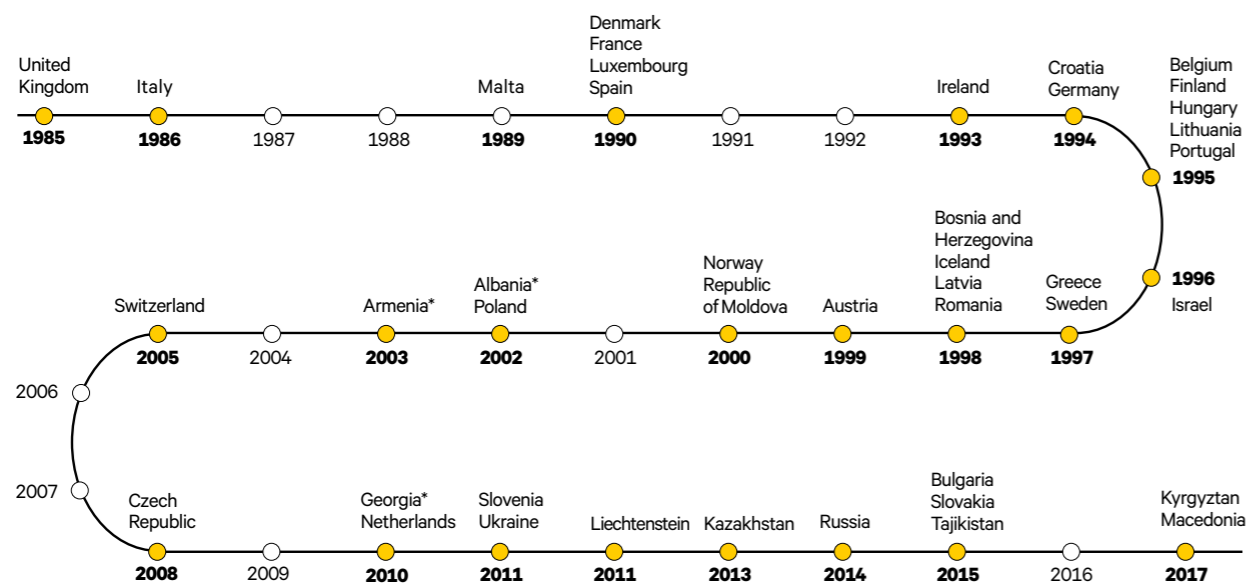
GROUPS DEDICATED TO PROMOTING THE RIGHTS OF PATIENTS IN NEED OF PALLIATIVE CARE, THEIR CAREGIVERS, AND DISEASE SURVIVORS

Across Europe, the most reported groups promoting the rights of patients in need of palliative care (and their families), are the professional national PC associations. There exist, to date, at least one national association in 39 countries, and some countries have more than one: Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Lithuania, Netherlands, Norway, Poland,

Portugal, Romania, Slovenia, Sweden, UK. Furthermore, main groups advocating for palliative care include children associations (present, at least, in Belgium, Croatia, Denmark, Greece, Ireland, Kazakhstan, Kyrgyzstan, Latvia, Netherlands, Norway, Slovenia, Spain, Switzerland, UK), as well as PC nursing societies, reported in countries like Croatia, Denmark, Poland, Portugal, Spain, Sweden, Türkiye and UK, to cite some.

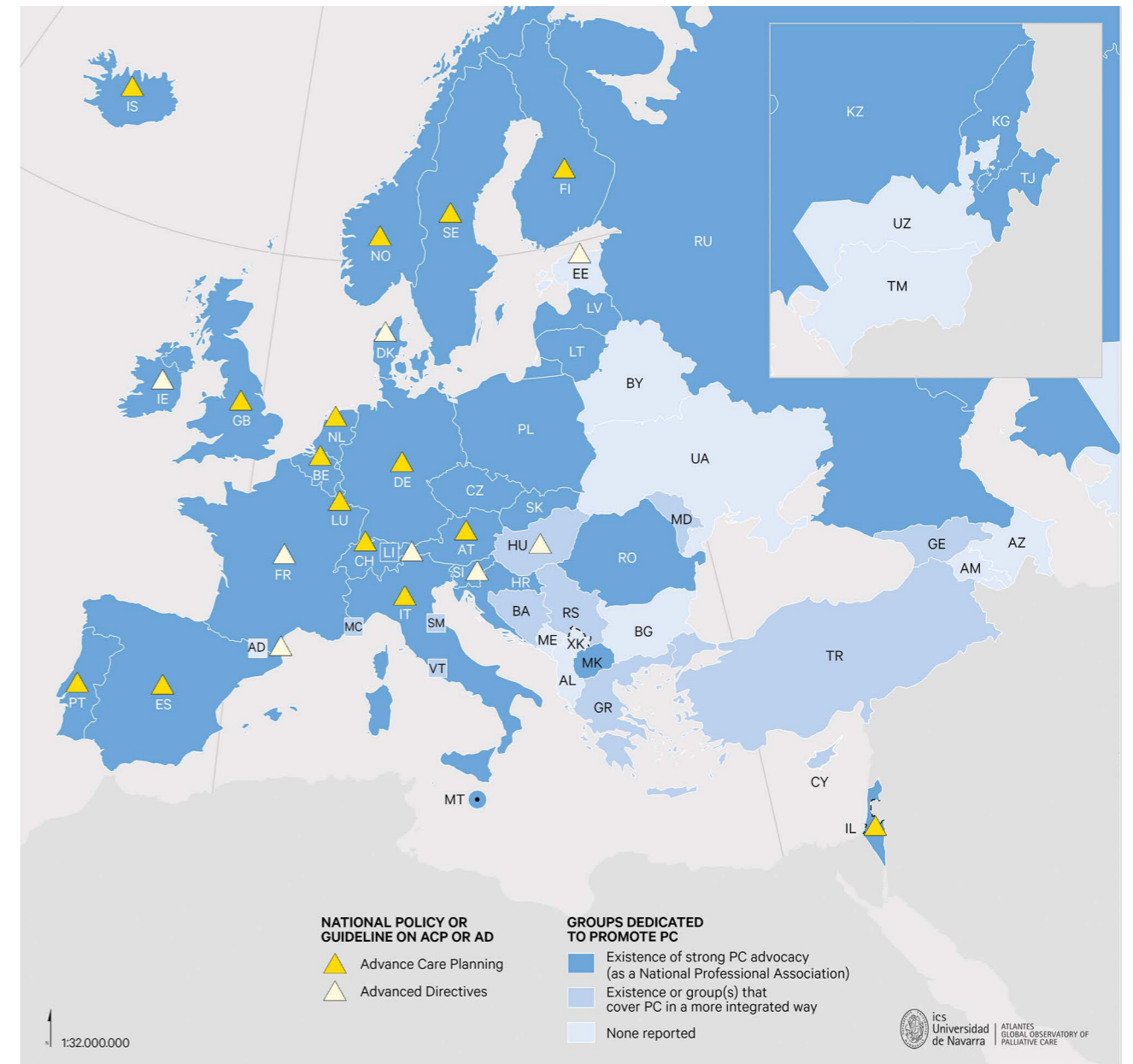
There is also documented activity of patients' organisations in Denmark, Estonia, France, Greece, Hungary, Iceland, Ireland, Israel, Norway, Poland, Portugal, San Marino, Serbia, Switzerland, UK, with particular relevance of groups fighting cancer in Croatia, Cyprus, Denmark, Hungary, Iceland, Ireland, Kyrgyzstan, Lithuania, Moldova, Poland, Portugal, Romania, San Marino, Spain, or Serbia. Other countries also report great activity held by NGOs (Kazakhstan, Kosovo, Moldova, North Macedonia, Russia, also for children, Serbia, Tajikistan, Türkiye, Ukraine). In others, advocacy is very much sporadic and dependent on individual professionals.

Time line of National Associations' creation



* Limited activity reported

EU Map 1: Empower people and communities



Map 1. Empowerment of people and communities.

EU Map 1: Empower people and communities

NATIONAL POLICY OR GUIDELINE ON ADVANCE CARE PLANNING OR ADVANCE DIRECTIVES

The partnership of individuals, families, and communities in the development of health services may be reflected in national policies that promote their engagement in shared decision-making about their own health. This shared-decision making can be a reality in the form of Advance Care Planning, Living wills, or Surrogate Decision-makers.

Advance Care Planning enables individuals to define goals and preferences for future medical treatment and care, to discuss these goals and preferences with family and health-care providers, and to record and review these preferences if appropriate*. **Living Wills** (or Advance Directives) is a legal document that specifies the type of medical care that an individual does or does not want in the event they are unable to communicate their wishes. Finally, surrogate decision-maker policies. These agents, also known as health care proxies or health care agents—are individuals who are legally designated to act on behalf of patients who are unable to make decisions about their own care. These policies ensure that when a per-

son becomes incapacitated, there is a recognised advocate who can make informed decisions aligned with the patient's preferences.

In Europe, 15 countries (predominantly Western countries), have national policies or guidelines regulating advance care planning: Austria, Belgium, Finland, Germany, Iceland, Israel, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom. A further eight reported living wills and another eight Surrogate Decision Making policies.

Although many countries have legal frameworks or official recommendations supporting advance care planning (ACP), its implementation remains inconsistent across the region. ACP is a recent development in Belgium and Iceland. In Israel, it is used only to a limited extent. In Italy, implementation is hindered by inadequate training, low awareness, and the lack of standardised procedures. In Poland and Sweden, ACP is not commonly recognised or applied in clinical practice. In Portugal and Spain, ACP is still in development, with efforts ongoing to improve implementation and raise public and professional awareness. ●

Key notes on some countries

AUSTRIA

The VSD Vorsorgedialog® is a legal instrument for the advance care planning process. This process is especially designed for people living in care homes or those who want to die in their own homes. Additional to the VSD Vorsorgedialog® process there exist specific other advance directive documents: Patientenverfügung; Vorsorgevollmacht, and other legal instruments for advance care planning like the “living wills” and the “power of attorney”.

SWEDEN

There is one national policy addressing ACP of medical decisions for use of life-sustaining treatment or end-of-life care from the National Board of Health and Welfare, SOSFS 2011:7. There are no possibilities for patients or relatives to write legally binding AD or “living wills”; the concept ACP is used in the everyday care process and is formulated in the National Program for PC (Adult and children), the National PC Pathway (including discussion between health care staff and the person and/or relatives around the transition to PC, wishes and goals of care and documented in the medical record), the National guidelines and the National Board of Health and Welfare's terms/concepts related to PC.

UNITED KINGDOM

All four nations have policy and guidance on advance care planning: NHS England, Health Improvement Scotland, NHS Wales, and NHS Northern Ireland. The UK's National Institute for Health and Care Excellence has published guidance on ACP: “Advance Care Planning: Guidance for care home managers”, “Decision making and mental capacity: Quality Standard 2, Advance Care Plans”, and NHS England has also issued Advance care decisions to refuse treatment (living will). In Paediatrics there is a national Advance care plan document with supported website and education.

* Rietjens JA, Sudore RL, Connolly M, van Delden JJ, Kuhnle E, Ayoub LH, et al. Definition and recommendations for advance care planning: an international consensus supported by the European Association for Palliative Care. *Lancet Oncol.* 2017;18(9):e543–51

EU Map 2: Health policy related to PC

The political commitment and leadership expressed in governance and policy frameworks (strategies, standards, and guidelines) is essential to palliative care development. It includes the development of a legal framework and regulations that guarantee the rights of patients, access to palliative care services and essential medicines, and the financing and inclusion of palliative care in the National Health Service and benefits package. It also includes health system design and health care organisation, in addition to stewardship and multi-stakeholder action.

NATIONAL PALLIATIVE CARE POLICIES OR STRATEGIES

Twenty-five countries have established national PC strategies or plans in the last 5 years (nine not audited), some twenty-one also accompanied by national PC law/legislation/government decrees on PC: Austria, Denmark, France, Germany, Iceland, Ireland, Israel, Italy, Lithuania, Luxembourg, Malta, Netherlands, North Macedonia, Norway, Portugal, Romania, Russian Federation, Slovakia,

Spain, Sweden. Few further countries (namely Belgium (Flanders region), Czech Republic, Greece, Poland and Slovenia) have national plans in preparation. Other countries have a dedicated PC section within another national plan such as for cancer, non-communicable diseases or HIV. This is the case for Albania, Bulgaria, Croatia, Czech Republic, Finland, Kazakhstan, Latvia, Liechtenstein, Moldova, San Marino, Serbia, Slovenia, Switzerland, Tajikistan, Türkiye, Ukraine, Uzbekistan.

Key notes on some countries

AUSTRIA

Financing Law (*Bundesgesetz über die Einrichtung eines Hospiz- und Palliativfonds–Hospiz- und Palliativfondsgesetz*) defined the financing mechanisms and introduced new quality criteria and indicators for hospice and palliative care institutions, as well as for staff education. The Austrian National Public Health Institute (*Gesundheit Österreich GmbH, GÖG*) monitors and evaluates progress on behalf of the Federal Ministry for Social Affairs, Health, Care and Consumer Protection.

NORWAY

Norway has established the ‘National Action Program for Palliative Care in Cancer Care’ (*Nasjonalt handlingsprogram for palliasjon i kreftomsorgen*), which provides national professional guidance for PC in the context of cancer care. While the Action Program is under the Cancer Programs, it is designed for use independent of diagnosis. The program's online version was published five years ago, and an active workgroup is continuously revising and updating it. Additionally, the ongoing implementation of the Report to the Storting (Norwegian Parliament) (White Paper) No. 24 (2019–2020) entitled “PC - We Shall All Die One Day. But All Other Days We Shall Live,” outlines the broader framework for PC in Norway.

