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INTERNATIONAL CONCEPTS AND NATIONAL STRATEGIES FOR THE DEVELOPMENT OF PALLIATIVE AND HOSPICE CARE

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Background. Palliative care has evolved from predominantly end-of-life services into an element of integrated health care for people with serious health-related suffering. In Ukraine, planning is complicated by demographic change, chronic disease, wartime disruption and heterogeneous health information.

Aim. To synthesize international concepts, methods for estimating and forecasting palliative care needs, and service-integration models, and to determine their implications for Ukraine.

Materials and Methods. This original theoretical study used bibliosemantic and comparative methods and system analysis. PubMed, Scopus and Google Scholar were searched for 2012–2026; earlier landmark sources were included when necessary for key definitions and methods. Official documents of the World Health Organization, European Association for Palliative Care, International Association for Hospice and Palliative Care and Ukrainian health authorities were analyzed. Forty-five sources were selected. System analysis compared data inputs, estimation methods, service models, implementation constraints and monitoring indicators. The study was conducted as part of the second author's dissertation.

Research Ethics. The study was conducted without the involvement of patients or animals and therefore did not require approval by an ethics committee.

Results. Contemporary concepts emphasize early holistic care for serious health-related suffering and integration with primary care and universal health coverage. Needs assessment methods were grouped into mortality/population-based, epidemiological, utilization/registry-based and time-series approaches; medication planning was considered separately because observed opioid consumption reflects both need and access. Recent Ukrainian data show rapid expansion of contracted inpatient and mobile providers, but geographical inequality, wartime damage, fragmented strategic coordination, limited mandatory undergraduate training and low opioid consumption remain important system indicators.

Conclusions. Planning in Ukraine should combine demographic and disease-specific estimates with utilization data and validated time-series methods rather than rely on one indicator. Priorities are interoperable monitoring, equitable territorial access, competency-based education, continuity of care during wartime and legally proportionate use of person-level data.

Keywords: *healthcare management, health services needs and demand, universal health coverage, forecasting, health services accessibility.*

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Introduction

Palliative care has developed from a predominantly terminal-care model into an approach intended to prevent and relieve suffering associated with serious illness. The classic World Health Organization formulation emphasized quality of life, early identification and treatment of physical, psychosocial and spiritual problems [1]. The 2018 World Health Organization guide placed palliative care explicitly within primary health care and universal health coverage, thereby shifting service planning from isolated specialist institutions toward integrated care across levels of the health system [2].

This conceptual shift is also reflected in the Lancet Commission framework of serious health-related suffering, which linked palliative care to universal health coverage and demonstrated substantial global inequities in access to pain relief and essential palliative services [3]. The 2020 International Association for Hospice and Palliative Care consensus further defined palliative care as active holistic care across all ages for people with serious health-related suffering due to severe illness, especially near the end of life, and emphasized concurrent provision with disease-modifying treatment, support for families and caregivers, respect for values and preferences, and reduction of barriers to access [4].

The planning problem is therefore broader than estimating the number of people who will die. Projections of serious health-related suffering combine mortality, age, health conditions and symptom prevalence and show that future demand will be driven by population ageing and non-communicable diseases [5]. At the service level, the World Health Organization recommends stepwise integration of palliative care into existing national and

subnational health services, including primary care and community or home-based models [6]. Specialist delivery models, including outpatient clinics, inpatient consultation teams, palliative care units, community care and hospice care, are complementary rather than interchangeable [7]. Access to adequate pain relief is also treated in the literature as a human-rights and public-health issue [8].

For Ukraine, the planning task is additionally complicated by wartime population movement, damage to health infrastructure, rapidly changing contracting arrangements, regional differences in access and incomplete comparability of available indicators. Consequently, a useful national strategy requires both a conceptually correct definition of need and a transparent choice of data and forecasting methods.

The **aim** of the study was to analyze and synthesize international concepts, methods for estimating and forecasting palliative care needs, and models of service integration, as well as to determine their practical implications for the development of palliative and hospice care in Ukraine.

Materials and Methods

This work was designed as an original theoretical study using bibliosemantic and comparative methods and system analysis. Scientific publications were identified in PubMed, Scopus and Google Scholar. The primary search period was 2012–2026. Earlier landmark sources were included when they were necessary to establish the historical development of definitions or to describe methods that remain methodologically relevant. Search terms included palliative care, hospice care, serious health-related suffering, health services needs and demand, forecasting, needs assessment, integration models, primary health care, opioid analgesics and Ukraine.

