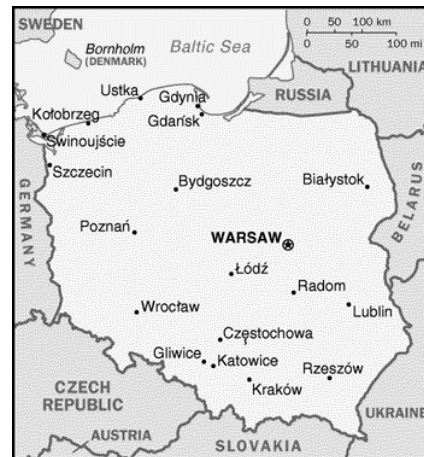


## Poland

*The Republic of Poland is the largest country in Eastern Europe in population and in area. Covering 312,685 km<sup>2</sup>, the country to the east is bordered by Belarus and the Ukraine, to the south by Slovakia and the Czech Republic, to the west by the Federal Republic of Germany and to the north by the Baltic Sea, the Kaliningrad enclave of the Russian Federation and Lithuania.<sup>1</sup>*



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<sup>1</sup> *Health Care Systems in Transition: Poland* (2000) Copenhagen: The European Observatory on Health Care Systems: 1.

## 1 Palliative care service provision

### 1.1 Current services (last updated: May 2002)

The following palliative care services are known to exist in Poland:

		<i>Existing services (2002)</i>
<b>Adult</b>	Inpatient - Freestanding	25
	- Hospital unit	50
	- Hospital mobile team	1
	Nursing home	0
	Home care	149
	Day care	8
	<b>Total</b>	<b>231</b>
<b>Paediatric</b>	Inpatient	25
	Home care	5
	Day care	0
	Unspecified	0
	<b>Total</b>	<b>30</b>
<b>Grand total</b>		<b>261</b>

### Current projects (last updated: May 2002)

The following palliative care projects are known to exist in Poland; these are not yet operational services

		<i>Known hospice/ palliative care projects (2002)</i>
<b>Adult</b>	Inpatient - Hospital	0
	- Hospice	0
	Home care	0
	Unspecified	30
	<b>Total</b>	<b>30</b>
<b>Paediatric</b>	Hospital	0
	Hospice	0
	Home care	0
	Unspecified	0
	<b>Total</b>	<b>0</b>
<b>Grand total</b>		<b>30</b>

Poland currently has 261 palliative care services. These are made up of 149 home care services; 23 free-standing hospice units; 8 day care centres; 50 hospital inpatient units; 1 hospital mobile team; 4 lone-standing paediatric home care services; 24 paediatric home care services attached to adult services and 2 inpatient units. In addition, there are 4 lymphoedema clinics.

The newly opened Hospicjum Palium complex in Poznan is an ambitious development that houses a number of services: a 14-bedded inpatient unit; a day care centre, bases for the home care team, on-call teams and the bereavement service; a palliative medicine clinic; chronic pain clinic and lymphoedema clinic. It also accommodates the palliative care resource centre and a residential training centre. As the centre was nearing completion Jacek Luczak looked forward to new possibilities for training:

‘And we are now trying to start the work of the education centre in Hospice Pallium ... We would like to provide people from eastern Europe with two weeks’ training: we have 8 places in the accommodation, the rooms, guestrooms will be ready. We need still some money to finish everything, to give furniture and so on and so on, but we will be probably ready to start in the next few months. So it is history.’<sup>2</sup>

Warsaw Hospice for Children exemplifies Poland’s paediatric home care services. Covering an area up to 100 kms from the hospice with a population of around 3.5 million inhabitants, 187 patients have been cared for to date: 100 patients with cancer, 87 patients with other diseases. The average number of patients at any one time in 2001 was 24. Hospice care (medical and nursing) is provided 24 hours a days, 7 days per week. To provide this service, nurses have a caseload of 4 patients; they usually visit 2 patients per day, spending around 2 hours per patient. Each nurse and doctor is provided with a car. General principles that underpin the Warsaw service have been incorporated into standards of paediatric hospice care currently placed before the Minister of Health.