ROMANIA

PC is recognised and incorporated into various policies like the National Palliative Care Program 2024 (administered by the National Health Insurance House and providing funding for PC services) or the Emergency Ordinance 106/2024 for amending and supplementing Law 95/2006 regarding the health reform (in which provisions for PC as part of the national healthcare system were incorporated). There are also amendments to some normative acts whose main scope is to draft the normative framework for the implementation of the National Program of PC in units with beds, at home and in outpatients and its development through health insurance companies, in accordance with the provisions of Law no. 293/2022 for the prevention and fight against cancer.

EU Map 2: Health policy related to PC

National palliative care laws across Europe

Country	Year	Law
France	1999	Loi n° 99-477 du 9 juin 1999 visant à garantir le droit à l'accès aux soins palliatifs (Law No. 99-477 of 9 June 1999 aimed at guaranteeing the right to access palliative care.)
Belgium	2002	Wet van 14 juni 2002 betreffende de palliatieve zorg (& Amendement 2016 Pal Zorg) (Law of 14 June 2002 on palliative care (& Amendment 2016 Pal Zorg))
Luxembourg	2009	Loi du 16 mars 2009 relative aux soins palliatifs, à la directive anticipée et à l'accompagnement en fin de vie et modifiant (Law of 16 March 2009 on palliative care, advance directives and end-of-life support, amending)
Italy	2010	Legge 38/2010 - Disposizioni per garantire l'accesso alle cure palliative e alla terapia del dolore (Law 38/2010 - Provisions to ensure access to palliative care and pain therapy)
Portugal	2012	Lei n.º 52/2012 de 5 de setembro - Lei de Bases dos Cuidados Paliativos (Law no. 52/2012 of 5th September - Basic Law on Palliative Care)
Albania	2014	Ligji Nr. 156/2014 - Për Kujdesin Paliativ në Republikën e Shqipërisë (Law No. 156/2014-On Palliative Care in the Republic of Albania)
Germany	2015	Gesetz zur Verbesserung der Hospiz- und Palliativversorgung in Deutschland (HPG) vom 1. Dezember 2015 (Law on improving hospice and palliative care in Germany (HPG) of 1 December 2015)
Armenia	2020	Հայաստանի Հանրապետության օրենք՝ Պալիատիվ մարզում ծառայությունների մասին (Law of the Republic of Armenia on Services in Palliative Care)
Austria	2022	Bundesgesetz über die Einrichtung eines Hospiz- und Palliativfonds - Hospiz- und Palliativfondsgesetz (National Hospice and Palliative Care Financing Law)

INCLUSION OF PALLIATIVE CARE IN THE LIST OF PRIORITY SERVICES FOR UNIVERSAL HEALTH COVERAGE IN THE NATIONAL HEALTH SYSTEM

In 31 European countries Palliative care is included in the list of health services provided at the primary care level in the General Health Law, and in further 12 PC is recognised within government laws or decrees. In 43 countries (76%), PC is part of the basic package of basic healthcare services for Universal Health Coverage. This package has as its goal the completion of SDG3.8, through which all persons should be able to have access to quality essential health services without facing financial hardship.

The way palliative care is included within general healthcare laws and governmental decrees varies significantly. Approaches range from designating specific responsibilities to general physicians, mandating its provision across all primary care settings, integrating it into pension schemes or insurance plans, or focusing on medication reimbursement. Additionally, policies may address the training requirements of professionals delivering basic care, the availability of services in primary care centres, or simply by classifying palliative care as part of the essential services offered by the public healthcare system.

By a Governmental decree	By General Health Law	
Andorra	Belarus	Lithuania
Armenia	Belgium	Luxembourg
Austria	Bosnia-Herz.	Malta
Czech Republic	Bulgaria	Moldova
Georgia	Croatia	Montenegro
Ireland	Denmark	Netherlands
Kazakhstan	France	Norway
Monaco	Germany	Poland
Portugal	Greece	Romania
Slovenia	Hungary	Russian Fed.
Switzerland	Iceland	San Marino
Türkiye	Israel	Serbia
	Italy	Spain
	Latvia	Sweden
	Liechtenstein	Ukraine
		United Kingdom

EU Map 2: Health policy related to PC

Key notes on some countries

BULGARIA
Article 96, items 2 and 3 of the Health Act stipulate that "Palliative medical care is provided by general practitioners, medical institutions offering outpatient and inpatient care, and hospices." Additionally, "The requirements for the provision of palliative medical care are specified by an ordinance issued by the Minister of Health."

FRANCE
PC is one of the priority services and its importance is recognised by law in the context of supporting people at the end of their lives and alleviating the suffering from serious illnesses. Legal context includes 1st) Law of June 9, 1999, 2nd) National plan for the development of PC (most recent, 2021-2024), and 3rd) the Law Claeys-Leonetti (2016). Services and priorities in the health system highlight a) accessibility: PC must be available both in hospital and at home, through mobile teams or specialised units; b) Training: Training of health professionals in PC is encouraged to meet growing needs, and 3rd) Territorial equality.

POLAND
Hospice and PC services are included in the catalogue of the guaranteed services within Polish public healthcare system. The beneficiary (patient) is entitled to guarantee healthcare services in the scope of palliative and hospice care). Act of 27 August 2004 on health care services financed from public funds (Art. 15 sec. 2 item 11: 2.). When patients with PC needs do not fulfil the referral criteria for specialised PC, the primary care physician is obliged to deliver care (PC approach) as per ACT of 27 October 2017 on primary care – art. 2.

NATIONAL AUTHORITY FOR PALLIATIVE CARE WITHIN THE GOVERNMENT OR THE MINISTRY OF HEALTH

Very few countries report a coordinating entity for palliative care, well-defined and structured (scientific and technical): Austria, France, Germany, Italy, Luxembourg, Netherlands, Norway, Poland, Portugal, Russian Federation, Slovakia, and Switzerland. Five countries report a responsible person/branch/ in the MoH, but with an incomplete structure (as per lacking scientific or technical section): Hungary, Iceland, Ireland, Lithuania, Slovenia, Türkiye, United Kingdom. ●

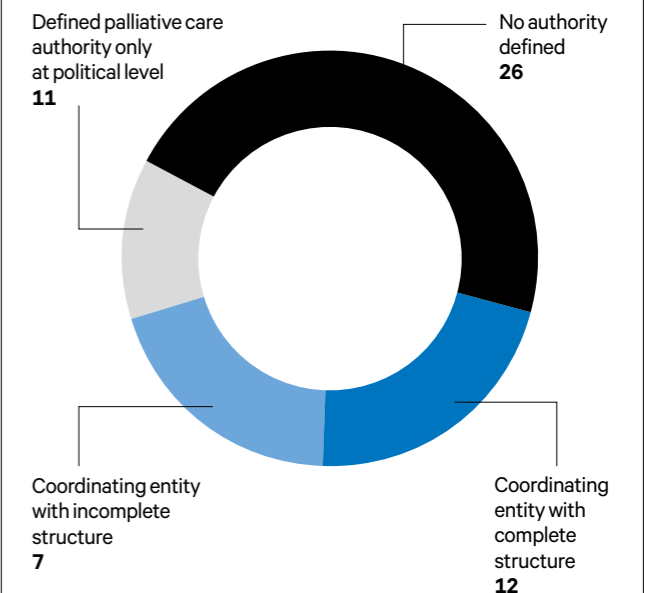
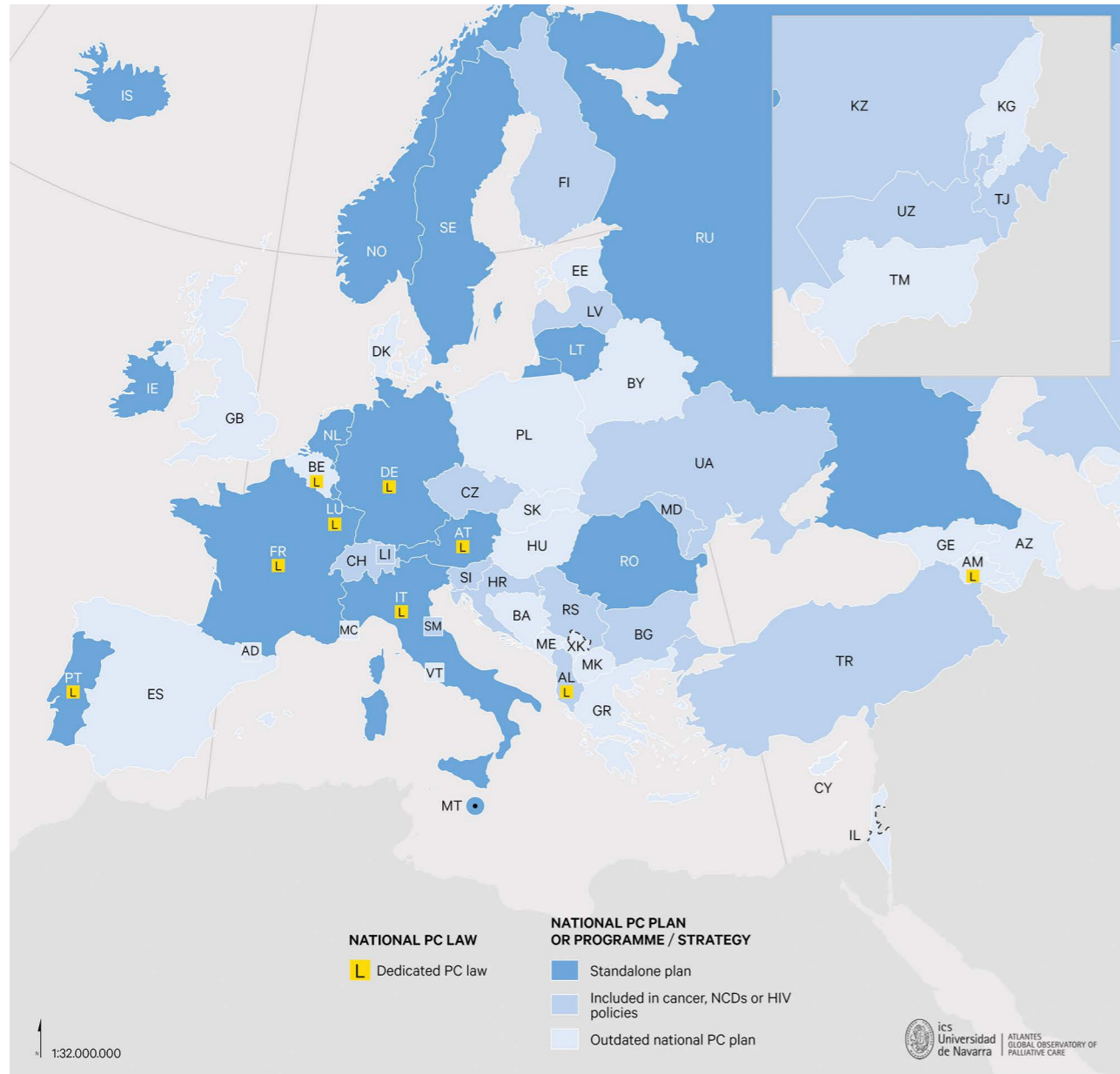


Figure 6. Responsible authority for PC within the Ministries of Health.

EU Map 2: Health policy related to PC



Map 2. Health Policy related to Palliative Care

Key notes on some countries

NETHERLANDS

The Steering Group of the National Palliative Care Programme, established by the government, is crucial in guiding the implementation and development of PC policies in the Netherlands. One steering group member, also serves as the Team Coordinator for PC and Spiritual

