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# Community readiness for palliative care services in Switzerland: Basis for public health strategy for health psychologists

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Integrated healthcare delivery is essential for ensuring health cost efficiency and high quality care for patients. In Switzerland, cantonal differences in approaches to palliative care implementation contribute to fragmented provision of palliative care services. 'Community readiness' is a practical tool for assessing the status and change in community health services. The aim of this paper is to assess community readiness for palliative care services in Switzerland. A document analysis was carried out in combination with expert interviews with palliative care members in four Swiss cantons (Ticino, Vaud, Basel-City and Lucerne). The findings indicate differences with respect to the history, provisional structure, coordination and financial support for palliative care in the cantons. Findings indicate that future research to improve provisional structures, financing and educational opportunities for PC in the cantons, specific to the needs of the canton, warrant investigation.

**Keywords:** community readiness, health psychology, integrated care, palliative care, Switzerland

Rising healthcare expenditures and the changing epidemiology of serious chronic diseases make palliative care (PC) services increasingly relevant for western society today (Connor, 2017). However, ensuring the provision of professional services to PC patients can be challenging in the current healthcare environment (Centeno et al., 2007). Collaboration and coordination of diverse professional groups and organisations in the field is still far from being achieved in many European countries (European Association for Palliative Care [EAPC], 2010). This has prompted increasing investment into strategies aimed at fostering integrated PC services in the community (Oishi & Murtagh, 2014; Murray et al., 2015).

Efforts to establish integrated PC services in Switzerland can be noted since the 1980's (EAPC, 2010). The increase in life expectancy and incline in the percentage of elderly people indicates a greater need for PC services, now more than ever, in Switzerland. Since the 1980s, various strategies and initiatives have been launched on a Swiss federal and cantonal level. Since 2010, two 'National Strategies for Palliative Care' have proposed guidelines for the implementation of respective PC services (Federal Office of Public Health [FOPH] and Swiss Conference of Cantonal Health Directors [SCCHD], 2009, 2011). From 2010 to 2015, numerous supportive measures were implemented in the areas of care, especially regarding financing, awareness raising, education, research and voluntary work. Moreover, in April 2017, a national platform for PC ([www.palliative.ch](http://www.palliative.ch)) was launched, which promotes the exchange and networking of all of the Swiss cantons and national stakeholders in the field (Steudter, 2017). Some experts have observed that these changes have contributed to noticeable changes to provisional services for PC across Switzerland (von Wartburg & Näf, 2012). However, recent studies still report considerable cantonal differences regarding provisional structures (Vodoz, 2010), with differences found also between rural and urban contexts (Alvarado & Liebig, 2015).

### Community readiness for palliative care

'Community readiness' (CR) can be described as a practical tool for assessing the status and change in community health services (Alvarado & Liebig, 2015; Oetting, Jumper-Thurman, Plested, & Edwards, 2001). More specifically, CR describes the capacity and support in a general community between providers and their organisations for healthcare programme implementation. The concept implies that the way in which healthcare initiatives are addressed, is largely determined by social norms, which influence the readiness for change in a community (Beebe, Harrison, Sharma, & Hedger). Bainbridge et al (2010) adopted this concept for the evaluation of healthcare initiatives, proposing that cultural norms contribute to a social and political climate, which influence how well initiatives for PC are accepted and implemented in local and regional contexts (Bainbridge, Brazil, Krueger, Ploeg, & Taniguchi, 2010). The authors propose, that the status of CR is characterised not only by openness for PC and its perceived importance, but also by other important factors, such as: financial support for PC, educational opportunities for PC, PC health care professionals, and provisional structures for PC. Importantly, high stage CR for PC services signifies that there is sufficient support for PC in the community, while a low status of CR implies resistance to PC initiatives, suggesting a need to address any areas identified as in need of development (Bainbridge et al., 2010). In high stage CR you could therefore expect good financial support for PC, many educational opportunities for PC and adequate provisional structures for PC. On the other hand, in a community with low stage CR, you could expect limited financial support and educational opportunities for PC, as well as inadequate provisional structures for PC.

