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Palliative Care in Romania and Lithuania- Between the Necessity of Terminal Patient Assistance and the Rigors of Resource Allocation

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Abstract: Background: Palliative care, seen as a fundamental human right, gains increasingly more importance worldwide, but the distribution of this kind of facilities is unequal. Aim: In this paper authors compare the palliative care systems of Romania and Lithuania, post-communist countries, characterized by shifting from a state healthcare system to a decentralized one, based on health insurances. Design: We have performed a desk research in Romanian and English languages, analyzing publications referring to this topic in the two countries. Data sources: Vilnius University Database and Google search engine using as keywords, Lithuania(n) palliative care", respectively „Romania(n) palliative care", published between 1975 and 2019. Eligibility criteria: articles published between the years mentioned above in English or Romanian languages. Results: In Romania, the palliative care network is better structured, including both hospital care and home care, for adults and children. Still, opioid consumption in Lithuania is higher than in Romania because of a more flexible prescribing legislation. In Romania, palliative care is a recognized as a medical sub-speciality, while in Lithuania no preoccupations exist in this regard. Conclusions: In both countries state budget funds allocation lacks transparency, and funds allocated for palliative care are insufficient. During the last 20 years Romania has undertaken bigger steps in palliative care than Lithuania, especially due to the effort of a few dedicated professionals. Still, the sub-financing of the two systems and the limited number of professionals limit the system efficiency.

Keywords: *palliation; ethics; resource allocation; Romania; Lithuania.*

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Introduction

Palliative care was defined in many ways over time, in more and more complex ways, adequate to its goals, characteristics and work methods. In 1987, palliative care was defined as „the study and care for patients with active, progressive, advanced diseases and limited life expectancy, for which the focus of care lies on the quality of life”. The strong point of this definition is the focus on life quality, not on prolonging life or curing the disease. This definition does not mention the care for the patient's family and the fact that a multidisciplinary team is involved in patient care, given the multitude of needs a terminal patient has (Post, 2004).

In 1990, the World Health Organization has elaborated a wider definition that has integrated the role of palliative care in the resolution of psychological, social and spiritual needs that are added to symptom control. This definition was revised and completed in 2002 to include aspects about intervention rapidity, life quality improvement, multidisciplinary approach and family support during the disease and the bereavement period.

In 1998, J. Andrews Billings defines palliative care as “the comprehensive and interdisciplinary care that focuses mostly on life quality for patients with terminal diseases and their families. Key elements include physical comfort, psychosocial and spiritual support and offering coordinated services in different care facilities” (Wright, 2003).

The first hospice in the world was created in 1967 in England- “St. Cristopher's Hospice”. But care for the dying roots in medieval times, when hospices were houses for wounded travelers. What separates modern facilities from those institutions is scientific rigor and holistic approach. At the beginning of the 2000s over 6200 palliative care institutions were set up in over 100 countries (Post, 2004). However, palliative care is not available for 75% of the world population (Post, 2004) and at the end of the 1990s, only 1,6% of the pages of world renowned medical treaties contained notions of palliative care (Block & Sullivan, 1998).

It is estimated that 60% of deaths could benefit from some form of palliative care. Still, only a limited number of those who die ever benefit from palliative care. Developing countries have two thirds of the world's morbid load, but only benefit from 5% of the world medical resources (doctors, nurses, medicines, equipment and funds) (Wright, 2003).

Worldwide, over 150 countries are involved in developing a national palliative care network. Their development is unequal; in only 15% of the cases palliative care systems reach acceptable standards. In countries with poorly developed systems, a certain type of care might be completely

inaccessible to most of the population. Despite efforts that are being made to make palliative care a basic human right, it remains far from being accessible to the whole population. Romania is seen as a country with a palliative care system that is close to being acceptable, while Lithuania is seen as one with unsatisfactory palliative care system (Wright, Wood, Lynch, & Clark, 2008).

Cancer is a major mortality cause in Europe, causing 16.32% of world deaths in 2016, the second most frequent cause of death after cardiovascular disease in the world (Ritchie & Roser, 2018).