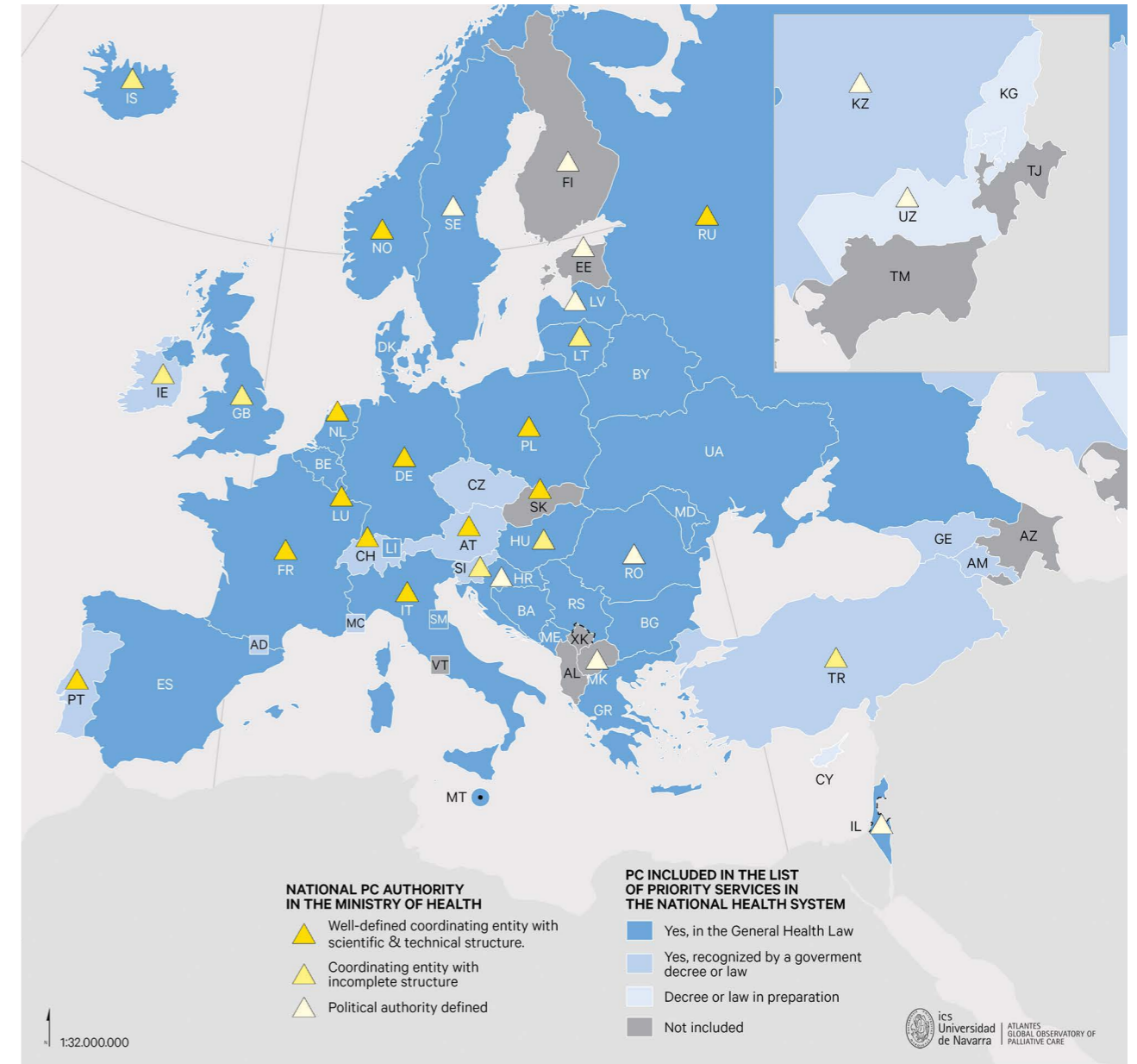
Care at the MoH, Welfare and Sport. Its involvement ensures a cohesive approach to integrating palliative and spiritual care services within the national healthcare framework. There is a broad government support for PC in general, also from the parliament, as part of human care. Scientific advisory tasks and research are performed via a

related research programme (Palliative II) with an independent committee.

GERMANY

Though not all federal states have a national authority, some do have rather prominent ones (e.g North Rhine-Westfalia has a staff position

EU Map 2: Health policy related to PC



Map 2. Health Policy related to Palliative Care

related to PC at the state MoH, which works closely with two coordinating and networking offices (ALPHA Rheinland and ALPHA Westfalen). Another example; Bavaria has an active coordinating office at the federal MoH. Also, the State of Lower Saxony has a coordination agency. Organised on the state level, the coordinating offices are part of the ministry, and are included in the budgets. In addition, there is a unit for the

elderly, dementia, hospice and PC: Referat 301 in the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, which is budgeted and staffed as regular part of the ministry.

RUSSIA

The working body of the MoH PC branch on federal level consists of 1) an institute of Chief Specialists,

embedded in the healthcare system, supervising provision and development of PC on their territorial unit; 2) a Profile Commission on PC of MoH of Russia, consisting of the Chief Specialists and prominent PC advocates, and 3) Federal Scientific and Practical Centre for Palliative Medical Care of the Sechenov University of the MoH since 2019 (role of coordination hub, monitor centre for availability and quality of PC provision).

EU Map 3: Research

Research aims at improving the level of scientific evidence to guide the care of people and decisions about the organisation of health services. Three indicators measure the extent to which countries are progressing with regard to PC research: a) existence of congresses or scientific meetings at the national level specifically related to palliative care, b) palliative care research on the country estimated by peer-reviewed articles, and c) inclusion of PC topics in National Research calls.

EXISTENCE OF CONGRESSES OR SCIENTIFIC MEETINGS AT THE NATIONAL LEVEL SPECIFICALLY RELATED TO PALLIATIVE CARE

Thirty-three countries (60%) report holding at least one national conference specifically dedicated to palliative care every year, with multidisciplinary attendance (nurses, psychologists, chaplains), accessible for professionals from remote areas, and paediatric topics included. Eight countries report one non-palliative care congress or conference (cancer, HIV, chronic diseases, etc.) that regularly has a track or section on palliative care, each 1-2 years. Amongst countries where there are national PC congresses, although some have a rather short trajectory (such

is the case for Andorra, 2023, Liechtenstein since 2022, Malta 2024, or Serbia 2023), many European countries have already a long trajectory like the Czech Republic or Sweden (since 2010), or longer (France since 1991, Greece since 1998, Romania since 2000). It is the case also for the UK, Ireland, Poland, Germany, Spain and others. Furthermore, a number of countries report an intense congress or conference activity arguably due to the existence of several PC associations but also to an increasing interest and need to gain evidence on PC: Austria, Belgium, Czech Republic, Denmark, Finland, France, Greece, Germany, Hungary, Ireland, Italy, Israel, Lithuania, the Netherlands, Norway, Poland, Portugal, Romania, Russia, Spain, Sweden, Switzerland and the United Kingdom.

PALLIATIVE CARE RESEARCH ON THE COUNTRY ESTIMATED BY PEER-REVIEWED ARTICLES

The perception of PC research on the country estimated by peer-reviewed articles varies greatly across European countries. Around two thirds report a low or very low production (37 countries), whilst 17 countries estimate a considerable-extensive amount of palliative care-related research papers.

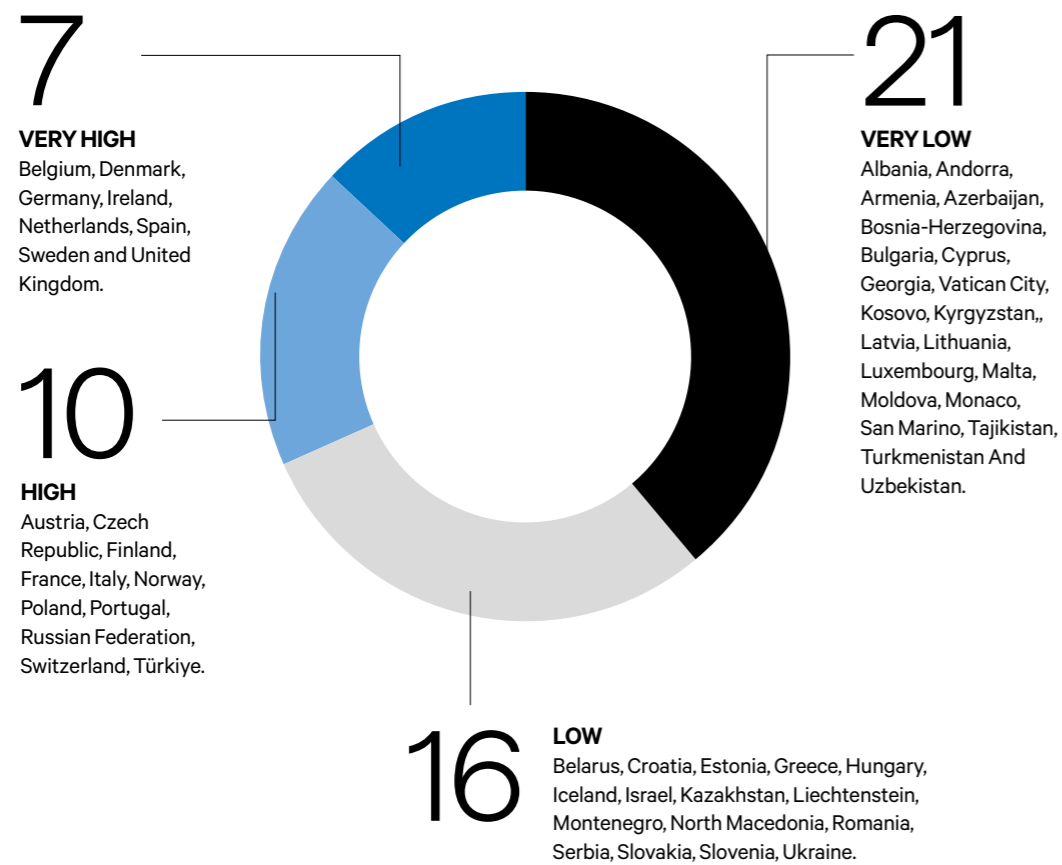
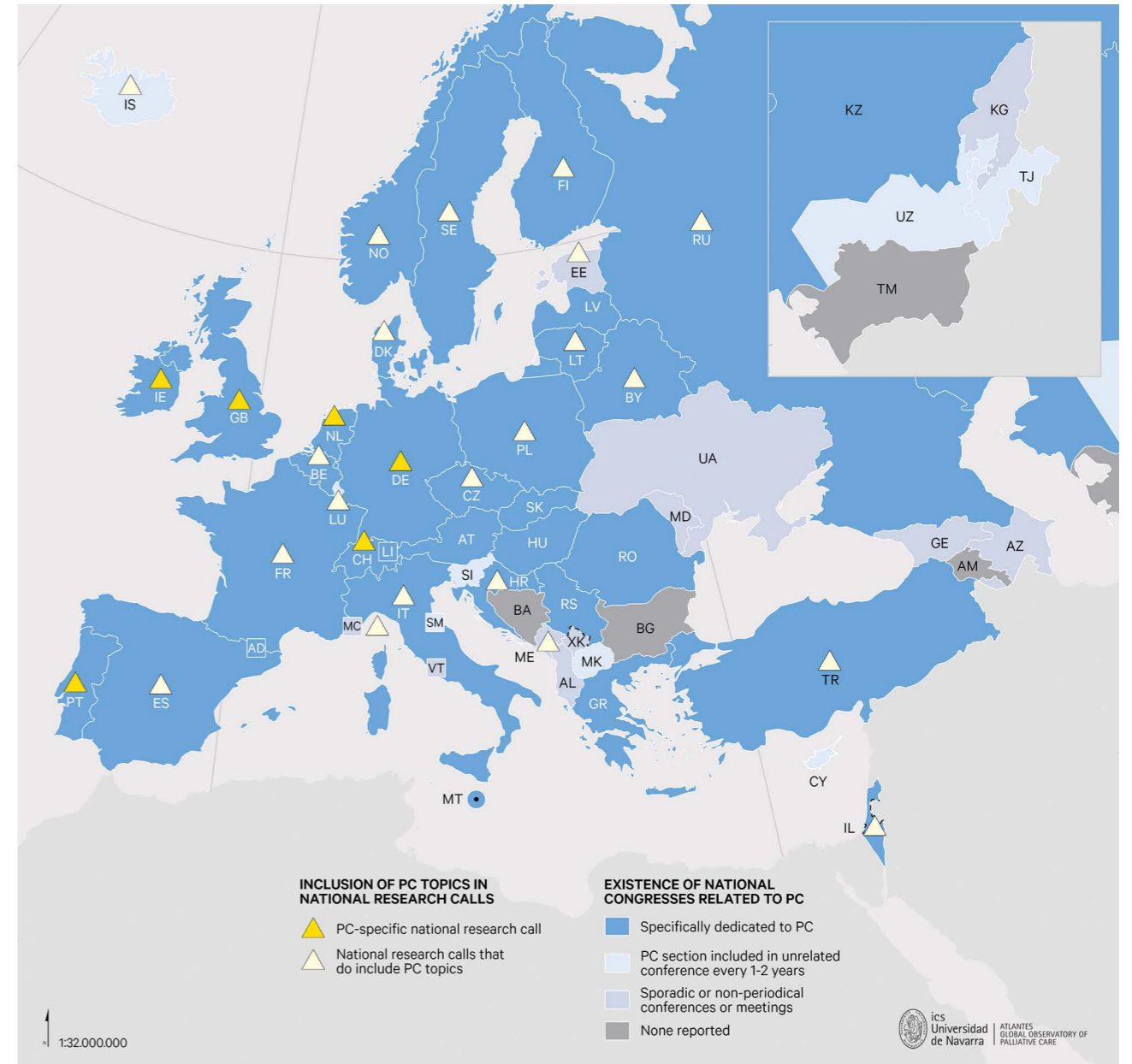


Figure 7. Perception of the production of PC-related peer-reviewed articles

EU Map 3: Research



Map 3. Research

EU Map 3: Research

INCLUSION OF PC TOPICS IN NATIONAL RESEARCH CALLS

Six countries have palliative care-specific national research calls: Germany, Ireland, Netherlands, Portugal, Switzerland and the United Kingdom. ●

Palliative care-specific national research calls

Country	Description
Germany	Palliative care, though with fewer resources than other medical fields, is part of national research. Some supporting institutions are: 1st) Federal Ministry of Education and Research (PC calls publicly funded in 2015 and 2020); 2nd) the German Research Foundation (under private law, central self-governing research funding organisations); 3rd) German Association for Palliative Medicine (including research and awarding grants and prizes); 4th) the PC Research Network (fostering collaboration between universities, clinics, and others); etcetera.
Ireland	In 2024, the Health Research Board issued a call for Collaborative Research Networks 2024: Dementia and Palliative care, where palliative care researchers could submit research proposals to a range of funders on the island including the Health Research Board, Irish Research Council and Higher Education Authority, but the calls are for research grants and are not palliative care specific.
Netherlands	The Palliantie. Meer dan Zorg program is a funding initiative by ZonMw (Netherlands Organisation for Health Research and Development). Launched in 2014, it focuses on promoting collaboration, innovation, and the implementation of best practices. The program supports research projects addressing the needs and wishes of patients, ensuring integration of PC into regular healthcare services and provided as close to home as possible. In 2021, Palliantie II 2021 to 2026 was launched. All papers from Dutch authors can be posted on 'Science summarised' on the website Palliaweb, and researchers are organised in PALZON.
Portugal	Besides some training grants, there are annual education and research grants like the Isabel Correia de Levy education and research grants, which is privately funded and managed by the Portuguese National Association for Palliative Care (APCP).
Switzerland	Currently there are no dedicated programmes to PC, but within the National Research Programme "End of life", of the Swiss National Science Foundation, 33 research teams studied aspects of the end of life in Switzerland. The recommended measures in the report "Better care and treatment for people at the end of life", adopted by the Federal Council, are based, on findings by the National Research Programme 'End of Life'. Furthermore, 4.4 million CHF were made available by the Stanley Thomas Johnson Foundation and the Gottfried and Julia Bangerter-Rhyner Foundation, through five calls, to support 34 research projects and to award four fellowships for an education and research stay abroad. The network 'PC Switzerland' is a cross-disciplinary association of researchers from all parts of Switzerland.
United Kingdom	UK Research and Innovation has regular funding calls for which palliative care clinical, social and applied health research are eligible. Palliative Care research received a low proportion of funds disbursed, but there is regular and predictable funding.

