An organized palliative care system was lacking in Turkey before 2010. One of the pillars of Turkish Cancer Control Programme is palliative care. The Pallia-Turk project in this respect has been implemented by the Ministry since 2010. The project is unique since it is population based and organized at the primary level. This means, the whole population (>70 million) will have the quickest and easiest way for access to palliative care. This manuscript briefly summarizes the situation before the project and updates what has been done in last 2 years with the project.

**Key words:** Pallia-Turk, Turkey, palliative care, ministry, Turkish Ministry of Health

**introduction**

Medicine has served human beings since ancient times. Symptoms, particularly pain, were actually the centre of all primitive medical interventions. Unfortunately, this is not anymore the case for modern patient care. Disease-targeted curative therapies have mostly replaced the common traditional philosophy of patient and physician relations. Medicine is no longer an art oriented at patients, but rather a set of guidelines and algorithms. Algorithms surrounding the malpractice issues are in the minds of doctors. However, it is not always possible to allocate all patients into a well-known algorithm.

This is why palliative care is still lacking in many countries. Both physicians and health directors have ignored this topic for many years. The health directors of governments should be alerted and change the existing medical training systems. We should recreate the ancient time medical staff, seeking to relieve symptoms and not only targeting directly the disease. We should again start to ask for pain, evaluate pain and relieve pain in our patients.

**situation before the Pallia-Turk Project**

The Turkish Ministry of Health has launched a national cancer control programme for the next 5 years in 2009 [1]. The programme includes five main headings: Registry, Prevention, Screening and Early Diagnosis, Treatment and finally Palliative Care. Among these, palliative care was the weakest part of current cancer control activities in Turkey [2].

The main reason for this seems to be the traditional Turkish family structure. Turkish families are extensive and when one family member becomes ill, all family members gather around this person. This implies that Turkish families had an intrinsic palliation propensity but this was not reflected in the professional public health system.

Currently, there are few palliative care centres across the country [1, 2]. The majority of the centres are pain units. Turkey is a country with a big population and a large area. There are thousands of small districts with few people residing in them. Accordingly, health care services are difficult to implement and are cost expensive for investments.

Despite the fact a great amount of (>20%) the raw material of medical and scientific opioids used globally is produced in Turkey, Turkey was lacking behind many countries with respect to morphine consumption rates per capita [3]. Not only the consumption rates were low, but also the availability of morphine products within the Turkish market were lacking. Many types of opioid are still absent from the market, such as sublingual opioid tablets or immediate-release morphine [2]. Another big concern was the current legislation about opioid prescription. General practitioners and family physicians were not permitted to prescribe morphine. Only few specialists had the right to prescribe opioids using red prescription papers. Also each physician and prescription was closely followed by the local health governors and also narcotic divisions of the police departments. These measures inevitably led to limitations in morphine prescription by physicians. Furthermore, the majority of the clinicians did not know appropriate algorithms for pain management. They did not have much experience with the use of morphine and to manage its side effects.

**after the Pallia-Turk Project**

The Turkish Ministry of Health, Cancer Control Department launched the Pallia-Turk to be implemented in
2010. The Project focuses on two main topics: opioids availability and implementation of a community-based palliative care model.

opioids: increase of morphine availability in the markets and new legislations for morphine prescription, training of medical staff against opiophobia

The Turkish Council of Ministers launched a new law and created the opportunity for the Cancer Control Department to import new morphine tablets by itself as a governmental agency. The Cancer Control Department now searches for international drug companies who may get interested in the import of opioids. The Ministry of Health is also in contact with local national drug companies for a national production capacity which may also serve as a basis for our surrounding countries. The Turkish Ministry of Health has received technical support from the Middle East Cancer Consortium (MECC), the Union for International Cancer Control (UICC) and also the European Union F7 ATOME Project to achieve these goals [4].

Previously, only few specialists had the right to prescribe morphine. With the new legislation, all family physicians (more than 20 000) and their related home care teams will have the right to prescribe opioids. All family physicians are paid according to their performance indices. Assessment of pain and its appropriate treatment will be one of the performance indices used from 2013: pain evaluation and treatment will thus influence the performance and income of family physicians. All patients have the right to choose and consult their family physicians for their pain and symptom control and patient number is another performance index used to evaluate family physicians.