Starting from the concept of CR described above, this article intends to highlight the current status of implementation of PC services in Switzerland. Specifically, we start from the assumption that the analysis of core dimensions of CR in different cantons may indicate relevant factors for its implementation. Besides provisional structures, we take into consideration the history of PC in each canton, financial support and educational opportunities for PC. The aim of this paper is to assess and compare the status of CR for PC in Switzerland. After providing a theoretical framework and

methodological approach for assessing the present conditions of PC provision, the status of CR in four selected cantons will be discussed and suggestions on how to accomplish better integrated PC services in these cantons will be considered. This analysis shall provide an indication of where the National Strategy for Palliative Care has been successful in implementing PC in Switzerland and importantly, indicate aspects of PC that might benefit from further development.

## METHODOLOGY

A qualitative-inductive approach was selected in order to gain a deeper understanding of the status of community readiness for palliative care in Switzerland. In a first step, four Swiss cantons were selected for examination (Basel-City, Lucerne, Ticino and Vaud), which differ in terms of demographics, social, cultural and language related factors. The four cantons not only illustrate the socio-geographical diversity in Switzerland but are also characterised by different histories in the development of PC services.

Data concerning the important dimensions of CR for PC was gathered at a federal and cantonal level, in order to allow assessment for the status quo. Statistical data, national inventories and official documents and publications about PC provision in Switzerland were systematically searched for online. On a cantonal level; national strategies ( $N = 2$ ), national guidelines ( $N = 8$ ), newspaper articles ( $N = 8$ ), prescriptions, information on structures, processes, tools and instruments on websites ( $N = 28$ ), postulates ( $N = 5$ ) and expert statements ( $N = 2$ ) in the fields of primary and specialised PC were identified from January 2010 to March 2018. In order to assess the status of CR, the data analysis focused on core indicators as described by Bainbridge and colleagues (2010), as well as on categories, which have been noted as important for the development of PC in Switzerland by the National Strategy for Palliative Care 2010–2012 (Radbruch & Payne, 2011). Additionally, expert interviews with six general practitioners (GP's) or nurses and four specialised doctors in PC were conducted in each canton in 2018. Interviews were subsequently thematically analysed with the use of content analysis (Kuckartz, 2012).

## FINDINGS

It may be implied that some individuals are engaging in in camouflaging behaviours so effectively that they are not identified and diagnosed, then is a diagnosis and relevant support really necessary? Many would naturally agree with this argument. However, Hull, Mandy and Petrides (2017) and Hull, Petrides, Allison, Smith, Baron-Cohen, Lai and Mandy (2017) have argued that although it would seem perfectly reasonable to hold the belief that camouflaging is an effective strategy which is relatively low-impact, the significant difficulties, such as exhaustion, which are reported by the participants in a number of the studies identified in the review by Allely (2018) strongly argue that individuals who are effective in engaging in camouflaging behaviours still require access to relevant support and services (e.g., Hull, Mandy, & Petrides, 2017; Hull, Petrides, Allison, Smith, Baron-Cohen, Lai, & Mandy, 2017).

The findings reveal considerable differences in the implementation of PC to date. The canton Lucerne demonstrates the lowest stage of CR for PC, whilst the data indicate good implementation of the National Strategy guidelines in Vaud, with respect to all aspects of consideration, i.e. history, provisional structures, coordination and financial support. Table 1 illustrates the overall findings.