EU Map 4: Essential Medicines

This chapter focuses on the availability and access to essential medicines for palliative care across all levels of the health system, with special emphasis on the use of opioids for the management of pain and other symptoms, supported by respective risk management strategies. This list of essential medicines includes non-opioids and non-steroidal anti-inflammatory medicines; opioids analgesics; and medicines for other common symptoms in palliative care.

This list of essential medicines as defined in the WHO

Acetylsalicylic acid	Docusate sodium
Ibuprofen	Fluoxetine
Paracetamol: acetaminophen	Haloperidol
Codeine,	Hyoscine butylbromide
Fentanyl	Hyoscine hydrobromide
Morphine. Therapeutic alternatives: hydromorphone, oxycodone	Lactulose
Methadone	Loperamide
Amitriptyline	Metoclopramide
Cyclizine	Midazolam
Dexamethasone	Ondansetron. Therapeutic alternatives: dolasetron, granisetron, palonosetron, tropisetron.
Diazepam	

To measure availability and accessibility, the following measures have been explored: a) Reported annual opioid consumption—excluding methadone—in oral morphine equivalence (OME) per million inhabitants/day, b) Availability of essential medicines for pain and palliative care in the country at the primary level, c) General availability of immediate-release oral morphine (liquid or tablet) at the primary level, and d) availability of different opioids and in different formulations at the primary level.

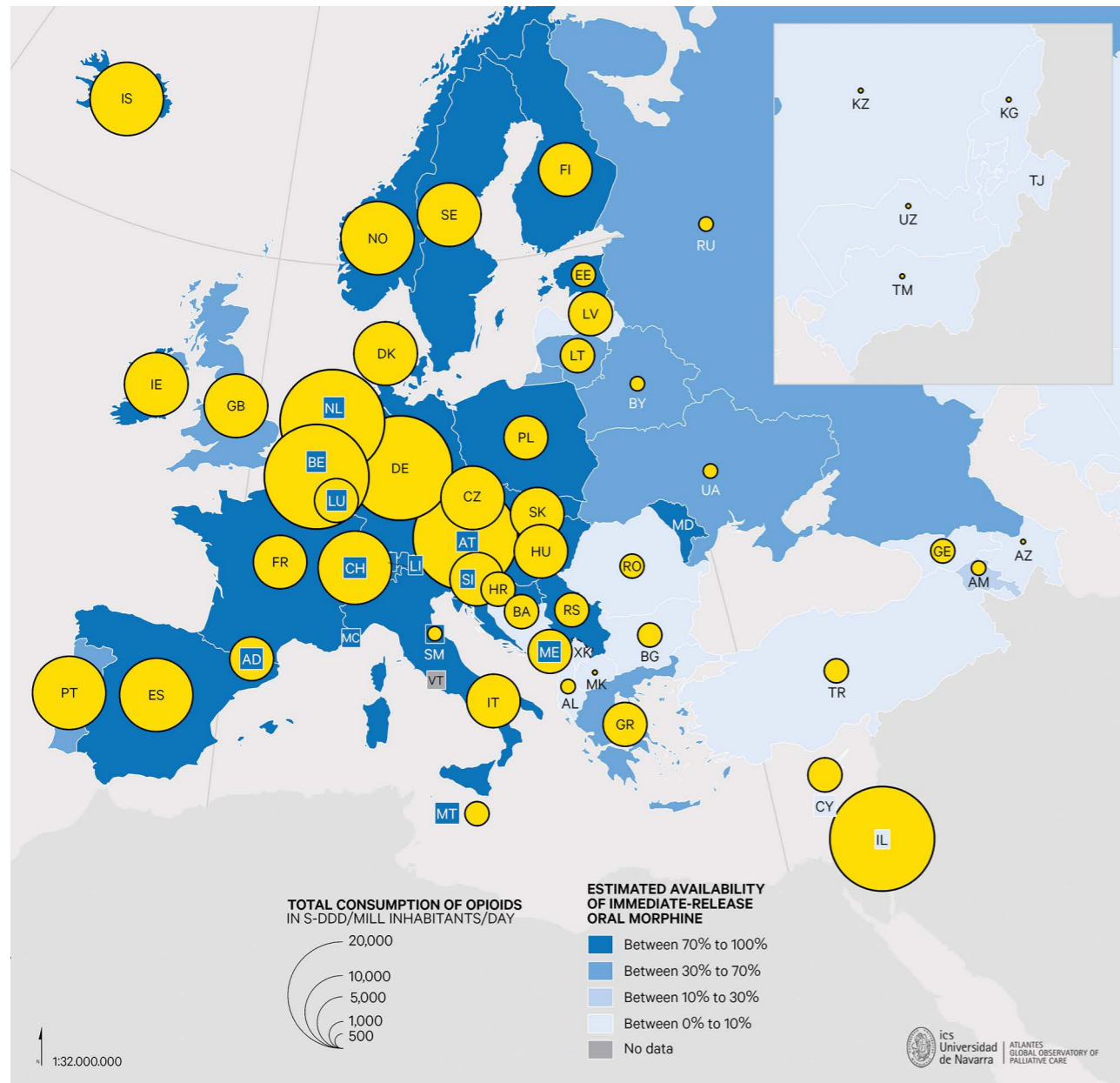
REPORTED ANNUAL OPIOID CONSUMPTION – EXCLUDING METHADONE – IN ORAL MORPHINE EQUIVALENCE (OME) per million inhabitants/day

According to the INCB, the average consumption of the six different strong opioids **morphine, codeine, fentanyl, hydromorphone, buprenorphine, and oxycodone**, 2020–2022, in defined daily doses per million inhabitants per day (2022) varies greatly across Europe. Use of opioids ranges from 6 S-DDD in Turkmenistan to 19,773 S-DDD in Austria. On average, Europe presents a consumption of 4,959 S-DDD, substantially higher than the world's average, calculated in 238 S-DDD.

Average consumption of opioids in DDD (S-DDD) for statistical purposes 2020–2022

Quartile	Country	S-DDD
Q1	Austria	19,773
Q1	Israel	16,761
Q1	Germany	15,252
Q1	Netherlands	15,074
Q1	Belgium	14,915
Q1	Spain	14,252
Q1	Switzerland	11,299
Q1	Iceland	11,172
Q1	Portugal	10,618
Q1	Norway	9,997
Q1	Denmark	9,193
Q1	Sweden	8,204
Q2	United Kingdom	6,999
Q2	Czech Republic	6,808
Q2	Ireland	6,615
Q2	France	6,414
Q2	Finland	6,391
Q2	Slovakia	6,123
Q2	Italy	4,813
Q2	Slovenia	4,394
Q2	Hungary	4,360
Q2	Luxembourg	4,354
Q2	Andorra	3,975
Q2	Greece	3,950
Q2	Montenegro	3,564
Q3	Latvia	2,402
Q3	Poland	2,349
Q3	Croatia	2,335
Q3	Bosnia-Herzegovina	2,300
Q3	Lithuania	1,783
Q3	Serbia	1,637
Q3	Cyprus	1,632
Q3	Estonia	1,300
Q3	Georgia	1,176
Q3	Romania	1,042
Q3	Malta	963
Q3	Türkiye	778
Q3	Bulgaria	754
Q4	Russian Federation	574
Q4	Belarus	465
Q4	Albania	421
Q4	San Marino	338
Q4	Ukraine	132
Q4	Armenia	81
Q4	North Macedonia	80
Q4	Kazakhstan	36
Q4	Kyrgyzstan	36
Q4	Azerbaijan	30
Q4	Uzbekistan	14
Q4	Turkmenistan	6

EU Map 4: Essential Medicines



Map 4. Essential Medicines

EU Map 4: Essential Medicines

GENERAL AVAILABILITY OF IMMEDIATE-RELEASE ORAL MORPHINE (LIQUID OR TABLET) AT THE PRIMARY LEVEL

30/56 countries reported a very good availability (in over 70% of the country's primary healthcare centres) of Immediate Release Oral Morphine. On the contrary, eighteen countries pointed out a lack of generalised availability of oral morphine: Albania, Armenia, Azerbaijan, Bosnia-Herzegovina, Bulgaria, Cyprus, Georgia, Israel, Kazakhstan, Kosovo, Kyrgyzstan, Latvia, North Macedonia, Romania, Tajikistan Türkiye, Turkmenistan, Uzbekistan.

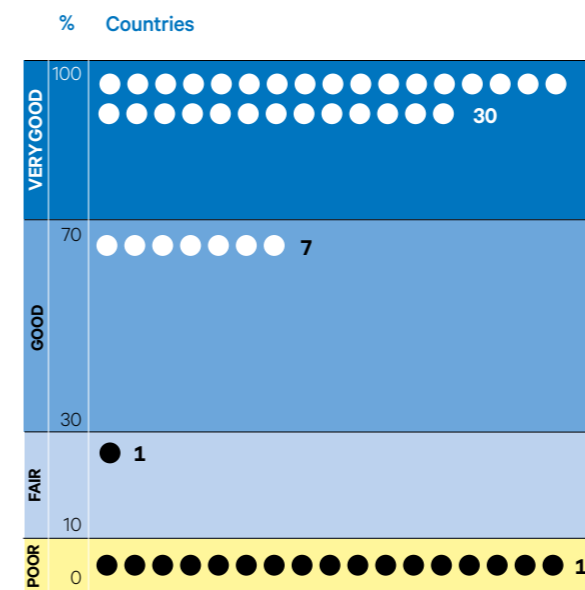


Figure 8. General availability of immediate-release oral morphine (liquid or tablet) at the primary level

The reasons for this unavailability vary country to country. In Albania, for example, morphine is only prescribed by oncologists for cancer patients; in Armenia, though added to the list of essential medicines, they are largely overregulated; and in Bulgaria, only parenteral morphine is available for pain management. In Cyprus, it is only available in hospitals and oncology centres, with few private pharmacies having very short amounts of stock, and only upon a doctor's prescription and patients' payment. Across Central Asia, countries face a series of noticeable challenges. In Kazakhstan, even if between 2016 to 2018, tableted morphine was produced by a local pharmaceutical company, due to the fact that physicians did not prescribe to patients, big amounts of morphine were discarded and destroyed. The local company terminated production of oral morphine due to financial losses. Oral dosage forms are not available, a slow-release oral morphine formulation has been registered, imported in a small amount in the country, but not included in clinical protocols. In Kyrgyzstan,

opioid medications are not provided at the primary health-care level, specialists can only issue a prescription, and the medications can only be obtained at specialised pharmacies. Lastly, in Uzbekistan, oral morphine is currently available only at the Taskin Children's Hospice and it has not yet been procured for use in other institutions.

AVAILABILITY OF DIFFERENT OPIOIDS AND IN DIFFERENT FORMULATIONS AT THE PRIMARY LEVEL

26/56 countries informed of a generalised availability of different opioids, and in different formulations, in over 70% of primary healthcare centres. The diverse opioids refer to the main six opioids (morphine, codeine, Buprenorphine, oxycodone, hydromorphone and fentanyl) and in these diverse formulations: transdermal (via patches), injectable (intravenous, subcutaneous or peridural), anal (via suppositories), and oral; and the speed of action could be immediate-release and sustained-release. These countries are Andorra, Austria, Belgium, Croatia, Czech Republic, Denmark, Finland, Germany, Hungary, Iceland, Ireland, Israel, Italy, Liechtenstein, Luxembourg, Monaco, Montenegro, Netherlands, Norway, Poland, San Marino, Serbia, Slovenia, Spain, Sweden, Switzerland.

EU Map 4: Essential Medicines

Key notes on the availability of different opioids in some countries

BELGIUM

Commonly prescribed opioids and their formulations include: Tramadol: Available in IR and SR tablets, capsules, and oral drops; Morphine: Offered in IR and SR tablets, oral and injectable forms; Oxycodone: Available in IR and SR tablets and capsules; Fentanyl: Primarily administered via transdermal patches (other formulations include lozenges and injectable forms, though these are less common in primary care, and Lollipops and intra-oral spray not available); Buprenorphine: Available as sublingual tablets and transdermal patches; Piritramide, available in injectable form; Tilidine: A synthetic opioid painkiller available in oral formulations, commonly prescribed for moderate to severe pain; and Tapentadol: Available in IR and SR tablets.

CZECH REPUBLIC

The availability of weak and strong opioids is very good in the Czech Republic. Doctors of all specialties are authorised to prescribe weak opioids (codeine, tramadol) and strong opioids (morphine, oxycodone, hydromorphone, fentanyl TDS and buprenorphine TTS) and these drugs are more than 90% covered by health insurance. The prescription of methadone and tapentadol is restricted to certain medical specialties (including palliative medicine).