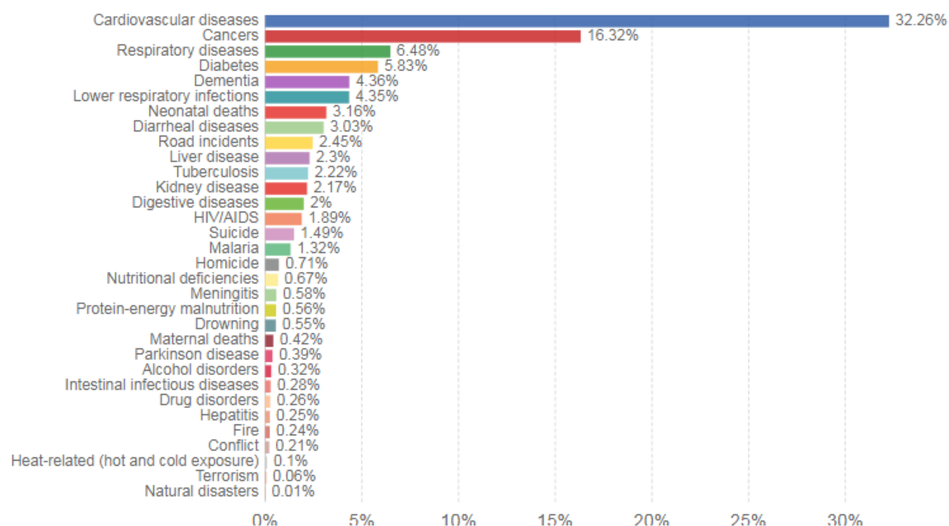

Figure 1: Share of death by cause (Ritchie & Roser, 2018)

In 2018 an estimated of 9.6 milion deaths occurred worldwide due to cancer, meaning that one in six deaths was caused by cancer last year (WHO, 2018). The highest incidence of this disease is noted in Hungary, Poland, Slovenia, Czech Republic, Slovakia, Latvia and Lithuania (EOHCS, 2000a) and most frequent types of cancer in this region include lung, colorectal, stomach liver, breast and prostate (WHO, 2018).

Any disease that reaches a terminal stage requires palliative care, but the costs of neoplastic palliation are often higher than those applicable to other diseases. Regarding cancer mortality, Romania and Lithuania are placed at the middle of the incidence curve in Europe.

In Romania, a higher incidence of leukemia and congenital malformations in children after the Cernobîl nuclear accident was observed. The most frequent types of cancer are: breast, cervical and digestive in women and pulmonary, prostate and digestive in men. Also, Romania houses almost half of the HIV infected children of Europe. Some of them have already reached the AIDS phase. Even if no new cases are encountered, those already afflicted need urgent palliation (Mosoiu, Andrews, & Perrols, 2000).

It is estimated that 17,036,901 new cancer cases were diagnosed in 2018 worldwide (WCRF, 2018), the most common types being lung, breast and colorectal. Cancer incidence is reported slightly higher in Lithuania than Romania (Eurostat, 2018) (Table I).

Table I: Major causes of death for persons aged 65 years and over (Eurostat, 2018)