Table 1  
 Results of the Document Analysis and Expert Interviews

Aspects	Lucerne (Poor community readiness)	Basel-City (Good community readiness)	Ticino (Good community readiness)	Vaud (Excellent community readiness)
<i>History</i>	PC history since late 1990s, rather slow development since	Fast development of PC provision and 'closing gaps' since 2013	Longest PC history since 1985 with solid ambulant structures; steady development since	Long PC history and steady development since 1988
<i>Provision structure</i>	Very few specialised facilities; only one mobile service for the city of Luzerne; no hospice (one in planning)	Sufficient specialised and long-term care facilities; sufficient outpatient care	Well-developed network structure with many mobile services and specialised facilities	Excellent, canton-driven PPC and SPC network and provision structures; great 24/7 care
<i>Coordination</i>	Poor coordination due to non-existent network, especially in the rural area; no main coordination office	Good coordination within the network due to main coordination office and specialised palliative care (SPC) facilities	Very good coordination due to strong networks within and between SPC and (Primary Palliative Care) PPC	Excellent coordination within the network due to main coordination office and cross-linked SPC and PPC
<i>Financial support</i>	Some financial support from the canton in order to expand the network	Very limited financial support from the canton	Partial financial support from the canton (e.g., training).	Some financial incentives from the canton
<i>Education</i>	Very few education opportunities for specialists and nurses	Few educational opportunities for medical doctors (only in canton of Basel-Landschaft); specific PC courses for nurses are being offered by Caritas	Very good education and training opportunities for all professionals working in PC	Best education and training opportunities for all kind of medical and psychosocial professions; courses are even available for volunteers

### Lucerne: Low-stage community readiness

The development of good supply structures in the canton of Lucerne seems to be slow to progress, which is partly due to the canton's relatively short history of specialised PC provision. Accordingly, the document analysis shows that it has the least provisional structures available for PC patients. Today, integrated services are provided between the cantonal hospital of Lucerne, a nursing home and a mobile palliative care team (MPCT). Yet, there is still a lack of comprehensive provision of outpatient PC services. In rural areas of the canton; practitioners, nurses and family members informally coordinate PC services. Critically, there is also no additional financial support for primary PC. Instead, tariffs for the services of family doctors are billed via the national tariff system ('TARMED') but usually do not cover crucial tasks such as consulting palliative caregivers or coordinating further specialised care. Similarly, specialists in the field do not receive much additional funding in Lucerne. As one professional remarks: 'If I take the time out to counsel a patient or advise a family member, this of course goes without reimbursement. I do it gladly, but it is much time spent, unpaid,' (specialist, Lucerne). Any additional costs, which go beyond the usual nursing services, are predominantly funded by donations. Further financial support is only provided through charity and volunteer organisations such as the NGO Caritas and a regional Cancer League. Finally, there are only a few educational opportunities available for nursing staff and volunteers. As a nurse reports: 'There are some basic and one or two advanced courses for palliative care available, that I know of.' Mostly they are financed by charitable institutions, including NGOs (Caritas, Curaviva or the local union of the Red Cross). The development of supply structures in Lucerne also appear to be slow to progress. Specifically, although services of MPCTs for the city of Lucerne and several agglomeration municipalities were completed in 2011, there is still a lack of comprehensive provision of outpatient, specialised PC services.

### Basel: Relatively good community readiness

Basel has a relatively long history of PC services, which can be attributed to the establishment of the very first hospice in the German-speaking part of Switzerland, in 1986. Compared to Lucerne, structures for PC are more developed in the urban canton of Basel and its agglomeration. Here, three major specialised institutions provide PC, alongside mobile medical services for the outpatient area and mobile nursing-teams, which are specialised for PC. These work in close collaboration with local organisations such as the cantonal Cancer League or the Red Cross. Moreover, PC services are partially coordinated by a main coordination office. The main coordination office is currently co-financed by the canton with a workload of 20%, but its future prospects for funding remain unclear. However, other PC financing opportunities for PC are available. Residents of Basel-city who regularly care voluntarily for an elderly, sick or disabled person at home are able to receive some financial aid from the 'Long-term Care Department'. However, doctors in primary and specialised palliative care receive equally limited financial compensation as their counterparts in LU. Notably, a family doctor reports: 'The financing for palliative care is very limited for workers in the field... I would be very interested to see more financial incentives for palliative care 'introduced,' (family doctor, Basel). The educational opportunities in the canton of Basel are also rather limited compared to the other cantons discussed here. As one nurse suggests: 'The canton could do with some more training courses for palliative care and specific palliative formation for new doctors'. However, several professional training courses are provided for nurses and health care providers in the urban region and its agglomerations. Notably, the health education centre and a large hospice at the periphery of the canton offers advanced training courses for nurses and medical doctors. Moreover, the cantonal Red Cross provides an educational program that volunteers are also eligible to take.