ITALY

Availability of various opioids in different formulations at the primary care level in urban areas is relatively high. Estimates suggest that about 80%-90% of facilities have access to essential opioids in multiple formulations, such as oral tablets, patches, and injectable solutions. Urban centres have comprehensive healthcare services, ensuring morphine, oxycodone, fentanyl, and buprenorphine for pain and PC. However, factors such as regulatory processes, prescription monitoring, and awareness can influence the distribution and usage of opioids. Occasional administrative and logistical barriers might slightly impact supply. In rural areas, availability is lower due to challenges in logistics, infrastructure, and healthcare workforce distribution. It is estimated that 60%-70% rural healthcare facilities have access to these opioids.

CROATIA

A wide range of opioids is generally available throughout Croatia in diverse formulations, including transdermal patches, injectable solutions, oral liquids, and both slow-release and immediate-release tablets. The primary factor affecting access to these medications is not their availability but rather the distribution of healthcare services within the public health network.

ICELAND

Availability is very good; however, the use of different opioids/different formulations is probably variable depending on the training and experience of the medical staff. No difference between urban and rural areas. Every year the Icelandic Agency of Medications publishes a list of most often prescribed medicines, and its formulations. The Icelandic Medicines Agency publishes if medicines are not available in the country and also when they become available again.

POLAND

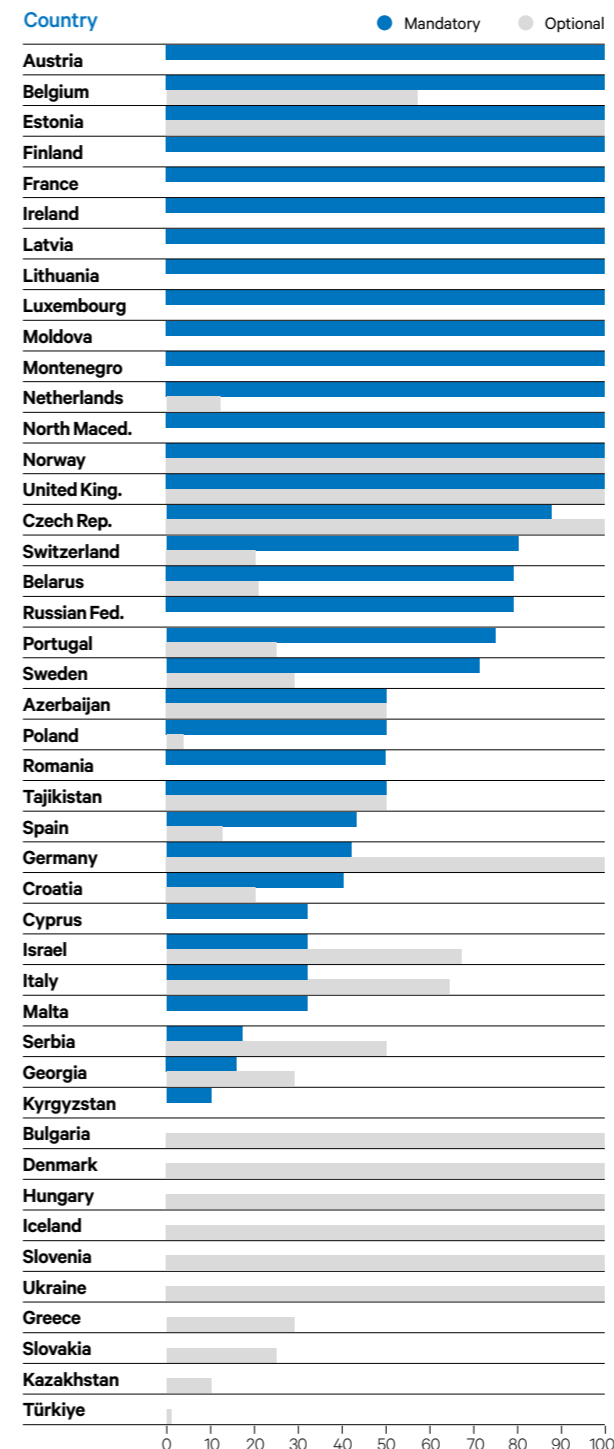
In Poland, different opioids in different formulations are available in healthcare settings. Any registered physician (including primary care physicians) is authorised to prescribe opioid analgesics. Nurses with appropriate training can also write prescriptions for opioids from tier II of the analgesic ladder.

EU Map 5. Palliative Care Education

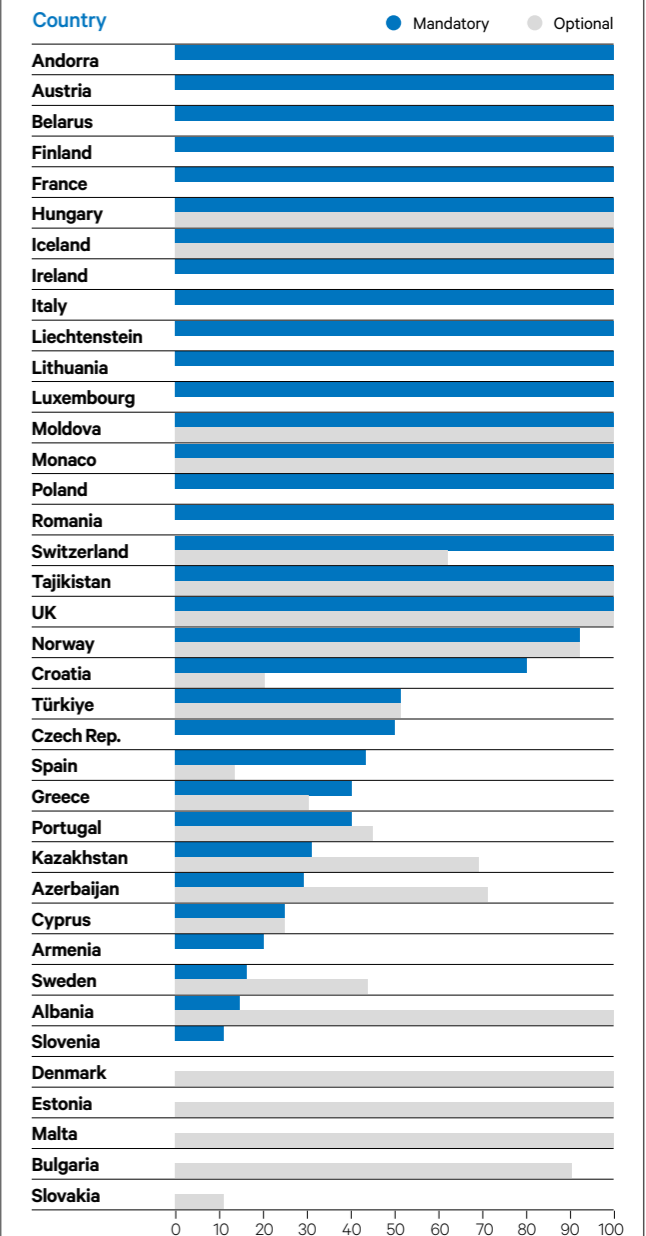
This chapter presents the availability of undergraduate education resources (integrated into curricula) in medicine and nursing schools, and the existence of a specialisation in palliative medicine. In only 15 countries all students receive mandatory palliative care teaching in their medical schools

(either as a separate or a combined module), and in the majority of countries less than 50% of the medical schools do teach mandatory palliative care. Somewhat similar happens with optional teaching of palliative care as nearly two thirds of countries report scarce presence in their medical schools.

Palliative Care Teaching in Medical Schools



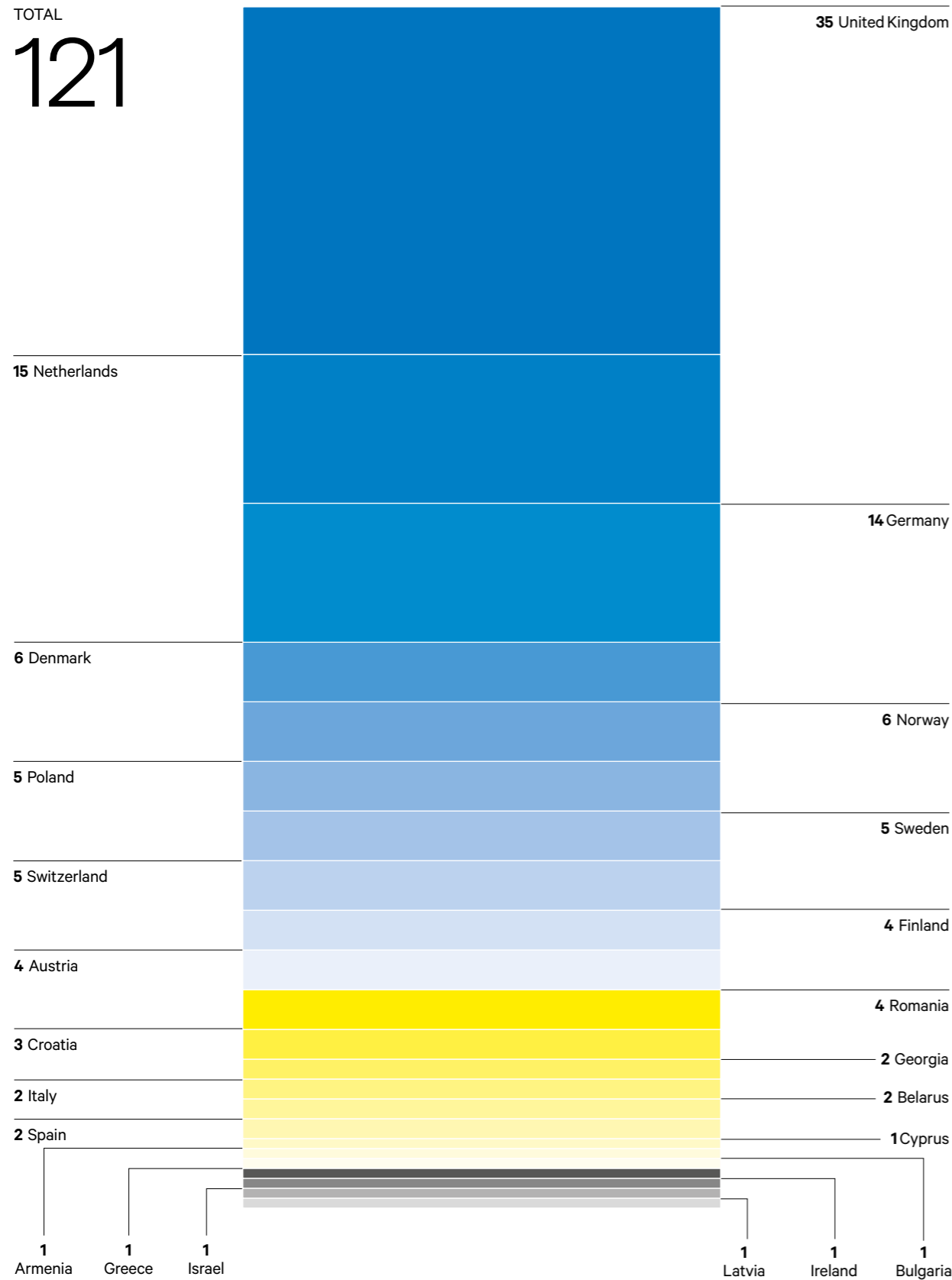
Palliative Care Teaching in Nursing Schools



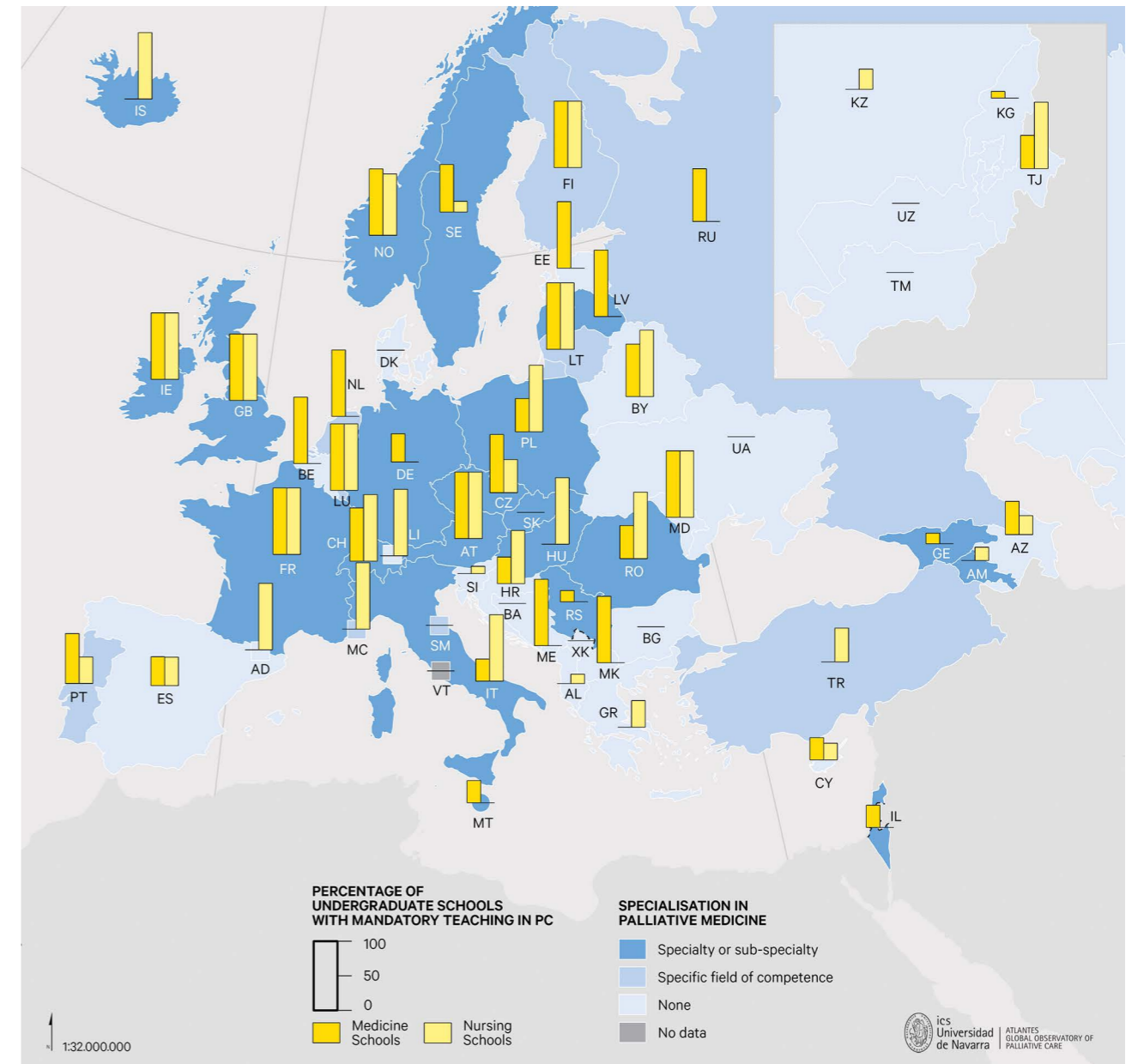
In 19 countries, 100% of the nursing schools teach mandatory palliative care versus 24 where less than 50% of the schools teach it (and further eleven countries with no available information). Ten countries teach palliative care optionally at all their nursing schools.