	Diseases of the circulatory system	of which: Ischameic heart diseases	Cerebrovascular diseases	Diseases of the respiratory system	Cancer (malignant neoplasms)	of which: Lung cancer	Colorectal cancer	Breast cancer (women only)	Prostate cancer (men only)
EU-28	1 766.4	574.3	401.7	413.2	1 014.8	197.7	126.2	111.4	191.0
Belgium	1 350.1	321.8	296.8	515.6	983.0	214.8	111.2	121.0	185.1
Bulgaria	5 154.5	875.2	1 561.4	244.7	817.8	127.8	137.2	101.4	173.4
Czechia	2 972.9	1 586.7	570.1	391.9	1 102.7	201.2	158.8	105.4	195.9
Denmark	1 180.1	346.9	324.7	558.6	1 200.6	278.5	148.7	139.5	293.0
Germany	1 951.7	681.2	310.2	357.5	993.6	183.9	119.3	128.3	196.8
Estonia	3 063.0	1 257.4	311.8	185.5	1 160.5	203.5	150.3	94.1	380.4
Ireland	1 505.0	691.6	323.8	659.8	1 138.8	234.5	134.7	126.7	216.6
Greece	1 741.9	399.3	566.3	590.9	976.4	228.0	99.2	114.9	163.4
Spain	1 183.2	307.5	275.5	509.3	891.2	168.3	136.6	74.4	152.1
France	949.6	216.3	212.6	286.9	932.1	163.7	109.6	111.0	171.2
Croatia	3 349.3	1 493.6	937.9	323.7	1 281.8	216.4	206.0	155.5	291.7
Italy	1 573.8	472.3	411.1	323.0	988.7	198.7	113.1	106.4	129.0
Cyprus	1 749.2	461.2	322.1	538.0	836.0	132.4	87.3	107.0	199.2
Latvia	3 920.8	1 973.6	1 313.6	138.7	1 077.5	156.1	146.4	109.2	332.4
Lithuania	3 968.6	2 711.6	974.5	186.2	1 032.5	153.7	139.3	95.1	294.6
Luxembourg	1 389.6	327.2	279.0	395.3	992.1	208.7	109.4	124.7	167.8
Hungary	3 569.6	1 809.3	673.3	398.0	1 207.2	281.0	213.1	132.2	198.3
Malta	1 825.2	977.3	393.2	517.8	892.1	180.1	138.6	130.4	107.2
Netherlands	1 306.1	281.2	324.4	419.9	1 146.4	255.2	140.6	127.6	223.9
Austria	2 101.0	861.6	301.3	253.5	967.0	170.7	105.2	116.6	180.7
Poland	2 774.2	556.5	458.5	359.8	1 150.5	247.5	156.4	104.6	222.8
Portugal	1 403.6	287.4	520.2	613.3	911.7	126.9	144.5	86.5	203.7
Romania	4 423.4	1 468.5	1 271.0	338.2	926.7	166.9	132.8	101.2	156.9
Slovenia	2 160.8	497.4	512.4	348.7	1 229.0	209.1	163.0	130.0	307.2
Slovakia	3 046.1	1 869.6	685.7	404.8	1 225.0	185.3	205.9	144.8	245.9
Finland	1 697.5	897.6	385.1	165.3	898.6	164.0	92.6	91.1	220.9
Sweden	1 557.8	572.9	306.2	315.9	977.6	158.3	122.7	96.7	300.5
United Kingdom	1 202.5	513.8	319.1	674.6	1 132.9	248.7	113.7	117.1	240.5
Iceland	1 550.4	639.3	322.9	363.0	1 032.7	209.9	132.1	135.0	279.2
Liechtenstein	1 151.4	406.6	303.2	442.0	766.0	130.7	81.0	86.5	173.5
Norway	1 264.6	444.1	291.1	475.2	1 030.8	206.0	154.7	81.0	310.6
Switzerland	1 355.9	456.7	225.1	289.0	909.3	161.2	96.3	122.3	224.3
Serbia	4 308.4	650.7	941.4	375.0	1 029.2	207.3	144.5	138.5	189.0
Turkey	2 420.8	906.4	610.4	672.3	744.5	201.2	76.7	44.5	146.6

Historical benchmarks

An important event of Central and Eastern Europe was the fall of communism that eliminated old certainties regarding healthcare and created new risks. Health systems decentralized and health insurance based models

gained ground. Unfortunately, healthcare systems in post-communist countries are chronically underfinanced (Wright, 2003).

In Lithuania, since the restoration of independence in 1990, there have been 4 phases in the development of the healthcare system. The first one was characterized by involution. The prevalent ideology was that doctors, hospitals and municipalities must decide on the range and quality of the healthcare system. The second phase lasted from 1993 to 1994 and was characterized by public debates regarding public versus private administration of health institutions and free choice of the doctor for the patient. The result was a general consensus for the need for a reform. In the third phase (1994-1995) numerous public decisions were made regarding the implementation of a health insurance layout and healthcare system decentralization by transferring hospital management from the Ministry of Health to the 10 counties. The last phase focuses on legal and institutional ability development (EOHCS, 2000a).

Since 1996, the Lithuanian healthcare system begun transforming from an integrated model to a contract based model. A decentralization process begun regarding the subordination of hospitals to city halls or municipalities. Until 1996, healthcare infrastructure resembled a pyramid. Municipal hospitals were at the top of the financial and administrative pyramid; below them were local specialized medical institutions and rural hospitals, followed by ambulatories, and finally at the base of the pyramid came general practitioner offices. The outpatient institutions image modified as a result of separating facilities (policlinics and ambulatories) from the hospitals. Now, authorities are confronted with the impossibility to optimally manage the healthcare system. The private sector plays an important role, especially in stomatology, cosmetic surgery, psychotherapy and gynecology.