The training of family physicians with respect to the pain management algorithms, use of morphines and to manage morphine-related side effects is a third challenge. Each of the 20 000 Turkish family physicians needs to be trained in pain control. The Cancer Control Department is now in close collaboration with some professional national (Turkish Society of Palliative Care, Turkish Society of Medical Oncology and Turkish Society of Oncology Nursing) and international societies (MECC, WHO ICO Centre, San Diego Hospice, ASCO, UICC) to implement nationwide training modules to all family physicians and their nurses. Core group people are already trained who will cover the whole country for training which is planned to be finalized in 2 years.

implementation of a community-based palliative care model

The unique properties of the Pallia-Turk project are:

1) A community-based system with family physicians, their nurses and home care teams so that every citizen will have the chance to receive basic palliative care services.

2) Integration of non-governmental organizations (NGOs) and local governors (municipals) to cover the psychosocial, economic and religious needs of patients.

The Pallia-Turk Project has three levels of organization: Primary, Secondary and Tertiary Palliative Care Centres.

1) Primary Level. Primary Level Organization includes family physicians, home care teams, NGOs and local governors. Patients who cannot be managed at this level are referred to secondary and tertiary level centres.

a) Home Care Team: Each ministerial hospital in Turkey has a home care team [5, 6]. The total number of home care teams is >600. Each team is composed of one general practitioner, three nurses, one driver and one car. Any patient who is in need of home care can directly call on to these teams, or if any family physician or any specialist doctor (e.g. general surgeon, internal medicine) needs home care for their patients, they can get in touch and involve the team in patient care. Home care teams will be responsible for simple acute measures such as pain relief, constipation, wound dressing and parenteral drug administration. They will take care for the patients who are not sufficiently mobile. Each home care team can also support patients economically in case of need which will be covered by the hospital circulating capital.

b) Family Physicians: Currently, Turkey has >20 000 family physicians. Each Turkish citizen has one family physician who will take care of him or her. All family physicians will be trained by the end of 2013. If family physicians were incorporated into palliative care, they can help their patients and their relatives how to handle future fear and anxiety due to disease-related symptoms and avoid unnecessary hospital admissions.

2) Secondary and Tertiary Level Centres. These are responsible to take care for patients with severe symptoms and for patients who are in need of acute–subacute and chronic palliation that cannot be managed by family physicians [7]. These centres are the centres of excellence. Teams include physicians (internal medicine, medical oncology, cardiology, thoracic diseases, anaesthesiology or algology, general practitioners), experienced oncology nurses (one for two patients), social workers, physiotherapists, nutrition experts, psychologists and religious people. These centres will also plan research activities within time.

experiences with community-based palliative care

Home care teams have been implemented by the end of 2010. The First International Home Care Congress was organized in October 2010 and attended by more than 1500 people. After the congress, training modules were developed by the national experts and a core group of teachers was trained for home care and palliative care basics.

A mass media campaign was started on national channels for home care. A telephone line has been implemented for all patients in need. Approximately, 83 358 people have been visited at home in the first 8 months of 2011 [8] and the total number of visits was 190 942 [8]. The majority of the patients in need for home care did not have cancer (4%) [8]. Chronic diseases were more common and this was not surprising since
the citizens still do not have the notion of palliative home care and only trust on their oncologist. Neurological diseases were the leading disease (45%) followed by cardiovascular diseases (21%) [8]. However, for many other chronic diseases the interest was enormous.

Certain medical devices were given free of charge to patients. The most common was glucometer \((n = 317)\), followed by pneumatic beds \((n = 149)\).

In 2013, a cost-effectiveness analysis will be performed but the Turkish Ministry of Health believes that palliative care is cost-effective and the cheapest health expenditure to keep the patients at their homes, rather than being hospitalized.

With the inclusion of family physicians, we believe and invest in home care and a palliative care system. The system seems cost-effective and directly targets the quality of life of patients. This is a unique, community-based system for all patients and will become a unique model for the world. Collaboration with NGOs and local majors in the near future is of great importance to improve the patient’s quality of life and serve further additional needs such as psychological, religious, environmental and financial support.

**conclusion**

The Pallia-Turk Project is a unique model of palliative care for countries like Turkey where the surface area is large and there is a large population. Primary level, family physician-based palliative care and home care systems seem to be difficult for implementation. However, even basic palliative care at the primary level seems to be cost-effective. Palliative care is a human right and all patients should have access to such care to ensure their quality of life. The fastest and most comfortable palliative care model is at primary level.

**disclosure**

The authors declare no conflicts of interest.

**references**