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<sup>2</sup> Observatory interview with Prof Jacek Luczak: Poznan - 28 February 2001.

### 1.2 Reimbursement and funding for services

According to Polish Health Services law, every citizen is entitled to die in dignity and peace – and a clear obligation is recognised on the part of government to provide support for hospice and palliative care services. Notwithstanding this obligation, government funds for palliative care were significantly reduced in 2002.

A doctor working in a palliative care unit comments on the funding situation for palliative care in Poland:

‘A number of centres dealing with palliative care and financed by the Polish equivalent of the NHS have sprung to life. There is a large group of postgraduate doctors and nurses training in palliative care, which has become *an independent* specialisation. However, we may still discern a lack of network; all these institutions have not yet become adapted into the entire system of palliative care and general medical care.’<sup>3</sup>

### 1.3 Opioid availability and consumption

During the last few years, oral morphine has gained ground in Poland as the drug of choice for moderate and severe cancer pain. Before 1991 the total amount of morphine on a single prescription could not exceed 100 mg; in 1995 this was changed to 4 grams per prescription for oral morphine and 8 grams for slow release morphine. In 1998, the total consumption of morphine in Poland was 259 kg, which had risen from 137 kg in 1994; codeine consumption remained fairly stable over the period, from 800 kg in 1994 to 794 kg in 1998.<sup>4</sup> Between 1994 and 1998 the average daily consumption of defined daily doses per million inhabitants of opioids was: morphine (486); codeine (622).<sup>5</sup> This compares with the morphine daily dose consumption in other CEE countries as follows: Hungary (509); Czech Republic (388); Estonia (216); and Albania (44).

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<sup>3</sup>Questionnaire data (EAPC East).

<sup>4</sup>International Narcotics Control Board (2000) *Narcotic Drugs: estimated world requirements for 2000. Statistics for 1998*. New York: United Nations.

<sup>5</sup>World Health Organisation (2000): Achieving balance in national opioids control policy. ‘The defined daily dose is the assumed average maintenance dose per day...Drug consumption figures are presented as numbers of DDDs per population per day for comparative purposes in drug utilization studies. In the INCB technical publications, DDD figures were calculated as the annual average dose of drug consumed, computed over 5 years, per million inhabitants in a given country’ (page 30).

The Ministry of Health accepted comprehensive guidelines for pain relief in 1998.<sup>6</sup> A programme of pain relief has been adopted that follows the WHO guidelines and also focuses on the training of staff, the availability of medication, and necessary improvements to the system of administration, distribution, and prescribing of analgesics. All opioids used to treat cancer pain in accordance with WHO guidelines (including fentanyl patches and all forms of morphine) are free of charge to patients.

The following opioids are registered for use: buprenorphine, codeine, ethylmorphine, fentanyl, methadone, morphine, pethidine and tramadol. Unavailable opioids include: oxycodone (available 2001), preservatives-free morphine sulphate ampoules (available 2002), methadone in ampoules (available 2002) hydromorphone (available 2003).<sup>7</sup>

In February 2002 issues relating to the use of opioids in Poland were summarised by an expert group<sup>8</sup> as follows, and an action plan was formulated to address them:

- (1) Does national policy require the use of a special prescription form?  
*Yes, duplicate form for opioids*
- (2) Does the physician or institution have to pay for the special prescription form?  
*Doctors, no; institutions, yes*
- (3) Does national policy establish a validity period for opioid prescriptions?  
*Yes*  
If so, what is the period? *30 days*
- (4) Does national policy establish a maximum amount that can be prescribed at one time?  
*Yes*  
If so, what amount? *10 times the single maximum dose as specified in 1992 Polish Pharmacopoeia*
- (5) Does national policy limit the length of time that a patient may be treated with an opioid?  
*No*