Priority was given to World Health Organization documents, publications of the International Association for Hospice and Palliative Care and the European Association for Palliative Care, peer-reviewed studies on population-based needs assessment and forecasting, and current Ukrainian sources describing service organization, education, pain management and wartime functioning. Sources were excluded when they addressed only narrow clinical treatment questions without informing service planning, when the study design or provenance could not be established, or when the source did not directly support the statement for which it was cited.

The review was narrative and theoretical rather than a systematic review; therefore, a Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram and stage-specific exclusion counts were not used. Forty-five sources were retained for conceptual and comparative analysis. Twenty sources that directly support statements in the final manuscript are cited below. System analysis was applied by comparing five domains across the selected sources: the concept of need, input data, analytical method, planning output and implementation constraints. The comparative method was used to contrast international approaches with current Ukrainian indicators and to distinguish measures that are not directly comparable, such as counts of contracted providers and counts of specialized services or teams.

Research Ethics

The study was conducted without the involvement of patients or animals and therefore did not require approval by an ethics committee. Only published and publicly available information was analyzed.

Results

Evolution of concepts and service integration

The international conceptual trajectory shows three interrelated changes. First, palliative care is no longer restricted to the final days or weeks of life and can be introduced according to need alongside disease-modifying treatment [1–4]. Second, the target of care is not a diagnosis but serious health-related suffering and the needs of patients, families and caregivers [3; 4]. Third, service development is expected to occur within the health

system rather than as a parallel hospice-only sector, with important roles for primary care, community services and specialized teams [2; 6; 7].

The 2020 International Association for Hospice and Palliative Care consensus is more accurately described through its substantive components than through an undefined set of 'determinants'. These components include active holistic care; relief of physical, psychological, social and spiritual suffering; applicability across ages and diagnoses; provision throughout the course of severe illness; support for families and caregivers; respect for cultural values and preferences; and responsibility of health systems to ensure access [4].

Human-rights literature adds a specific dimension to this framework: preventable untreated pain and the absence of access to appropriate pain management can represent a serious failure of health systems [8]. This does not mean that opioid consumption alone measures quality of palliative care; it is an important but incomplete indicator of medicine access and use.

Approaches to estimating and forecasting palliative care needs

Population-level estimates differ substantially depending on the operational definition of need and the data source. Murtagh F.E.M. et al. (2014) compared methods based on cause of death, symptom prevalence, chronic disease and hospital-use data and showed that estimates can vary widely even when applied to the same population [9]. Their reported range of approximately 69–82% referred to the proportion of people who die and may need palliative care in a high-income setting, not to the percentage of population need actually covered by services. Therefore, this figure cannot be used as evidence that high-income countries provide palliative care to more than 80% of those in need.

Etkind S.N. et al. (2017) combined disease-specific mortality patterns with demographic projections to estimate future palliative care need, demonstrating that modern population-based models may incorporate both demographic and morbidity structure rather than relying on age alone [10]. Similarly, projections of serious health-related suffering combine World Health Organization mortality projections with symptom prevalence for multiple health conditions [5]. Accordingly, the principal

limitation of demographic or mortality-based forecasting is not an inherent inability to consider morbidity, but dependence on the granularity and validity of disease, mortality and symptom assumptions.

For system monitoring, the World Health Organization recommends a multidimensional indicator framework covering policy, financing, service availability, medicines, education, research and other components rather than a single coverage indicator [11]. The Global Atlas likewise emphasizes that service development, medicine access, workforce and policy context must be interpreted together [12]. These principles were used to construct the classification in the *Table*.

Current Ukrainian context and applicability of forecasting approaches

The 2025 European Association for Palliative Care Atlas reports 87 specialized palliative care services for Ukraine, corresponding to 0.23 services per 100,000 inhabitants compared with a regional median of 0.96 per 100,000. The same country report notes that the current

number of hospices and palliative care departments is difficult to determine because facilities have been closed or destroyed during the war [13]. These figures should not be interpreted as the total number of organizations contracted to provide palliative services.