### Ticino: Advanced community readiness

In the southern Italian speaking canton Ticino, PC professionals can rely on well-developed outpatient PC provision, which is exemplary in the Swiss homecare sector. This may be partly attributed to the cantons longstanding history of ambulatory care (Bainbridge et al., 2017; Wyss & Coppex, 2013). The canton is home to the first (mobile palliative care team) MPCT in Switzerland, founded in 1990, followed by the opening of one of the main palliative care wards of the canton within the Oncological Institute (IOSI) in the regional capital, Bellinzona. Thus, the outpatient PC structures are important pillars of PC in Ticino. While a specialised MPCT offers its services for the whole canton, there are several mobile nursing teams available and six PC outpatient clinics at four different cantonal hospitals available. Ticino offers some of the best financing for PC services. Firstly, PC is financed in the same way as any other health service via health insurance. What is more, as one Specialist praises: 'MPCTs and nursing services are co-financed whilst for the patient it is completely free of charge'. Additionally, homecare teams and general geriatric palliative care beds in nursing homes are also partially financed by the canton. In addition, compared to Basel and Lucerne, many educational training opportunities in PC are available. Regular PC courses are provided at the cantonal University (SUPSI) for healthcare professionals. In particular, education and training opportunities for family doctors and nurses are widely available across a variety of health care settings in the canton. As highlighted by a PC nurse educational provision is rated highly in Ticino: 'Of course, improvements can always be made, but we can be proud of the offers that we have for palliative care services in our canton, especially when it comes to all the training possibilities that are available' (hospice nurse, Ticino).

### Vaud: Exemplary community readiness

The French-speaking canton of Vaud has previously been described as a 'best practice' canton of PC in Switzerland (Radbruch & Payne, 2011). The findings of this study support this. Not only does the canton have its own coordination office for PC services, but also in terms of specialised PC structures, Vaud has the best options available. Notably, since 2003, it has developed a supply of eight MPCTs that work closely alongside specialist providers and offer extensive 24/7 care. This wide range of services is partly due to the early establishment of PC in 1988, with the opening of the Rive-Neuve Foundation and an oncology service at a small clinic. Moreover, since family doctors work closely together with a high range of specialist services, there is a high level of inter-professional collaboration and coordination between family doctors, specialised facilities, MPCTs and ambulant nursing teams. Yet, similarly to the other cantons, family practitioners in Vaud receive no additional financial support and the costs of primary care are calculated on the basis of the TARMED individual service tariff. In contrast to the cantons of Lucerne and Basel-City however, the structures in hospitals and hospices are very well supported by the canton in terms of financing. For example, MPCTs are financed entirely by the cantonal health office, although additional financing would always be well received. As well summarized by a specialist: 'I think we do get good remuneration, compared to other cantons, but if you ask me about financing in the whole canton, then I must say that more financial provision needs to be given; especially when I think of some GPs and nurses, who work so much but perhaps don't see their work really appreciated' (specialist at a regional clinic, Vaud). Also in terms of educational opportunities for PC, this canton seems to be the most advanced. Not only does it offer basic PC courses for healthcare professionals but advanced training courses for doctors, nurses, volunteers, physiotherapists and other healthcare professionals are available. These courses are readily accessible at many different locations across the canton in hospitals, clinics, universities and PC units. As one nurse who attended a PC course remarks: 'The course was easy to find and I know a few people who have also done some courses' (nurse, MPCT, Vaud).