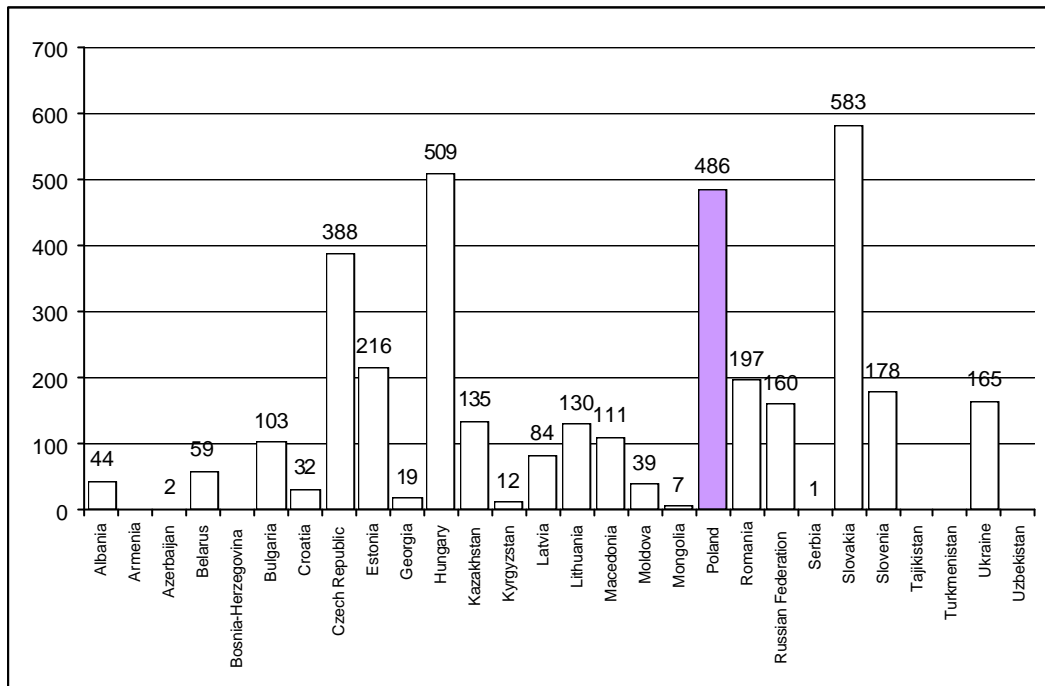
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<sup>6</sup> The Ministry of Health accepted recommendations produced by the National Council for Palliative and Hospice Care contained in the document entitled *Program of developing Hospice/palliative care in Poland* (1998).

<sup>7</sup> Luczak J, Kotlinska-Lemieszek A, Kluziak M. Cancer pain and palliative care in Poland. *Journal of Pain and Symptom Management* – forthcoming.

<sup>8</sup> WHO/OSI Workshop on Assuring Availability of Opioid Analgesics for Palliative Care, Budapest, 25-7 February 2002.

Average defined daily doses of morphine, Central and Eastern Europe (1994-1998)



Source: Clark D, Wright M (2002) *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press

#### 1.4 National and professional associations

Poland is a signatory of the Poznan Declaration and its palliative care leaders subscribe to the aims of the Eastern and Central European Palliative Care Task Force ECEPT; these include: the call for national policies, palliative care education, increased drug availability, a growth in palliative care services and an increase in public awareness. Jacek Luczak is Chair of ECEPT and Maciej Kluziak (both of Poznan) is Secretary. Around 120 members are drawn from 17 countries.

Three Poland-based organisations have made significant contributions to the development of palliative care. The Polish Society of Palliative Care was established in 1990 and became affiliated to the European Association of Palliative Care. Branches have been established in 16 regions of the country; membership in 1995 exceeded 400. The National Forum of the Hospice Movement (1991) represents the interests of independent hospices, while the National Council for Palliative and Hospice Care (1993) is affiliated to the Ministry of Health and Welfare.