Private health insurances are permitted and there are a few private companies that cover the costs of healthcare for Lithuanian citizens who travel abroad and of foreign citizens that visit Lithuania.

The Semashko type healthcare system that was implemented in Romania before the revolution was typical for all Central and Eastern European countries. The central idea of this system was that the state ensures to all citizens the coverage of their health needs, while restricting their freedom of choice, but trying to obtain a high level of equity. Between 1990 and 1995 the Government and Health Ministry issued a series of papers with important consequences in time. The new regulations have modified the whole structure of the health system and set legal grounds for the translation from a state, centralized and integrated system to a

decentralised one, based on health insurance, with contractual relationships between health insurance funds and healthcare providers. Most hospitals are still state-administered, but there are some private practice initiatives, also. Delegation and privatization play an important role in the decentralization process (EOHCS, 2000b).

Romanian healthcare system receives currently 5.2% of the gross national product, ranking lowest from this point of view in Europe, according to a study published by the European Commission in 2018 while Lithuania spends 6.3% of the gross national product on healthcare, according to the same source (OECD/EU, 2018).

Material and method

We have performed a desk research in Romanian and English languages, analyzing publications referring to this topic in the two countries, using Vilnius University Database and Google search engine using as keywords „Lithuania(n) palliative care”, respectiv „Romania(n) palliative care” published between 1975 and 2019. The search has returned approximately 515 results, and “in extenso” articles were available in 24 cases. Relevant data was extracted and compiled. The two countries were chosen because of the simmilarities in the recent history (the fall of communism) and their different rythm of alligning to European standards.

Results and discussions

Romania and Lithuania, two post-communist countries, are characterized by the dissolution of old certainties about jobs, ensured for everyone by the state, but also about free health provision, events that are inherent to the democratization process. This process started in Romania with the events in December 1989 and in Lithuania in 1990, when the country stated its independence from the Soviet Union.

Health system reform in both countries is characterized by decentralization and privatization. The centralized systems characteristic to the communist period for both countries were defined by inefficient management and resource allocation. Decentralization was based on the segregation of primary assistance- family physicians, secondary assistance- medical specialties practiced in small hospitals and tertiary assistance- university clinics.

The private healthcare system has emerged during the latest years in both countries, but it has low addressability because of the co-payment requirement.

Decentralization is characterized in both countries by the transfer of the management responsibilities from the Ministry of Health to the municipalities. The latter are responsible for resource allocation to medium and small hospitals within their area.

Until 1989, respectively 1990, the whole pharmaceutical system of both countries belonged to the state. Afterwards, the governments have decided to align to European standards, which meant opening the pharmaceutical markets and importing medicines produced in other countries.

Palliative care development in Romania and Lithuania

In 2012, there were 49 services and institutions for palliative care in Romania, for a total population of 20.254.866 inhabitants, according to the 2012 census. Most offered palliative care at home and were funded by non-governmental organization. There were 7 palliative care centers, 10 home care teams, one day center and 2 consulting teams within adult hospitals. There were also 5 palliative care centers for children, 6 pediatric home care teams, one child day care center and 2 consulting teams within pediatric hospitals. Although no state hospital was especially designed for this purpose, many of them have wards or beds for this purpose, especially within oncology departments. Patients are cared for by doctors and nurses that have undergone palliative care training organized by "House of Hope" Hospice, Brasov.

The geographical distribution of palliative care services in Romania was unequal (TopSanatate, 2018). Moldova and the Eastern Romanian counties had 7 institutions of this type, there were 12 such centers in Ardeal and none in the south-west of the country. Bucharest had 9 palliative care centers and Constanta has 7. Some were private institutions, some were just hospital beds dedicated to palliative care. The "success stories" of Romania are represented by "House of Hope" Hospice in Brasov and "Emanuel" Hospice in Oradea.

Since 2012 more centers were opened. A paper published in 2018 (Mosoiu, Mitrea, & Dumitrescu, 2018) noted the existence of 78 palliative care inpatient units, 24 palliative care home care services, 5 palliative care outpatient services , 4 palliative care day centers and 4 palliative care mobile hospital teams.