## DISCUSSION

In light of national efforts to implement PC services across Switzerland, the aim of this paper was to investigate the status of CR for PC services in the Swiss cantons. The findings reveal that there still exist considerable differences in the status of CR. To some degree, this seems to be due to the history of PC. However, some cantons have made significant progress in PC within the past few years. Generally, Lucerne demonstrates the lowest stage of CR in the list of the cantons studied here, whilst the canton of Vaud indicates the highest stage of development with respect to; provisional structures, coordination, education and financial support. Between these extremities lie canton Ticino and Basel as in these cantons, some structural preconditions for PC seem to be lacking here, whilst other aspects are commendable.

Overall, with respect to Bainbridge and colleagues' (2010) assumptions about CR, no clear pattern of relations between different dimensions of system support can be identified as relevant for the status of implementation of PC, except the federalist organisation of the Swiss health care system which appears to prevent uniform standards in PC. Provisional structures rely strongly on cantonal health care policy and legal framings, which has developed differently across regions and cantons (Binder & von Wartburg, 2009). Thus, a uniform national legal basis for PC may empower cantonal health authorities to take action for installing a comprehensive PC system (Alvarado & Liebig, 2016).). Moreover, the data indicates a strong impact of the financial backing of PC on CR in the cantons. Where least financial support for PC services are available, a lower level of CR is visible also with respect to other dimensions. Specifically, the canton Lucerne shows the least financing for PC services and correspondingly, the least available provisional structures and educational opportunities for PC. Conversely, high stage CR can be observed together with a wide range of PC services, including 24 hours/7 day per week (24/7) care or more developed educational opportunities. Evidently, financial support for PC has a substantial impact on the availability and quality of care provided (Wright, Wood, Lynch, & Clark, 2008). A wide range of literature supports this finding. Sufficient resources, good infrastructure and continuous funding is inevitable where aimed at achieving sustainable, integrated health care delivery – and especially in PC (Bliss, Cowley, & While, 2000; Ouwens, et al., 2009). Moreover, failure to provide certain services such as 24/7 care, as seen in LU, pose a risk for adverse effects like patient transfer from home to emergency or acute care facilities in times of crises. Similarly, the financial backing of formation and funding of educational opportunities in PC is associated with higher quality healthcare provision (Bainbridge at al., 2010), while failure to provide such can contribute to a lack of recognition and understanding of formally acquired competencies (Alvarado & Liebig, 2015). For instance, it has been reported, that some physicians, e.g. surgeons, still define PC as a rather 'naturally given' human competence, and therefore not an issue of formal learning (Gross, Cairns, & Baker, 2000). The implication of this is that failure to provide educational opportunities in PC might also be a contributing factor to low stage CR for PC because it implies that PC is not important or that PC can be provided without formative preparation.

## CONCLUSION

The results of the analysis suggest that adequate provisional structures and educational opportunities for PC are important for high stage CR for PC in the cantons. However, notably, the analysis indicates that adequate financial provision for PC is essential for higher stage CR, since it is a fundamental determinant for PC service provision and implementation. In this respect, the canton of Vaud sets a good precedent for financial support for PC, educational opportunities and provisional structures for PC that health policy in the other cantons might benefit from considering. On the basis of the findings, future research to improve provisional structures, financing and educational opportunities for PC in the cantons, specific to the needs of the canton, warrant investigation. Specifically, whilst Basel and

Lucerne could improve efforts to improve educational opportunities for PC, all cantons could benefit from further backing for PC service provision. Lastly, limitations of the document analysis must be acknowledged. Although the four cantons were selected to represent the socio-geographical diversity in Switzerland, the findings on the situation here are not generalisable for the whole of Switzerland. Moreover, since data is not always readily available concerning the specific elements from which we infer CR from it is possible that not all data on this topic has been considered.

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