The Polish Hospices Fund is a charity based in the United Kingdom. Administered by Gillian Petrie Hunter and chaired by Muir Hunter, it provides support for the training of Polish doctors and nurses in British hospices. Originally financed by the Know-How Fund, it has since become funded by the Stefan Batory (Soros) Foundation. It began finding and supporting training placements for Polish doctors in UK hospices and palliative care units in 1992 and has provided training to more than 100 doctors in this way.

St Christopher's Hospice, London, has established a special relationship with St Lazarus Hospice, Krakow, and provides materials, information and education to the unit. A similar partnership of more than 10 years' duration has been established between the Department of Palliative Medicine, Poznan and Sir Michael Sobell House, Oxford, UK. Other support comes from the British Council.

### 1.5 Palliative care 'coverage'

There is a service providing palliative care for every 0.15 million people in Poland.

*Ratio of hospice/palliative care services per million population, Central and Eastern Europe (2002)*

	<i>Ratio 1:</i>
Estonia	1: 0.14m
Poland	1: 0.15m
Slovenia	1: 0.32m
Bulgaria	1: 0.36m
Hungary	1: 0.37m
Latvia	1: 0.48m
Lithuania	1: 0.62m
Czech Republic	1: 1.02m
Albania	1: 1.03m
Romania	1: 1.07m
Slovakia	1: 1.33m
Macedonia	1: 1.98m
Bosnia-Herzegovina	1: 2.00m
Croatia	1: 4.60m
Serbia	1: 10.50m

Source: Clark D, Wright M (2002) *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press

In spite of the overall number of palliative care services in Poland, they are disproportionately distributed throughout the country. Better coverage is achieved in

central (Warsaw, Bydgoszcz and Lublin) western (Poznan and Gdansk) and eastern regions (Krakow, Katowice and Wroclow). Coverage in rural areas is sparse.

*1.6 Palliative care workforce capacity*

No information currently available.

## 2 History and development of palliative care in Poland

### 2.1 Narrative history of palliative care in Poland

Uniquely amongst the countries of central and Eastern Europe, the hospice movement in Poland began during the 1970s, when the country was under communist rule.

Against a backdrop of debate about the nature of Christian love<sup>9</sup>, a group of parishioners from the Lord's Ark Church in Nowa Huta, led by Halina Bortnowska, began to visit the dying in the local hospital; an initiative that came to be regarded as Poland's first informal hospice service. From the outset, it was recognised that 'Krakow's beginnings were not totally imported from abroad and from the west.'<sup>10</sup> The visit and lectures of Cicely Saunders in 1978 added momentum to this nascent movement. After she left:

'Several groups were initiated with the aim of visiting patients at home to bring them help, medicine, companionship and love.'<sup>11</sup>

As the 1980s began, an outburst of energy resulted in significant developments. The first registered hospice, the Society of Friends of the Sick, was established by volunteers at Krakow in 1981. In Gdansk, Hospicjum Pallotinum - a voluntary home care team - was founded in 1984 by Fr Eugeniusz Dutkiewicz, a Catholic priest. This home care model became very popular and was replicated by numerous groups, both religious and secular. In 1987 the first palliative care service to be organised within the national health structure opened in Poznan, led by Jacek Luczak.

Alongside the development of hospice, the 1980s saw the growth of *Solidarity*, a trades union that aimed to support the people of Poland by supplementing provision within the national health service. Consequently when plans were put forward to establish a church-based hospice in Krakow, the project became incorporated into the demands of the union at the Lenin foundry.<sup>12</sup> Although the church came to favour a different option, *Solidarity's* support for hospice is emblematic of the common values within the two organisations. Jacek Luczak comments:

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<sup>9</sup> Sikorska E (1991) The hospice movement in Poland. *Death Studies* 15: 309.

<sup>10</sup> Bortnowska H. In E. Sikorska. The hospice movement in Poland. *Death Studies* 1991; 15:309.