Palliative care progress was due to a few factors: the country developed a strong infrastructure, palliative care experts presented the actual needs to the government, and the government approved modifying national politics regarding opioid administration and formed special committees in

this respect. The support offered by the World Health Organization allowed a set of basic rules to be formed, and using international guidelines made the formulation of national policies easier. Despite all these efforts, opioid consumption remains low in Romania (IOELC, 2014).

In Romania almost 90% of deaths occur at home, partly because of the previously expressed preference by patients and/or their families, partly because of the tendency of hospitals to discharge terminal patients if proper care cannot be offered. Where home teams are not available, some patients and families prefer hospice institutions (IOELC, 2014).

In 1990, reverend John Walmsley and some volunteers visited Romania. He founded the "Romanian Children's Aid" Humanitarian Foundation, later known as "Children in Distress" Foundation. In March 2002 this foundation opened the first palliative care service in Romania, at Cernavoda, "St. Laurence Hospice", that offered care for children with AIDS. Other facilities were later opened at Bucharest and Curtea de Arges. In April 1992 "House of Hope" Hospice opened in Brasov, presently the largest palliative care center in Romania. It also includes a pediatric section since 1996. This hospice is a Romanian-English charity, founded by the Ellenor Foundation.

The Romanian Association for Development of Palliative Care was founded on January 5th, 1992, at Berceni Hospital in Bucharest. Palliative care was accredited as a subspeciality in 2002. The same year national standards for palliative care were in place, due to the collaboration between Romanian Association for Palliative Care and the National Hospice and Palliative Care Organization in the United States (IOELC, 2014).

In Lithuania there are 13 home palliative care teams for adults and 3 for children. In 2010, 37 healthcare facilities were licensed for palliative care; 13 provide full palliative care at home (doctors, nurses and social workers). Full palliative care services are provided in 8 hospitals and there are 8 palliative care services with 86 beds in non-Tertiary hospitals. There are 2 children's services with 1 bed (St. Luke's Hospice, 2012).

Lithuania's first hospice, and the first of the Baltic States, was Kaunas Hospice, sponsored by the Caritas Association, that opened in august 1993 and had 9 beds at that time, but that expanded to 35 beds in just 3 years. This institution includes a mobile homecare team since 1995 and offers practical nursing training to first year medical students of Kaunas University.

In 1994 an algesiology clinic was opened at Vilnius University, where 2 doctors and 2 nurses care for patients from the whole country. Vilnius Oncology Center has a consultant on palliative care. There is also a palliative

care ward at Panevezys Oncology Hospital, that includes a daycare center and a mobile team.

Existing services include: one mobile palliative care team at Vilnius University Oncology Institute, between 5 and 11 beds for palliative care at Kaunas Hospital, "St. Clara" Hospital, Panevežys Hospital, Kaunas Red Cross Hospital, Kaunas K. Grinius Hospital and Kaunas K. Grinius Hospital. The Panevežys integrated help center offers outpatient services and home care and "Vilniaus Sandora" Evangelic-Lutheran Community Office offers home care. Caritas Organization hosts the "Palliative care at home" Project (EOHCS, 2000a).

Medicine availability and consumption

Symptom control is a basic component of palliative care and is clearly influenced by medication availability. Effective pain control is limited in Romania by limited education of doctors regarding pain management and by limited drug availability, especially of strong opioids (Mosoiu et al., 2000).

Buprenorphine is not available in Romania. Injectable morphine, hydromorphone, pethidine, and methadone tablets are produced in the country. All others (including oral morphine and Fentanyl patches) are imported. Before the introduction of a change in legislation in 2002, opioid consumption was low because of the lack of medical information and because of the difficulty of prescribing them. The country had a very restrictive prescription system that made it impossible for outpatients to receive opioids; opioid consumption at that time in Romania was among the lowest in Europe.

Legislative changes made opioid prescription easier, so that the maximum daily dose of morphine has been increased from 60 mg, new opioid drugs and new routes of administration have been approved (IOELC, 2014).