EU Map 5. Palliative Care Education

Full professors in Palliative Care



EU Map 5. Palliative Care Education



Map 5. Palliative Care Education.

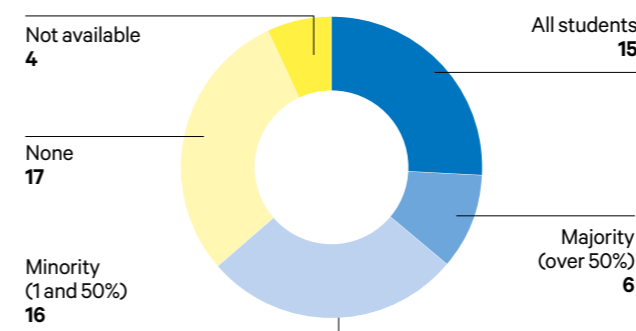


Figure 9. Proportion of future physicians across Europe receiving mandatory palliative care

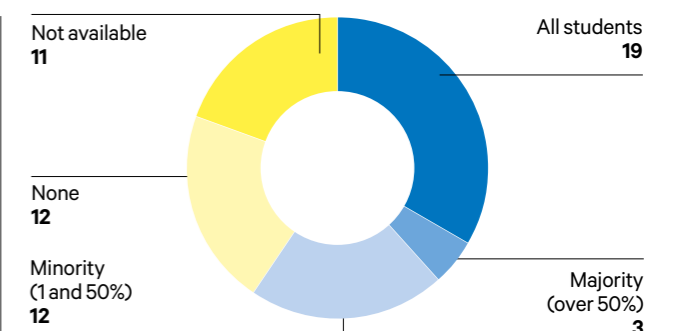


Figure 10. Proportion of future nurses across Europe receiving mandatory palliative care teaching in

EU Map 5. Palliative Care Education

SPECIALISATION IN PALLIATIVE MEDICINE FOR PHYSICIANS

Palliative medicine is a speciality or subspecialty (another denomination equivalent) recognised by competent national authorities in 21 countries (38% of European countries). Where specialisation does not exist, there are other forms of recognised palliative care education (certification of the professional category or of the job position

of palliative care physician). Overall, 30 countries (54%), have some sort of specialisation on palliative medicine for physicians. In nine further countries, there are other types of professional training diplomas without official, national recognition (i.e., advanced training courses or masters in some universities), and in 16 countries there is no recognition at all for palliative care. ●

Specialisation in palliative medicine for physicians

Country	Description
Armenia	Sub-specialty, a 1295-hour course (400 hours of theory and 895 hours of practice) for specialised training.
Austria	Specialty (Spezialisierung)
Czech Rep.	Palliative medicine is recognised by law as a subspecialty for physicians and its required training lasts twelve months.
France	France establishes it as a Special Field of Competence with a "University Diploma of Specialised Training in Palliative Care".
Georgia	Palliative medicine is recognised as a subspecialty within the medical field. This classification was established by Order No. 136/n, issued on April 18, 2007, by the Minister of Labour, Health and Social Protection of Georgia. The order, titled "On Determining the List of Medical Specialties, Related Medical Specialties and Subspecialties" officially defines the status of palliative medicine.
Germany	Palliative medicine is a subspecialty (Zusatzbezeichnung Palliativmedizin), but the qualification level is rather low. Some federal states require only 4 weeks theoretical courses for training and an oral exam, though many physicians take the longer road and work at least six months in a specialist service.
Hungary	It was accredited as a sub-specialty by the Decree on the continuing professional training of medical specialists, dentists, pharmacists and psychologists (23/2022 EMMI rendelet). In Annex 1 to the EMMI Decree No 23/2012 (IX. 14.), it is listed at the "List of medical licences".
Iceland	In 2015, Palliative Medicine was recognised as a subspecialty to Internal medicine. Since 2023 it is a subspecialty to internal medicine or it can be an add-on specialty to another clinical specialty.
Ireland	Palliative Medicine is a speciality in the Republic of Ireland (Higher specialist training in palliative medicine outcome-based education – obe curriculum).
Israel	Since 2015 there is a sub-specialty in palliative medicine for physicians, under the Israel Medical Association (see the list of specialties and subspecialties). Since 2013 (two years earlier than physicians), there is a palliative specialty for nurse practitioners.
Italy	The long process of implementing the art. 8 of law 38/2010 concluded with the establishment of the specialisation school in 'Medicine and Palliative Care' starting from the 2021-2022 academic year (art. 5-ter of the Legislative Decree of 19 May 2020, no. 34, converted with law no. 77 of 2020).
Latvia	Palliative care is a subspecialty under the name 'Palliative Care Specialist' study course at Rīga Stradiņš University, Department of Residency.
Malta	Palliative medicine was recognised as a medical specialty in Malta since 2003. This means that healthcare professionals can pursue specialised training and certification in palliative medicine.
Norway	Palliative medicine was recognised as a formal area of competence since 2011. In 2020, the Norwegian Parliament decided to establish either an independent medical specialty or an add-on specialty.
Poland	Palliative medicine is a recognised specialty for physicians since 1999. The updated document on specialisations for physicians in Poland is the Regulation of the Minister of Health of May 4, 2023.

EU Map 5. Palliative Care Education

Romania	PC subspecialty training is organised by the National institute for the Management of Healthcare Services. It was regulated by Order no.418/2005 for the approval of the National Catalogue of complementary studies, palliative care being one of the sub specialty certifications for physicians with clinical specialties.
Serbia	Specialisation in Palliative Medicine was officially established on 2013. It is included in the Faculty of Medicine University of Belgrade since 2013 and in Faculty of Medical Sciences University of Kragujevac since 2022.
Slovakia	Palliative medicine was recognised as a sub-specialisation in Slovakia since 2012. The accreditation of the palliative medicine program is managed by the Department of Palliative Care at the Slovak Health University in Bratislava.
Sweden	Palliative medicine was recognised as an add-on speciality in Sweden in 2015 by the National Board of Health and Welfare/the government.
Switzerland	There is a nationally recognised specialist medical qualification (<i>Schwerpunkt</i>) in palliative medicine. These so-called <i>Schwerpunkte</i> are subspecialties and are considered a confirmation of structured and controlled further training in the field of clinical and non-clinical medicine.
United Kingdom	Palliative medicine is a speciality under the name: Specialist training and Consultant in Palliative Care.

EU Map 6. Integrated Health Services

This chapter refers to the **capacity of the national health and social system to meet the needs of adults and children with serious health-related suffering**. This entails services integrated into primary care and specialised services (hospice, home care, hospital, and outpatient), its interaction with other areas of the health system, accessibility and commitment to private sector providers.

OVERALL LEVEL OF PALLIATIVE CARE PROVISION

For this study, we explored whether there exist in European countries, a system of specialised palliative care services or teams that has a geographic reach and is delivered through different service delivery platforms. Different levels were possible depending on whether a country had:

1. No or minimal provision of palliative care specialised services or teams,
2. Isolated provision (only in some geographic areas),
3. Generalised provision (in many parts of the country but with some gaps.
4. Integrated provision (specialised palliative care services or teams systematically provided).

According to these definitions, only 17 countries reported an integrated provision of palliative care.

Overall level of Palliative Care provision

Level 1. Emerging	Level 2. Progressing	Level 3. Established	Level 4. Integrated
1. Azerbaijan,	1. Albania	1. Andorra	1. Austria
2. Vatican City	2. Armenia	2. Croatia	2. Belgium
3. Kosovo	3. Belarus	3. Cyprus	3. Denmark
4. Kyrgyzstan	4. Bosnia&Herzegovina	4. Czech Republic	4. France
5. Montenegro	5. Bulgaria	5. Finland	5. Germany
6. Tajikistan	6. Estonia	6. Hungary	6. Ireland
7. Turkmenistan	7. Georgia	7. Italy	7. Israel
8. Uzbekistan	8. Greece	8. Latvia	8. Liechtenstein
	9. Iceland	9. Moldova	9. Lithuania
	10. Kazakhstan	10. Monaco	10. Luxembourg
	11. North Macedonia	11. Portugal	11. Malta
	12. Serbia	12. Romania	12. Netherlands
	13. Slovakia	13. Russia	13. Norway
	14. Slovenia	14. Spain	14. Poland
	15. Türkiye	15. United Kingdom	15. San Marino
		16. Ukraine	16. Sweden
			17. Switzerland

PALLIATIVE CARE SPECIALISED SERVICES

Specialised PC services or teams refer to health care services/teams whose main activity is the provision of PC. These services/teams often provide care for patients with complex needs or severe suffering and, therefore, require staff with specialised training. For the purpose of this comparative study, within a service, if there are teams identified with distinct functions (such as some teams dedicated to Home Care and others to Hospital Care), these teams are counted as separate services. If a service's staff performs different roles, like attending to both home and hospital care, it is regarded as a single service.

The number of specialised services detected in this Atlas has increased to 7119 specialised PC services (average 0.96

services per 100,000 inhabitants across the region), reflecting an improvement compared to the 2019 Atlas (6387 services, 0.80 services per 100,000 inhabitants). The number of services varies from nearly inexistent provision in countries like Azerbaijan, Uzbekistan, or Kosovo (though some notable advances have been reported), to countries that exceeded the 2010 EAPC standard of 2 services every 100,000 inhabitants*. This would be the case of countries such as Switzerland, Austria or little populated countries like San Marino, Liechtenstein or Monaco. However, more interestingly, a big number of countries near that ratio: Sweden, the Netherlands, Norway, Czech Republic, Ireland, Belgium, Finland or Luxembourg. ●

EU Map 6. Integrated Health Services

Palliative Care Specialised Services

Quartile	Country	N	Services per 100,000 inhab.
Q1	Monaco	3	7.70
Q1	Liechtenstein	3	7.53
Q1	San Marino	2	5.91
Q1	Austria	336	3.68
Q1	Lithuania	72	2.51
Q1	Switzerland	187	2.10
Q1	Sweden	200	1.90
Q1	Netherlands	331	1.85
Q1	Norway	101	1.83
Q1	Czech Republic	182	1.68
Q1	Ireland	87	1.64
Q1	Belgium	182	1.54
Q1	Finland	85	1.52
Q1	Luxembourg	10	1.50
Q1	Poland	522	1.42
Q1	Portugal	150	1.42
Q2	United Kingdom	865	1.27
Q2	Andorra	1	1.24
Q2	Israel	113	1.16
Q2	Germany	941	1.13
Q2	Croatia	41	1.06
Q2	Denmark	63	1.06
Q2	Iceland	4	1.02
Q2	Italy	592	1.00
Q2	Cyprus	13	0.97
Q2	Hungary	92	0.96
Q2	Latvia	18	0.96
Q2	Spain	463	0.96
Q3	France	615	0.90
Q3	Malta	4	0.72
Q3	Slovakia	35	0.64
Q3	Georgia	23	0.62
Q3	Romania	107	0.56
Q3	Armenia	16	0.53
Q3	Moldova	12	0.49
Q3	Türkiye	415	0.49
Q3	Slovenia	10	0.47
Q3	Bulgaria	25	0.39
Q3	North Macedonia	7	0.38
Q3	Serbia	17	0.26
Q4	Albania	7	0.25
Q4	Ukraine	87	0.23
Q4	Estonia	3	0.22
Q4	Kazakhstan	37	0.18
Q4	Belarus	14	0.15
Q4	Bosnia-Herzegovina	3	0.09
Q4	Tajikistan	9	0.09
Q4	Kyrgyzstan	5	0.07
Q4	Greece	4	0.04
Q4	Turkmenistan	1	0.01
Q4	Azerbaijan	1	0.01
Q4	Uzbekistan	3	0.01
Total		7,119	0.96

Key notes on some countries

AUSTRIA

There are 336 specialised PC services; 296 specialised adult (as per the PC directory by Hospiz Österreich), and 38 paediatric ones. The diverse adult teams are distributed as follows: 176 teams (sometimes including volunteer hospice teams), 57 home care teams, 18 inpatient hospices and 45 palliative care units. Per regions, Vorarlberg has 10 services, Tirol 41, Salzburg 21, Karnten 35, Steiermark 50, Oberösterreich 36, Niederösterreich 68, Burgenland 8, and Vienna 27. Austria has a system for specialised hospice and PC provision that also counts on day hospices and volunteer hospice PC teams that do operate across the country. These day hospices and Volunteer hospice teams are legally part of the Austrian specialised Hospice and PC services and, with those included, the number would increase up to the 400 services. Furthermore, recently, some new three services were founded in Austria.