<sup>11</sup> Zyllich B (1991) Palliative care in eastern Europe – a personal view. *Palliative Medicine* 5:171

<sup>12</sup> Luczak J (1997) Palliative care in Eastern Europe. In: D Clark, J Hockley, S Ahmedzai. *New Themes in Palliative Care*. Buckingham: Open University Press.

To the ‘ethos’ of solidarity as a social, economic and political movement was added the ‘ethos’ of the hospice movement, as a symbol of humanity.<sup>13</sup>

Robert Twycross, in an interview undertaken within the Hospice History project of the University of Sheffield, comments on the special relationship that developed between *Solidarity*, early hospice and the Catholic Church:

‘After a year or two, *Solidarity* was outlawed. Now quite a number of leading academic doctors had been members of *Solidarity*, so when it was outlawed they ... had to take lowly posts down the road in the municipal hospital. So they were then stuck: they no longer had this outlet called *Solidarity* to dig at the government and they wanted to have some other outlet. So certainly in Gdansk, the home of *Solidarity*, they decided to set up a hospice. Now of course you can’t set up a hospice programme in protest against the government, it would be illegal, you have to have legal permission, but they would never get legal permission, so they did it within the umbrella of the Catholic Church. But early hospice, certainly in Gdansk, in Poland, was a subtle protest movement by displaced medical academics... So a protest movement with a difference.’<sup>14</sup>

As the decade came to a close, hospice in Poland had developed clear features that differentiated it from other countries, particularly in the west. Writing in 1991, Ben Zyllicz observes:

Those features are the result of communist rule, a rule which restricted the amount of space available for these types of activities. All care is given free by unpaid volunteers, including many doctors, nurses and medical students who visit patients at home in their free time. The final responsibility for the patient (including morphine prescriptions), however, lies with the local health authorities and district doctors who turn a blind eye to the activities of the hospices due to their own workload, and also to their ignorance.<sup>15</sup>

With the collapse of communism and the introduction of a market economy, a broader vision of palliative care could begin to develop. This vision was debated during a ground-breaking conference held at Radziejowice (near Warsaw) in May 1990. As a result, a call was made for the inception of international conferences, a programme of courses by visiting teachers, the participation of Eastern European countries in the activities of EAPC, the initiation of research in palliative care, and the establishment of palliative care units in large teaching hospitals.

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<sup>13</sup> Luczak J (1993) Palliative/hospice care in Poland. *Palliative Medicine* 7: 68.

<sup>14</sup> Hospice History Project Interview, Robert Twycross, Sir Michael Sobell House – 11 December 2001.

<sup>15</sup> Zyllicz Z (1991) Palliative care in eastern Europe – a personal view. *Palliative Medicine* 5:171.

Fired by this new sense of direction, wide-ranging developments took place during the next decade. In 1991, the National Forum of the Hospice Movement was founded in Gdansk. A new unit opened at the Medical Academy, Poznan, followed by a unit in Bydgoszcz. The first free-standing unit was established at Elblag in 1992; others followed at Bialystok, Torun, Myslowice and Lomza.<sup>16</sup> In 1994, Tomasz Dangel established the Warsaw Hospice for Children, providing a model for other paediatric services in Lublin, Lodz, Poznan and Myslowice.

An academic collaboration was established between the Medical Academy, Poznan, and Sir Michael Sobell House, Oxford. This resulted in a succession of foundation and advanced courses held at Puszczykowo conference centre (near Poznan). These courses had a formative influence, not only upon palliative care in Poland, but in the wider region.

Education was also developed at centres in Bydgoszcz, Gdansk, Krakow, Lodz, Wroclaw and Szczecin - which in turn had an influence upon undergraduate and postgraduate palliative care education. The post of national palliative care consultant was established in 1994 with Jacek Luczak as the first incumbent. There are now four Chairs of Palliative Medicine in Poland. – at Poznan (J Luczak) and Bydgoszcz, where the Polish School of Palliative Medicine is led by Zbigniew Zylicz, medical director of Hospice Rozendaal in The Netherlands.