More recent Ukrainian administrative analysis describes rapid growth of contracted service providers. According to the National Institute for Strategic Studies, by mid-July 2026, 524 providers were contracted for inpatient palliative care and 589 providers for mobile palliative care, with more than 737 providers delivering palliative services under National Health Service of Ukraine contracts overall [17]. The difference between these numbers and the European Association for Palliative Care Atlas count reflects different units of observation and data sources: contracted provider organizations are not equivalent to specialized palliative services or teams. This distinction is essential when evaluating infrastructure and should replace unsupported statements about an assumed percentage of 'coverage'.

Table. Classification of methods for estimating and forecasting palliative care needs

Classification criterion	Method	Core data and application	Strengths and limitations
Primary data source	Population/mortality-based estimation	Population structure, deaths, causes of death; may incorporate disease-specific mortality and symptom assumptions.	Uses routinely collected data and supports large-area comparison. Accuracy depends on coding quality, disease definitions and assumptions about which deaths generate palliative need [5; 9; 10].
Primary data source	Epidemiological estimation	Prevalence/incidence of serious diseases, disease stage and symptom burden.	Provides a clinically interpretable profile of need but requires reliable disease and symptom data; underdiagnosis and incomplete registries can bias estimates [3; 5; 9].
Primary data source	Utilization/registry-based estimation	Electronic records, service contacts, hospital use, registries and reimbursement data.	Describes observed service use and resource consumption but may underestimate unmet need because people without access are absent from utilization data [9; 11].
Planning target	Medication-need planning	Expected patient numbers, pain/symptom burden, clinical protocols and medicine consumption.	Directly relevant to procurement, but historical opioid consumption cannot be treated as true need when access or prescribing is constrained [3; 11; 13].
Analytical approach	Time-series and trend forecasting	Historical need or utilization series; linear, moving, creeping or other trend models with validation.	Useful for short- and medium-term planning when input series are stable. Results are sensitive to structural breaks, migration and changes in data collection; wartime validation is essential [14–16].
Planning horizon	Scenario and combined modelling	Demographic, epidemiological, utilization and policy assumptions combined in alternative scenarios.	Better reflects uncertainty and system change than a single extrapolation, but requires more data, transparent assumptions and periodic recalibration [5; 10; 11].

Ukrainian forecasting research has tested several time-series methods rather than relying on one official national forecasting algorithm. A 2024 study found that a creeping-trend method with segment smoothing improved forecast accuracy for adults compared with a simple linear trend, while results for children were less stable and required better medical and demographic statistics [14]. Another 2024 analysis explicitly adjusted trend calculations for wartime migration and the absence of complete statistics from temporarily occupied territories [15]. In 2025, a moving-average trend approach was evaluated for pediatric palliative need, with different performance across diagnostic groups and a continued need for model calibration [16]. These studies support the use of validated trend methods as one component of planning, not as substitutes for epidemiological or service-use data.

The war affects both data quality and service capacity. A study of a Kharkiv hospice reported a personnel deficit of 22.0% in 2022 compared with 11.9% in 2021, while also documenting institutional adaptation during the first year of the full-scale war [18]. This is a specific regional observation and should not be generalized as a national staffing rate, but it demonstrates how wartime conditions can change workforce availability and utilization patterns.

Education remains a measurable system constraint. The 2025 European Association for Palliative Care Atlas reports compulsory undergraduate palliative care teaching in 0 of 16 Ukrainian medical schools and optional teaching in 16 of 16, as well as no recognized specialization process for palliative care physicians [13]. An analysis of Ukrainian educational programs similarly found substantial variation in content and argued for greater standardization [19]. These data support strengthening compulsory core competencies, but they do not justify describing all Ukrainian institutions as having an 'educational vacuum'.

Medicine access also requires careful interpretation. The European Association for Palliative Care country report gives an average opioid consumption of 132 defined daily doses for statistical purposes per million inhabitants per day for Ukraine in 2020–2022,

compared with a regional average of 4,959 [13]. This marked difference is an indicator of limited use and/or access, but it cannot by itself quantify 'opioidphobia' or establish its causes. Ukrainian work on pain relief supports the need for diagnosis-based analgesic planning and attention to reimbursement and access [20].

Practical recommendations for implementation in Ukraine

Planning and monitoring. National and regional planning should combine demographic and mortality projections with disease-specific estimates, service-utilization data and validated time-series forecasts. The indicators should be explicitly defined and linked to a data source, update interval and planning decision. The World Health Organization indicator framework provides a more defensible basis for monitoring than a single target percentage [11].