FINLAND

Specialised PC services are provided across the vast majority of Finland, with 85 services available. These services include outpatient units, in-hospital consultation teams, PC wards, hospices, and hospital-at-home teams. However, there are still some gaps in rural areas. Consultation teams are available in all large hospitals, including all university hospitals and central hospitals within the 21 counties of Finland. Inpatient specialised PC is primarily arranged through PC and end-of-life care wards, which offer services similar to those of hospices, in addition to the four dedicated hospices. Specialised PC at home is organised through hospital-at-home units. The criteria for these services are outlined in the Recommendation on the Provision and Improvement of PC Services by the Ministry of Social Affairs and Health. While hospital-at-home services are increasingly available nationwide, some gaps still remain in certain areas.

EU Map 6. Integrated Health Services

Key notes on some countries

POLAND

According to data from the National Health Fund database for May 2023, 522 PC services, overall financed by National Health Fund operate in Poland: 177 facilities providing palliative medicine outpatient services, 593 home palliative care teams for adults, 254 inpatient hospices, 81 home care hospices for children and 20 perinatal PC teams. Almost half of these services deliver PC in various settings. 450 (84.4%) PC units are exclusively for adults, 26 (4.9%) — exclusively for children and 54 (10.1%) — for both adults and children. The number of hospital-based PC teams in hospitals is very low. This type of services for patients who are admitted to various inpatient units and need specialist PC consultations are not financed by the National Health Fund. The National Health Fund signed 593 contracts for (PC) home care for adults and 80 for children in 2023.

SERBIA

There are 17 specialised services with Palliative Medicine Specialist or a trained professional: General Hospital Kikinda (6 beds with Specialist); Health Center Uzice, Unit Pozega, (12 beds with Specialist); General Hospital Leskovac, Unit Vlasotince (10 beds Specialist); the General hospital Prokuplje (5 beds with Specialist); the General Hospital Pozarevac (12 beds with Specialist); University Clinical Center Kragujevac, (10 beds); General Hospital Cuprija (10 beds, with trained HCP); the University Clinical Center of Novi Sad (22 beds with consultative Specialist); the Institute for Pulmonary Diseases of Vojvodina (Palliative consultation team with Specialist, 10 beds);

the Specialised hospital for internal diseases Vrnjacka Banja (Unit with 12 beds with Specialist); Institute for geriatrics and PC Department for home treatment, nursing and PC, Belgrade (with specialist); and the Institute for Oncology and radiology of Serbia, Belgrade (HCP with PC education). Furthermore, there are four centers with palliative wards or dedicated beds (58 beds, 630 discharged patients in 2023): Klinikal center Dr Dragisa Misovic (10 beds), KC Zvezdara (30 beds), KC Zemun (13 beds), and KC Bezanijaska kosa (5 beds). In Belgrade, there is one institution for geriatric and PC on primary healthcare level providing home care. Besides, there is a variety of services led by doctors from other specialties, with palliative care skills. Primary healthcare, through the Primary healthcare center - Dom zdravlja, offers home care services for long-term conditions with immobilization, injured patients, discharge from the hospital, and PC. In Serbia, 159 public primary healthcare centres provide PC but not with specialised teams.

PORTUGAL

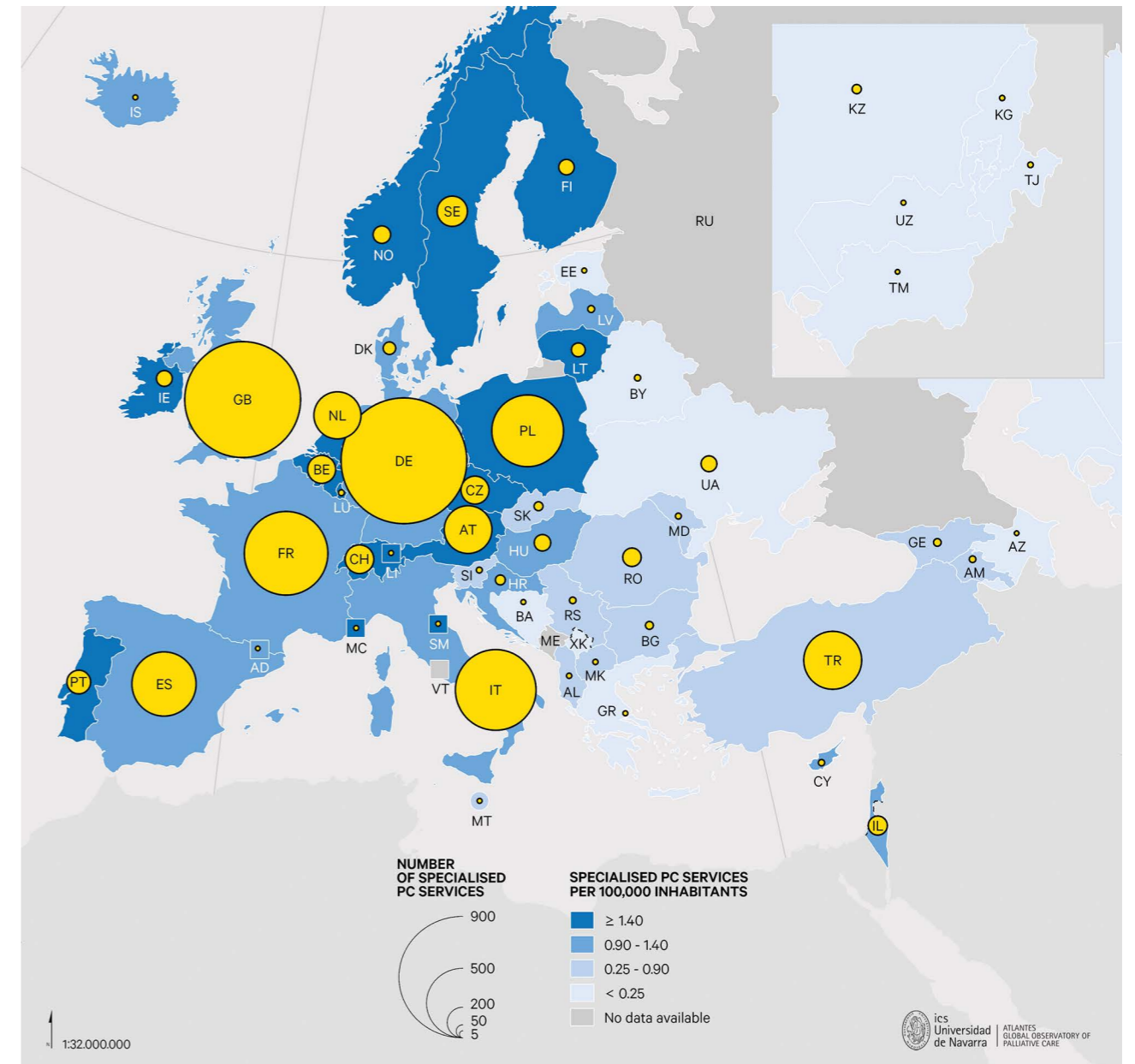
According to the Directory of specialised PC services by the Portuguese Observatory of Palliative Care, 150 specialised services operate in Portugal (including islands). However, some of the teams accounted for are extensions within the same teams meaning that two teams may be operated by the same professionals. Considering this, there are 52 hospital support teams, 38 units, 48 community support teams (home teams), and 12 paediatric teams; with greater number of services in Northern Region and Lisbon area

(up to 97 teams), 24 in Centro, 12 in Alentejo, 7 in Algarve, 6 in Açores and 3 in Madeira. While there are no hospices in Portugal, there are in-patient “long term care units” in the National Continuing Care Network, for dependent people; however most do not have the support of a PC team. In geographic terms, there are more teams in Northern Portugal and Lisbon, with most hospitals and health centres. In Algarve, there are two public hospitals and three primary health care centres, all of which have PC teams covering the region; and, in Alentejo, there are public Local Health Units all with different model-type services.

ROMANIA

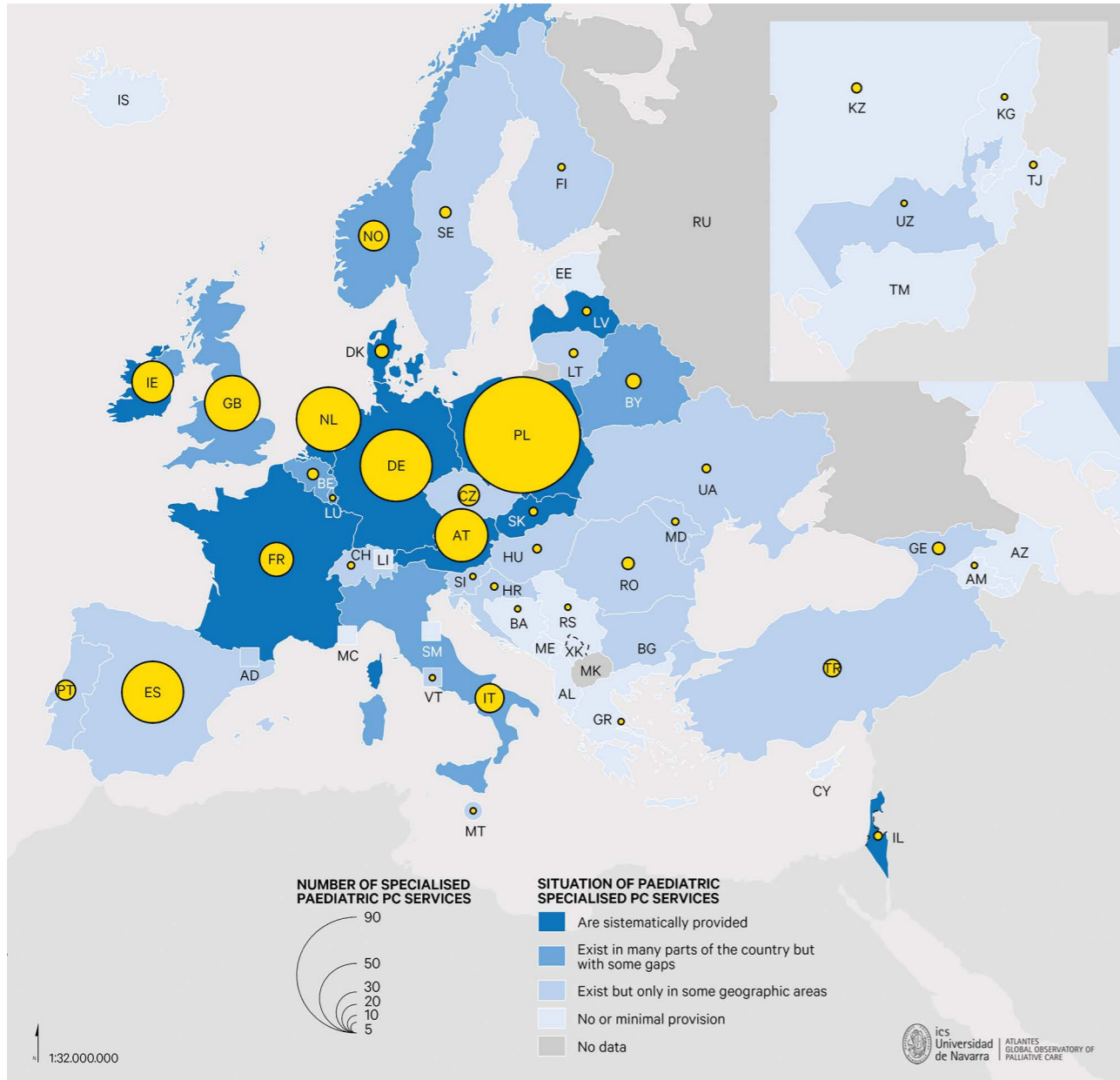
There are 87 PC inpatient units in Romania distributed in 30/42 counties (1985 beds). From these, 44 are in public system, 12 private non-profit and 31 private. Of the total of 1985 PC beds in public and private inpatient units, 904 (45.54%) provide services unrestricted in terms of patient accessibility (free at the point of service provision) and 1081 (54.46%) beds are in the private system (paid or co-paid). There exist also 6 free-standing hospices, all in charitable non-governmental organisations (2 hospices have distinct inpatient units for adults and children) and 9 palliative home care services in 6/42 counties - 5 charitable and 4 for-profit private organisations. In total, 107 services provide palliative care in the country. PC is a newly regulated field in Romania, and providers are not equally distributed nationwide. At national level there are still counties where these services are still absent.

EU Map 6. Integrated Health Services



Map 6.1. Specialised palliative care services across Europe.