Significantly, the Ministry of Health and Social Welfare introduced a programme in 1991 to establish palliative care throughout the country as part of national health policy. Two years later a defining moment occurred when a sum c4.2 million new Polish zlotys or cUS\$1.5 million was allocated by the Ministry of Health to the budgets of the voivoids (provincial authorities) for the development of palliative care. During the same year, the National Council for Palliative and Hospice Care was established - an organisation that encouraged the introduction of provincial palliative care councils and addressed the issue of palliative care standards.

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<sup>16</sup> Ministry of Health and Social Welfare (1998) The program of developing palliative-hospice care in Poland. Warsaw: Ministry of Health.

A formative meeting took place in 1998 when participants at the 9th annual conference at Puszczkowo issued a statement that became known as the Poznan Declaration. Delegates from Belarus, Bulgaria, Czech Republic, Hungary, Latvia, Lithuania, Poland, Romania and Slovakia commented on the status of palliative care in their countries. They called for the development of national policies, a programme of palliative care education, increased drug availability, a growth in palliative care services and increased public awareness. The following year, this declaration prompted the establishment of the Eastern and Central European Palliative Care Task Force (ECEPT), headquartered in Poznan.

In 1999 palliative medicine was accepted as a medical specialty in Poland. The Ministry of Health published guidelines for palliative care alongside policies for cancer pain relief. To improve pain control 150,000 copies of a booklet were distributed to doctors, nurses and pharmacists. Polish standards of paediatric palliative care were published in the same year and the first international conference on paediatric hospice care was held in Budapest at Tomasz Dangel's instigation; the second took place in Warsaw in 2001.

Palliative care is more developed in Poland than in any other country in the region. Indeed, Poland alone has more palliative care services than all of the other countries in this study combined. Zbigniew Zylicz suggests why this is so:

'I think there are a number of factors influencing this, one of them is that I see this as a very historical development ... I'm reading now the history of Poland by [Norman] Davies and what is striking me is the formation of the whole intelligentsia, the descendents of richer, noble people, and in the 19th Century they moved to the cities, they left their farms and they moved to the cities, and this was very unique in Europe. I mean we had a separate class of this intelligentsia and this is something that is very important in the development of culture in Poland.

In the time of communist, in many countries, the tiny, small numbers of intelligent people, the intelligentsia, they were killed away, they were smashed away and deported to Siberia, or whatever, or they emigrated to the west. And in Poland there were so many of these people - we're talking about 10 or 20 percent of the whole nation - so this made Poland much more able, together with the Catholic Church, to defend against destruction. So these people survived and all this tradition survived.

So these people were very much involved in societal developments...and in Poland you needed just a spark and the fire started, and ... I think

Cicely was the spark. Cicely Saunders was the spark that started this fire, and the background was ready for it and was sensitive to it...When she came in 1978, this spark made a fire and it never stopped, and this makes so much difference than in other countries, where single people were busy with developing palliative care, and they had more difficulties than we had in Poland.<sup>17</sup>

## *2.2 Hospice/beacon case studies*

No information currently available.

## *2.3 Life/oral histories*

No information currently available.

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<sup>17</sup> Hospice History Project Interview with Z Zylicz: Nijmegen, The Netherlands - 5 April 2002.

### 3 Public Health Context

#### 3.1 Population

In 1997, the total population of Poland was 38.6 million: Warsaw, the capital, has 1.8 million. Poles comprise 97.5% of the population, the remainder being made up of Belarusian, German, Lithuanian and Ukrainian minorities. Ninety-five per cent of the population is Roman Catholic. In terms of ethnicity, language and religion, Poland is more homogeneous than most countries in the region.

#### 3.2 Epidemiology

In 1996 the life expectancy in Poland at birth was 68.1 for males and 76.6 for females. Figures for 2000 indicate a rise: 69.2 for men, and 77.7 for women. During the 1970s and 1980s there was a rise in the mortality of middle-aged men although an improvement has been seen since 1993. Diseases of the circulatory system are the major causes of death amongst both men and women, followed by cancer.