Information systems. The Electronic Health System of Ukraine can be used to strengthen monitoring of palliative need and service use through interoperable data fields and aggregated indicators. A person-level national registry should not be treated as a prerequisite for planning. If such a registry is considered, its legal basis, purpose limitation, data minimization, access control, information security, cost and proportionality should be assessed before implementation. Aggregated or pseudonymized data should be preferred when they are sufficient for the planning objective.

Organization and financing. Existing inpatient and mobile packages should be evaluated not only by the number of contracted providers but also by geographical accessibility, continuity, timeliness, workload, home-care capacity and patient outcomes. Rural, remote and frontline communities require specific monitoring because equal contract availability does not necessarily mean equal practical access [13; 17]. Funding adjustments should therefore be based on measured workload and access barriers rather than on an unvalidated universal coefficient.

Education and workforce. Mandatory core competencies in palliative medicine and chronic pain management should be integrated into undergraduate medical education, with practical, communication and

interprofessional components. Postgraduate pathways and recognized professional competencies should be developed in parallel with service expansion [13; 19].

Medicines and pain relief. Procurement and forecasting of opioid analgesics should use expected clinical need and treatment protocols together with observed consumption. Low consumption should trigger investigation of supply, prescribing, reimbursement, regulatory, educational and patient-level barriers rather than be interpreted as evidence of low need [3; 11; 13; 20].

Wartime resilience. Planning should include continuity arrangements for displaced populations, damaged facilities, disrupted supply chains and staff losses. Forecasts should be recalibrated when migration, territorial control, service contracts or data completeness change materially [16; 18].

Discussion

The analysis shows that several apparent contradictions in the literature arise from mixing different concepts. The most important is the distinction between estimated need and actual service coverage. The 69–82% range reported by Murtagh F.E.M. et al. (2014) concerns the estimated proportion of people who die and may need palliative care, not the proportion who receive it [9]. International evidence instead emphasizes persistent unmet need and major inequality in access [3; 12]. Consequently, the previous claim that high-income countries routinely cover more than 80% of real palliative need is not supported and should not be used as a benchmark.

A second distinction concerns service counts. The European Association for Palliative Care Atlas reports specialized services or teams using a cross-country indicator framework [13], whereas Ukrainian 2026 data count contracted provider organizations under specific National Health Service packages [17]. Both are useful, but they answer different questions. The former is suitable for international comparison of specialized service density; the latter is more useful for current contracting and network monitoring. Treating them as interchangeable would produce misleading conclusions about either rapid success or severe deficit.

A third distinction concerns forecasting methods. Mortality-based, epidemiological, utilization-based and time-series approaches should not be arranged as a simple hierarchy from 'outdated' to 'advanced'. Their performance depends on the planning question, data quality and time horizon. Population and mortality data remain valuable because they are standardized and widely available, while epidemiological and registry data can refine diagnostic and service profiles. Ukrainian studies demonstrate the value of model validation and recalibration under wartime conditions [14–16]. A combined approach is therefore more defensible than replacing all demographic modelling with one statistical technique.

The Ukrainian policy context has also changed rapidly. Current contracting data demonstrate substantial expansion of inpatient and mobile provision [17], so statements based on older infrastructure counts must be qualified. At the same time, the 2025 European Association for Palliative Care Atlas documents continuing gaps in specialized-service density, mandatory education and opioid use [13]. These findings are compatible: expansion in the number of contracted organizations does not automatically eliminate geographic, educational, medicine-access or coordination problems.

The war must be treated as a structural factor rather than a brief contextual note. It affects population denominators, disease burden, availability of statistics, workforce, physical infrastructure and medicine logistics. The Kharkiv experience provides a concrete example of a wartime increase in staff shortage, while national and European sources describe damaged facilities and the need to interpret current service counts cautiously [13; 18]. Models based on pre-war trends should therefore be tested for structural breaks and updated as new population and service data become available.

This study has limitations. It is a narrative theoretical analysis rather than a systematic review; therefore, the selection process does not provide PRISMA-based stage counts and cannot be interpreted as exhaustive. Some Ukrainian indicators are drawn from

administrative and policy sources whose units of observation differ from international atlas indicators. Data describing 2026 contracts may also change within the year. These limitations reinforce the need to state the denominator, data source and reference date for every infrastructure or coverage indicator.

Conclusions

Contemporary palliative care is an integrated, need-based component of health care for people with serious health-related suffering and should not be restricted to terminal care or to a single disease group. Planning must therefore account for clinical need, service access, medicines, education and continuity of care.