The following opioid analgesics are registered in Lithuania: alfentanyl; codeine; dihydrocodeine, ethylmorphine, fentanyl, methadone, morphine, pethidine, piritramide, remifentanyl, tilidine. One company has a license to produce injectable morphine using imported substances. Since 1997, every physician may prescribe opioids using special prescription forms. It is forbidden to prescribe narcotics for more than 7 days, although since June 202 transdermal patches may be prescribed for 30 days. Opioid consumption in Lithuania is medium compared to other east-European countries (Centeno, Lynch, Donea, Rocafort, & Clark, 2013) (Figure 2).

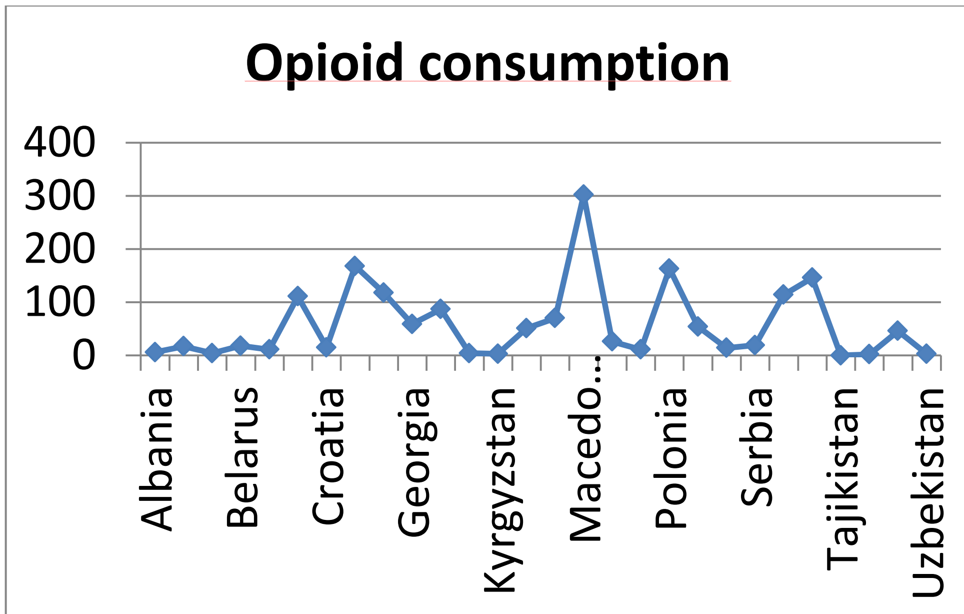

Figure 2: Opioid consumption in Europe (Centeno et al., 2013)

Both countries have signed the Poznan Declaration and are members of Eastern and Central European Palliative Care Taskforce (ECEPT). In 2005, the ratio between hospice/palliative care institution number per inhabitant number in Romania was 1:0,59 million, compared to 1:0,34 million in Lithuania.

Palliative care accreditation

Since 2000, palliative care in Romania is recognized as a sub-specialty, by Health Ministry order. Professionals who provide palliative care services need to undergo a training program that takes 12 weeks (8 weeks of theoretical lectures and 4 weeks of practical activities) and a critical mass of trained specialists already exists (Centeno et al., 2013).

In Lithuania palliative care services are provided by professionals accredited on a 36 hour course. This course was recognised in 2007 and over 600 people have completed it, so that . Of the 9 medical schools, only Kaunas & Klaipeda University have provided mandatory training in palliative care. Klaipeda and Utena Colleges provide optional courses in palliative care for nurses (EOHCS, 2000a).

Health resource allocation

In Lithuania, until Health Insurance Law was implemented in 1997, resource allocation was made on historical criteria. Funds were distributed to municipalities based on the head count and past expenses. Municipalities distributed resources to institutions also based on past expenses.

Since 1997 resource allocation policy has drastically changed. Primary health services are financed based on the number of users, with a few supplementary bonuses for rural areas. Outpatient units and hospitals are financed according to the provided services. Still, reform does not imply more equitable allocation of funds (regions with a better infrastructure offer more services and get more public resources) (EOHCS, 2000a).

In Romania, the National Health Insurance Fund and the Chamber of Physicians annually negotiate a frame contract, endorsed by the Health Ministry and approved by the government. This contract contains the proportions for resource allocation for different types of health services (primary care, hospital, ambulatory, stomatology and others). In 1997, Health Insurance Law has changed the Romanian healthcare system from a Semashko type, state financed one to one based on health insurance.