In 2000 there were 82,600 deaths from cancer, 213.9 per 100,000. Around 55% of these deaths occurred in hospital. Amongst the patients who died of cancer, 35% to 40% accessed hospice palliative care services; 7.6% died in hospice. Twenty-one per cent of patients who died at home were in receipt of palliative care.<sup>18</sup>

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<sup>18</sup> Luczak J, Kotlinska-Lemieszek A, Kluziak M. Cancer pain and palliative care in Poland. *Journal of Pain and Symptom Control* – forthcoming.

*Population and life expectancy, Central and Eastern Europe (2000)*

	<i>Population</i>	<i>Life expectancy</i>	
	<i>Millions</i>	<i>Male</i>	<i>Female</i>
Albania	3.1	64.3	72.9
Bosnia- Herzegovina	3.9	68.7	74.4
Bulgaria	7.9	67.4	74.9
Croatia	4.6	69.8	77.7
Czech Republic	10.2	71.5	78.2
Estonia	1.3	65.4	76.5
Hungary	9.9	66.3	75.2
Latvia	2.4	64.2	75.5
Lithuania	3.7	66.9	77.2
Macedonia	2.0	70.2	74.8
Poland	38.6	69.2	77.7
Romania	22.4	66.2	73.5
Serbia	10.5		
Slovakia	5.3	69.2	77.5
Slovenia	1.9	71.9	79.4

Source: World Health Report 2001

*WHO age standardised death rates per 100,000 population, Central and Eastern Europe (1995-1998)*

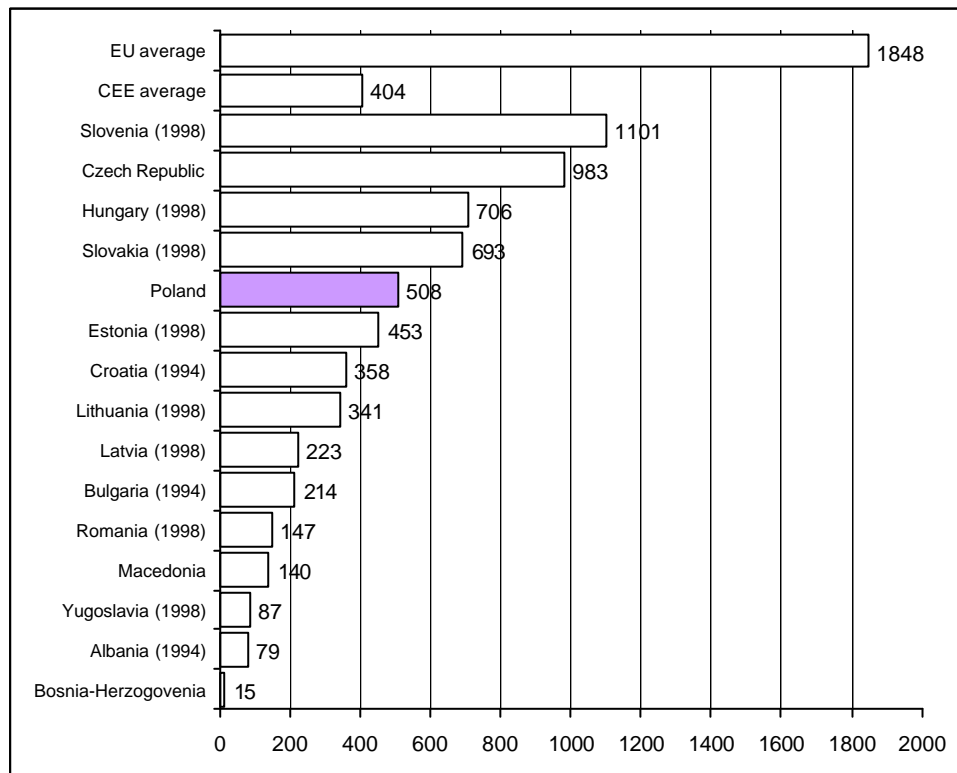
	<i>Year</i>	<i>All causes</i>	<i>Cancer</i>
Albania			
Bosnia- Herzegovina			
Bulgaria	1998	958.9	123.3
Croatia	1997	836.0	174.2
Czech Republic	1998	706.6	182.9
Estonia	1998	907.7	157.8
Hungary	1998	917.8	219.4
Latvia	1998	955.2	152.1
Lithuania	1997	817.2	149.4
Macedonia	1997	809.1	126.6
Poland	1996	812.2	165.2
Romania	1998	933.9	130.6
Serbia			
Slovakia	1995	820.9	172.3
Slovenia	1997	666.1	167.5