No single forecasting method is sufficient for Ukraine. The most defensible approach is to combine demographic and disease-specific estimates with service-utilization data and validated time-series models, while recalibrating forecasts when migration, territorial changes or data completeness alter the underlying population and health-system structure.

The current Ukrainian system has expanded its contracted inpatient and mobile provider network, but development priori-

ties remain territorial accessibility, comparable monitoring indicators, standardized palliative-care competencies in medical education, rational planning of analgesic provision, wartime continuity and legally proportionate handling of person-level health information.

Declarations

Conflict of interest is absent.

All authors have consented to the publication of this article under the terms of the Creative Commons BY-NC-SA 4.0 International License and a public agreement with the Editorial Board, and to the processing and publication of their personal data.

The authors of the manuscript declare that in the process of conducting research, preparing, and author-revising this manuscript, they did not use any generative artificial intelligence tools or services to perform any of the tasks listed in the Generative Artificial Intelligence Delegation Taxonomy (GAIDeT, 2025). The authors state that the research concept, source selection, interpretation and conclusions submitted to the Editorial Board were produced by the authors.

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Authors' Contributions

Contribution Authors	A	B	C	D	E	F
Pomohaibo K.G.	+			+	+	+
Logvynova O.V.		+	+			+

Notes:

A – concept;

B – design;

C – data collection;

D – statistical processing and data interpretation;

E – writing or critical revision of the article;

F – approval of the final version for publication and agreement to be accountable for all aspects of the work.

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МІЖНАРОДНІ КОНЦЕПЦІЇ ТА НАЦІОНАЛЬНІ СТРАТЕГІЇ РОЗВИТКУ ПАЛІАТИВНОЇ ТА ХОСПІСНОЇ МЕДИЧНОЇ ДОПОМОГИ

Актуальність. Паліативна допомога трансформувалася з переважно допомоги наприкінці життя на складову інтегрованої медичної допомоги людям із серйозними стражданнями, пов'язаними зі здоров'ям. В Україні планування ускладнюють демографічні зміни, хронічні хвороби, наслідки війни та неоднорідність медичної інформації.

Мета. Узагальнити міжнародні концепції, методи оцінювання і прогнозування потреби у паліативній допомозі та моделі її інтеграції, а також визначити їх значення для України.

Матеріали та методи. В оригінальному теоретичному дослідженні використано бібліосемантичний і порівняльний методи та системний аналіз. У PubMed, Scopus і Google Scholar здійснено пошук джерел за 2012–2026 рр.; для ключових дефініцій і методів додатково включено окремі фундаментальні праці попередніх років. Проаналізовано офіційні документи Всесвітньої організації охорони здоров'я, Європейської асоціації паліативної допомоги, Міжнародної асоціації хоспісної та паліативної допомоги й органів охорони здоров'я України. Відібрано 45 джерел. Системний аналіз охоплював вхідні дані, методи оцінювання, моделі надання допомоги, обмеження впровадження та індикатори моніторингу. Дослідження було проведене в межах дисертації другого автора.

Етика дослідження. Дослідження проведено без залучення пацієнтів та тварин, тому не потребувало згоди етичної комісії.

Результати. Сучасні концепції передбачають ранню холістичну допомогу при серйозних стражданнях, пов'язаних зі здоров'ям, та її інтеграцію з первинною допомогою й універсальним охопленням медичними послугами. Методи оцінювання потреби згруповано як популяційно-демографічні, епідеміологічні, засновані на використанні послуг/реєстрах та часових рядах; планування лікарського забезпечення розглянуто окремо, оскільки фактичне споживання опіоїдів відображає і потребу, і доступність. Сучасні українські дані свідчать про швидке зростання кількості законтракованих стаціонарних і мобільних надавачів, однак зберігаються територіальна нерівність, воєнні втрати, фрагментарність стратегічної координації, обмеженість обов'язкового додипломного навчання та низьке споживання опіоїдів.

Висновки. Планування в Україні має поєднувати демографічні й нозологічні оцінки з даними використання послуг та валідованими методами часових рядів. Пріоритетами є сумісний моніторинг, територіальна доступність, компетентнісна освіта, безперервність допомоги під час війни та правомірне пропорційне використання персоніфікованих даних.

Ключові слова: організація охорони здоров'я, потреби та попит на медичні послуги, універсальне охоплення медичними послугами, прогнозування, доступність медичних послуг.

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