EU Map 6. Integrated Health Services



Map 6.2. Specialised palliative care services for children

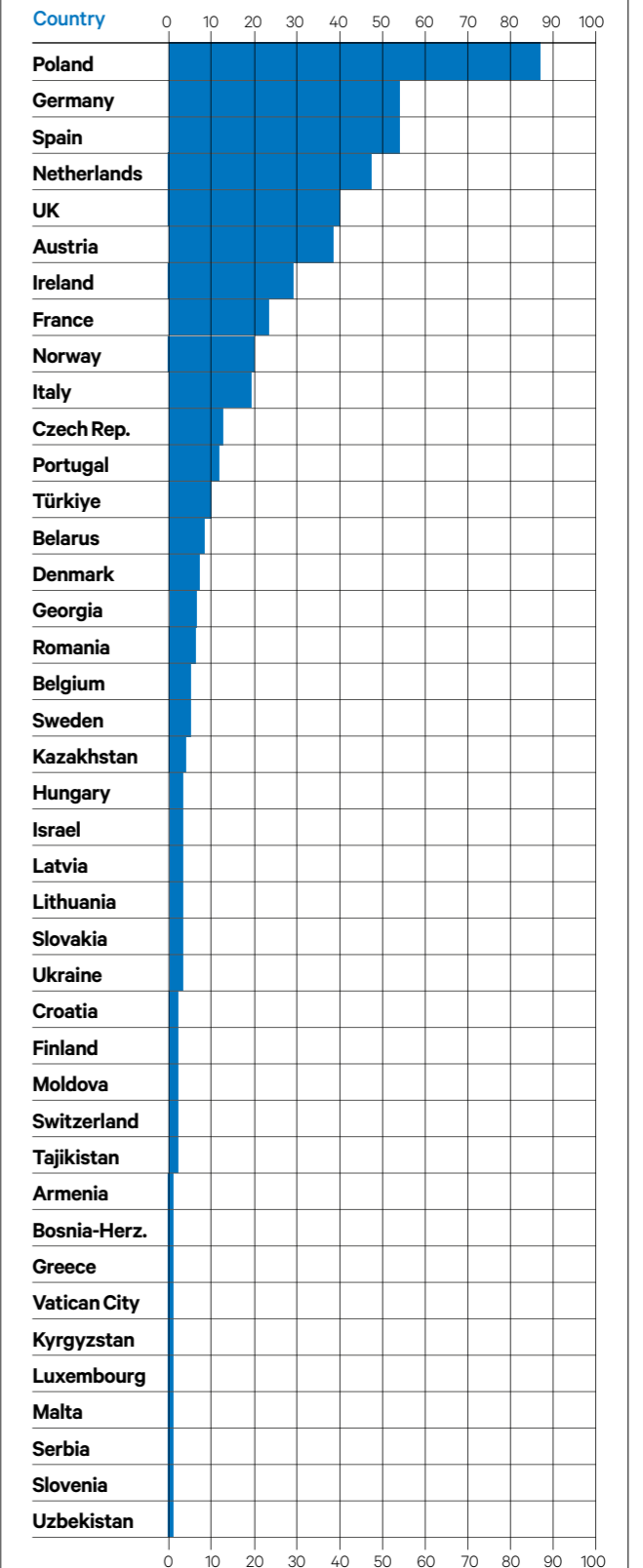
EU Map 6. Integrated Health Services

PAEDIATRIC SPECIALISED PALLIATIVE CARE SERVICES

Only ten countries reported a level of advanced integration, meaning that specialised palliative care services or teams for children are systematically provided across the country. These countries include Austria, Denmark, France, Germany, Ireland, Israel, Latvia, the Netherlands, Poland, and Slovakia.

In total, Europe is home to 524 paediatric palliative care services across 41 countries. These range from isolated services – as seen in Armenia, Bosnia and Herzegovina, Greece, Kyrgyzstan, Serbia, Slovenia, and Uzbekistan – to countries where such provision is more widespread, with a reasonable number of specialised teams. Examples of the latter include Poland, Germany, Spain, the Netherlands, and the United Kingdom.

Number of Specialised Paediatric PC Services



EU Map 6. Integrated Health Services

Key notes on some countries

ALBANIA

In Albania, the only dedicated facility is the Onco-hematology hospital in Tirana, the capital city. This hospital primarily provides curative treatments, with very basic palliative care.

ANDORRA

Andorra lacks a specialised children's palliative care team within its borders. Instead, the country's general palliative care team collaborates closely with a specialised children's palliative care service in neighbouring Catalonia, Spain, to provide comprehensive care for paediatric patients.

ARMENIA

There is only one service provider currently operating but there are 32 palliative care services operating not only in Yerevan but also in the regions of Armenia 32.

AUSTRIA

They exist 38 specialised palliative care services for children.

BELARUS

There are eight palliative care teams.

BELGIUM

Paediatric PC for children/adolescents is provided through 5 paediatric liaison teams (PLTs), each of which is attached to a university hospital. They support the hospital team that looks after the patient based on their own paediatric multidisciplinary expertise.

BULGARIA

Children with oncological diseases receive treatment in specialised hospital facilities within university hospitals, where palliative care is also provided for paediatric patients. Specialised paediatric oncology care, including palliative services, is available at university hospitals in major cities such as Sofia, Varna, Plovdiv, Stara Zagora, and Plevnen. Palliative care for children is performed by specialists through day hospitals and individual beds on wards and in cooperation with mobile palliative teams in the primary care. The two existing NGOs provide palliative care services only for adult cancer patients.

CZECH REPUBLIC

The Czech Republic has established a paediatric palliative care infrastructure. This includes four hospital-based specialist palliative care teams, some of which care to both adult and paediatric populations.

DENMARK

There are seven paediatric palliative care units: two paediatric hospices (one in Seeland and one in Jutland), and one paediatric palliative care team in each of the five Danish regions.

FINLAND

In Finland, there are two specialised palliative care teams for children, but their resources are limited, and are not available throughout the country.

FRANCE The French national territory is covered by 23 Regional Paediatric Palliative Care Resource

Teams (ERRSPP= *équipe ressource régionale de soins palliatifs pédiatriques*), supplemented by 3 intra-hospital teams in Paris. This system is financed by the health system. These teams can be mobilised for all children in palliative care in the various health establishment.

GEORGIA

There are six paediatric palliative care teams in Georgia (one non-governmental hospice that is free of charge for female patients).

GERMANY

There are 36 paediatric palliative care outpatient teams and 17 inpatient hospices for children; 53 in total. According to other data provided at the ministry, there is 68 services: 47 paediatric palliative care outpatient teams, 17 inpatient hospices, and 4 palliative care units.

GREECE

Only one specialised service run by an NGO and another one is currently under preparation to run by the University of Athens Palliative Care Unit.

VATICAN CITY

Tough no physically in Vatican, Bambino Gesù Hospital, which is the Vatican's pediatric hospital, opened a new PC center near Rome in March 2022. It is the largest palliative care center for children in Italy, with 30 beds.

HUNGARY

One inpatient centre for children (5 beds), two home care services for children (In Pécs, there is the Sze-

EU Map 6. Integrated Health Services

mem Fénye Alapítvány – the Light of My Eyes Foundation for sick children, the Public Foundation for children oncology and hospice at the university of Pécs, and in Budapest, the Tabitha Pediatric Hospice House).

ICELAND

There are very experienced nurses and physicians providing care to children at Landspítali University hospital.

IRELAND

Laura Lynn Ireland's Children's Hospice provides an Inpatient Unit in Dublin and home care services to certain areas. There are three Children's Palliative Medicine consultants located in Children's Health Ireland PC. Adult PC services also support the care of children and young people in need. All community support PC teams provide care to adults and children and are linked locally to a paediatrician and centrally with Children's Hospital Ireland. While few programs exist in hospitals, some private home care contractors provide service for children. Ten regions and 2 autonomous provinces established the Regional Reference Centre of Pain Therapy and PC for children; in another 2 there are centres working in specialist PPC.

KAZAKHSTAN

In Kazakhstan there are three specialised palliative care services: one Charitable Children's Hospice in Almaty with one mobile team (18 beds), and 2 palliative care departments in major cities Astana and Shymkent (40 beds). In addition, there are 41 individual beds (not wards or units) in regional children's hospitals where personnel has not been trained in palliative care.

KYRGYZSTAN

The children's hospice in Bishkek opened in 2016 thanks to the efforts of a charitable foundation. The hospice provides PC to children and is staffed by doctors, nurses, psychologists, and volunteers who provide all-around support to children and their families. Although there is just one hospice, there are palliative care departments to assist patients.

LATVIA

Two specialised palliative care services for children have been established in Latvia: at the Children's Clinical University Hospital and Liepāja Regional Hospital in collaboration with the Children's Palliative Care Society.

LITHUANIA

There are three specialised palliative care services for children: two specialised departments in university hospitals - Vilnius and Kaunas - with inpatient units and day care centres, tailored to meet the needs of children, and a children hospice in Vilnius, with a strong development in Klaipeda.

LUXEMBOURG

Luxembourg provides paediatric palliative care through the Paediatric Clinic at Centre Hospitalier de Luxembourg (CHL), the only dedicated facility for children.

MALTA

Puttinu Cares Foundation is a children's cancer support group, officially set up in 2002. It is a non-profit-making NGO. Among its various aims it seeks to advocate on behalf of affected children and their families by representing their needs; to promote models of good care and practice; and to support families

with a national information service. Malta has recently appointed a paediatric palliative care consultant at the Mater Dei hospital, responsible for offering palliative care for children who are either nearing death or suffer from long-period disease. There are some hospital beds and some community outreach.

MOLDOVA

In Moldova, there are only two institutions with beds that provide paediatric palliative care: 1. Institutul Mamei si Copilului (Institution of Mother and Child) – A state medical institution that offers general paediatric medical care, including palliative care beds, and 2. Fundatia Hospice Angelus Moldova – A free-standing paediatric hospice providing specialised paediatric PC services. All seven University Medical Centers have specialised PC comfort teams for children. There is a countrywide spread of organisations offering inpatient respite and hospice care. Same holds for home care teams offering PC for children and their families (Center of Expertise in Paediatric PC). There are 12 organisations offering inpatient respite care for seriously ill children and their families.

NORWAY

Norway is home to 19 public hospital trusts, of which 17 provide a dedicated PC service for children, along with one hospice-like department (Nordre Åsen).

POLAND

PC for children in Poland is delivered mainly by home hospices. There are only a few in-patient settings that deliver palliative care for children. In total in 2023 in database of the National Health Fund 81 contracts for palliative care for children were reported.

EU Map 6. Integrated Health Services

PORTUGAL

According to *Relatório de implementação do Plano Estratégico para o Desenvolvimento dos Cuidados Paliativos Biénio 2021-2022*, 6 paediatrics PC teams provided palliative care. According to the most recent directory, up to 12 teams provide for palliative care for children (not accounting for adult PC services also admitting children).

ROMANIA

There are 4 PC services for children in Romania, 3 private (ONG) one in public hospital.

RUSSIA

There are around 500 services providing PC for children (250 being home care teams).

SERBIA

There is one specialised team for paediatric PC that started to work in Belhospice Cenet in Belgrade since 2023.

SLOVAKIA

The mobile hospice 'Plamienok' in Bratislava, established in 2003, is a pioneering non-profit organisation that commenced providing home hospice care services back in 2004. The mobile hospice 'Svetielko pomoci', in Košice, founded in 2011, is a non-profit organisation dedicated to providing home hospice care and supporting families in eastern Slovakia.

SLOVENIA

There is one team for Palliative Care for Children, University Children's Hospital Ljubljana.

SPAIN

According to the Evaluation Report 'Paediatric Palliative Care in the National Health System: Care Criteria', 2022, produced by the Paediatric Palliative Care Association, interdisciplinary PC services for children are available in 14 regions, and operated by 45 specialised teams. Latest data suggest there are 53 services/teams registered, almost all mixed units, providing care both in hospital and at home. Only two provide care exclusively at home. There is an intermediate care centre in Barcelona, with convalescence, respite, admissions for family instruction, and admissions for symptom control.

SWEDEN

There is only one specialised PC ward/hospice for children in Sweden, called Lilla Erstagården, localised within the private foundation Ersta clinic. There is one specialised PC home care service in Sweden, called Sjukhusansluten Avancerad Barnsjukvård i Hemmet, localised at the Karolinska University Hospital. Both these services are located in Stockholm. In the rest of the country children in need of specialised PC are cared for in their homes or in a PC ward/hospice by a specialised PC service for adults in collaboration with the Department for children's diseases at the local hospital.

SWITZERLAND

The FOPH commissioned an in-depth study of palliative care needs, with a focus on new-borns, children and adolescents (ref. short report), and conducts a survey every three to five years in order to monitor and measure the development of regulatory requirements, care structures and palliative care services in Switzerland.

TAJIKISTAN

A nurse-led City Nursing Hospital, funded by the Dushanbe City Authority, has 12 beds used for palliative care—four for men, four for women, and, since 2023, four for children.

TÜRKIYE

There are around 10 specialised palliative care services for children. The number of the beds for children patients has increased up to 181 beds.

UKRAINE

There are several palliative care units in Ukraine for children: 1) Mobile hospice for children, Western Ukrainian Specialised Children's Medical Centre, 2) Nadvirna First Children's Hospice, and 3) Children's City Polyclinic No. 6 Compass in Odesa.

UNITED KINGDOM

Specialist Paediatric PC teams exist in some paediatric hospitals and children's hospices. There is still significant disparity of access ranging from no service to a fully functioning service. There are around 38 children's hospices and the provision at home is patchy - about 30% of services have 24-hour home care provision.

UZBEKISTAN

One specialised palliative care service is available in Taskin hospice. Furthermore, in accordance with Presidential Decree No. PQ-693 dated October 31, 2023, 120 paediatric palliative care beds are planned to be established across Uzbekistan by 2025. (lex.uz)

Country reports