Decisions regarding resources allocation in healthcare were the result of an annual political process by which the Parliament decided the percentage of the gross national product that would go to healthcare. Until 1996, the Parliament has also decided the minimum budget that would go to each county. Since 1998, since most of the healthcare costs are covered by health insurances, the importance of these decisions was expected to decrease. As a result of decades of centralized plans that failed to insure a fair distribution between regions of human and material resources, there are still inter-county disparities in Romania.

Health Ministry is responsible for healthcare state budget administration. State financing for healthcare is allocated for the whole year before it is distributed to the Health Ministry and other ministries that have a health network. Funds allocated to one category cannot be transferred to another. The Health Ministry allocates funds to Public Health Directorates and subordinated units especially on historical criterion. From the total amount of money collected in one county, 25% is sent to the National Health Insurance Fund to be redirected to sub-financed counties.

Resource allocation for different specialties is determined by a frame-contract and associated regulations by negotiation between the National Health Insurance Fund, the Chamber of Physicians and the Health Ministry. Basic healthcare services are granted to all citizens, but home care

is only granted to insured individuals, according to the Health Law, modified in 2018 (Law no. 95/2006 on health reform).

In both countries resources invested in palliation are mostly private, while state financing is almost non-existent. Of course, some patients have health insurance, that covers some costs, but some services are not supported by the state. Moreover, a group of uninsured patients exist, that often come from poor social and economic environments, with minimum or null income, which represents another source of vulnerability (Centeno et al., 2013).

Resource allocation for palliative care in Romania and Lithuania in numbers

Palliative care is beginning to receive some funds from the state budget in Lithuania (St. Luke's Hospice, 2012), but these funds are insufficient. There is a system of reimbursement for palliative care (147 Lt= 43,2 Euro / day / patient), but this sum does not cover all necessary costs. In 2008 10.000.000 LT (2,9 million Euro) were allocated for future palliative care system development (beds and technological resources). Payment for palliative care services is on a tariff basis and one consultation with a palliative care doctor is 9.3 euro (St. Luke's Hospice, 2012).

In Romania the government partially finances palliative care via the National Health Insurance fund.

Approximatively 20,3% of Hospice Brasov income came from state financing, respectively 384.198 E in 2011 (Hospice Casa Speranței, 2012), while inpatient financing in 2009 was covered by a percentage of 80% by Brasov Health Insurance Fund (Hospice Casa Sperantei, Raport anual 2017). The total income of this institution in 2012 was 1.920.990 Euro, out of which 19,9% came from individual donations, 12,8% from England and the United States, 27,7% from grants, 10,2% from event organizing, 7,8% from various coorporations, 1% from education and 3,3% from other resources. Funds were allocated within the institution: 69% for medical services, 15% for education, 10% for fundraising and 6% for administrative expenses.

In 2017, Hospice Casa Sperantei had a 3.780.408 Euro total income. 43.7% came from fundraising, 20.7% from statutory funding, 10% from Hospices of Hope UK, 18.7% from trusts, 0.8% from courses and educational materials and 6% from other sources. These funds were used for patient care (73%), educational and development programs (9%), fundraising and communication (10%) and administration (8%) (Hospice Casa Speranței, 2017).

In neither one of the two studied countries home care is financed by the state, beneficiaries have to pay directly for the received care. Many hospice type institutions depend on international support and private donations (Hospice Casa Speranței, 2017).

Conclusions

The comparative analysis of the palliative care system in Romania and Lithuania indicates a series of differences regarding the level of development and utilisation, but also some similarities, which are normal bearing in mind the relatively recent common history of the two countries. In Romania, the palliative care network is better structured, including both hospital care and home care, for adults and children. Still, opioid consumption in Lithuania is higher than in Romania because of a more flexible prescribing legislation. In Romania, palliative care is a recognized as a sub-speciality, while in Lithuania no preoccupations exist in this regard. In both countries state budget funds allocation lacks transparency, and funds allocated for palliative care are insufficient. Additional funds are necessary, that come from private funds.

Our analysis shows the fact that during the last 20 years Romania has undertaken bigger steps in palliative care than Lithuania, especially due to the effort of a few dedicated professionals. Still, the sub-financing of the two systems and the limited number of professionals limit system efficiency.

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Conflict of interest:

The Authors declare that there is no conflict of interest.

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