Source: World Health Organisation: World Health Statistics 1997-1999

### 3.3 Health care system

During the period of Polish independence, from 1918 to 1938, health services were expanded and some extra finances were accessed through a Bismarckian system of health insurance that covered around 7% of the population. Under communist rule health care was declared a public responsibility and strongly centralised, although some aspects of the Soviet model were resisted in Poland. During the 1990s major proposals were put forward designed to decentralise the health care system, strengthen primary care and establish compulsory health insurance.

*Health care expenditure (US\$) per capita, Central and Eastern Europe*



Source: WHO Regional Office for European Health for All database and HiTs

### 3.4 Political economy

Poland was the first Eastern European state to break with the USSR and to re-establish democratic government. This was driven by the economic problems of the 1980s and the rise of a strong, independent trades union, *Solidarity*. Lech Walesa was elected President in 1990 and the first full parliamentary election was held in 1991. The economy is based on industry and agriculture. The economic downturn during the late 1980s and early 1990s produced inflation of 585% in 1990, which fell to 70.3% in 1991 and to 19.9% in 1996. In the same year the unemployment figure was 13.6%.<sup>19</sup> In 1999, the GDP per capita was US\$4,000.<sup>20</sup>

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<sup>19</sup> *Health Care Systems in Transition: Poland* (2000) Copenhagen: The European Observatory on Health Care Systems: 1.

<sup>20</sup> Poland Country Profile: United States Agency for International Development, website <http://www.usaid.gov/pl>

## **4 Ethics and ethnography**

### *4.1 Ethical issues*

No information currently available.

### *4.2 Ethnographic studies*

No information currently available.

## 5 References and further reading

### 5.1 References

- 1: *Health Care Systems in Transition: Poland* (2000) Copenhagen: The European Observatory on Health Care Systems: 1.
- 2: Observatory interview with Prof Jacek Luczak: Poznan - 28 February 2001.
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- 4: International Narcotics Control Board (2000) *Narcotic Drugs: estimated world requirements for 2000. Statistics for 1998*. New York: United Nations.
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- 6: The Ministry of Health accepted recommendations produced by the National Council for Palliative and Hospice Care contained in the document entitled *Program of developing Hospice/palliative care in Poland* (1998).
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- 9: Sikorska E (1991) The hospice movement in Poland. *Death Studies* 15: 309.
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- 14: Hospice History Project Interview, Robert Twycross, Sir Michael Sobell House – 11 December 2001.
- 15: Zylicz Z (1991) Palliative care in eastern Europe – a personal view. *Palliative Medicine* 5:171.

- 16: Ministry of Health and Social Welfare (1998) The program of developing palliative-hospice care in Poland. Warsaw: Ministry of Health.
- 17: Hospice History Project Interview with Z Zylicz: Nijmegen, The Netherlands - 5 April 2002.
- 18: Luczak J, Kotlinska-Lemieszek A, Kluziak M. Cancer pain and palliative care in Poland. *Journal of Pain and Symptom Control* – forthcoming.
- 19: *Health Care Systems in Transition: Poland* (2000) Copenhagen: The European Observatory on Health Care Systems: 1.
- 20: Poland Country Profile: United States Agency for International Development, website <http://www.usaid.gov/pl>