

# Access to Palliative and Geriatric Palliative Care and the Implications of Socioeconomic Status: A Literature Review

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## Abstract

Understanding how socioeconomic characteristics such as age, deprivation, and ethnicity relate to the symptoms and concerns of patients with terminal illnesses is essential for planning more fair treatment delivery. The older population and widening socioeconomic disparities make this work even more important. According to the "Korea Declaration" on hospice/palliative care, hospice and palliative care shall be provided in accordance with equitable principles, regardless of color, gender, sexual orientation, race, faith, social position, national origin, or ability to pay for treatments. Despite demands for improved resources, very minor progress has been made in transforming access to resources for vulnerable populations for palliative care, particularly those living in poverty on the edge of society. Several patient-related factors are connected to the likelihood of obtaining a referral for or using palliative care services. According to research, there is a high correlation between socioeconomic position and comprehension of palliative care. Various research from across the world showed that socioeconomic and demographic characteristics such as age, gender, education level, race, disease type and severity, financial capacity, religion, and marital status may influence access to palliative care services. Furthermore, studies have revealed that significant barriers to utilizing palliative care may include insufficient knowledge, training, and views of palliative care, inadequately trained professionals in the area, insufficient funds for therapy, and regulatory restrictions. According to studies, individuals from poorer socioeconomic backgrounds, particularly those with low educational attainment, and men are less likely to get palliative care (PC) or hospice care and are more likely to receive "curative" chemotherapy weeks before death. In many countries, older patients and their families may have less access to palliative care than younger patients. According to research, differences in palliative care access have frequently been the focus of socioeconomic disparities studies as individuals age older. A significant number of older individuals die in hospitals while undergoing expensive, ineffective care for illnesses that may be better treated with a compassionate approach. There is evidence that cultural change is essential to eliminate ageist perspectives and lower financial barriers to healthcare access, which can improve health outcomes. Thus, efficient implementation of the World Health Organization's (WHO) palliative care regulations might be a solution to lowering socioeconomic barriers to accessing palliative and geriatric palliative care services.

**Keywords:** Palliative care; Geriatric palliative care; Barriers to access; Socio-economic status

## Introduction

The idea of access to healthcare implies the availability of suitable and efficient services and providers, physical accessibility, cost, the degree to which services and service providers are accommodating, and the acceptance of services and service providers to the patient (McLaughlin, 2002). The three main metrics for determining whether a population has access to healthcare are availability (counting the number of healthcare providers in a specific location), utilization (rates of the target population using a particular type of healthcare service or resource), and target population health outcomes [1].

Prior studies show that those from lower socioeconomic backgrounds may feel greater pain, anxiety, despair, and total symptom load and have inferior emotional well-being and quality of life. Low socioeconomic status (SES) was linked to a more advanced illness stage and less aggressive therapy for those with breast, prostate, and colon cancer, according to a retrospective cohort research from a US national cancer registry conducted in 2008. The same study mentioned that, people with breast and prostate cancer who have low SES have a greater death risk.

The chance of receiving a referral for or using palliative home care services was linked to several patient-related factors. Utilization probability of such services was lowered by factors including not

having a caregiver at home, being older, male, socially poor, and having specific conditions such as hematological malignancy. Thus the use of palliative care services by older persons is likewise shown to be lower than that of their younger counterparts [2].

Understanding how socioeconomic factors like age, deprivation, and ethnicity connect to the symptoms and concerns of patients with terminal diseases is necessary to plan the delivery of more equitable treatment (Davies, 2022). The aging population and rising socioeconomic inequalities make this task more crucial [3]. To comprehend the effects of socioeconomic position on access to palliative care in general and for older persons, this review paper purposefully draws observations from a wide range of literature while mentioning disparities in access to palliative care, specialist palliative

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care (SPC), and geriatric palliative care as well as how socioeconomic status (SES) is crucial to access all these healthcare services.

## Method

### Search strategy:

This study is a literature review. A comprehensive search of the medical and nursing literature on palliative care was conducted to identify studies relevant to the primary objective of the study. Sources for this review included studies, and records identified from a systematic search of computerized databases (Google Scholar, MEDLINE, CINAHL), manual searches of palliative care journals, and studies bibliographies and reference lists [4].

### Selection Criteria:

The searches were restricted to English-language journal articles published throughout 1998 and 2022, and did not include individual case reports. Selection Criteria Items that clearly met the following criteria were excluded, those that were fewer than 50 case studies; those not considering palliative care; these were published in non-English periodicals; reviews of non-systematic clinical trials of chemotherapy, radiation therapy, stenting, laser, endoscopy, or surgery; description of ethical, legal, or regulatory issues; description of the research process; editorials, stories, personal narratives, and other descriptive nonclinical articles, educational articles (where clinical or patient outcomes are not described), and results from laboratory or radiological or other physiological endpoints. Studies covering more than one point and a target population of advanced illness or palliative care were the inclusion and assessment criteria. 75 of the 234 literatures found through searches were considered potentially relevant and subject to abstract assessment. The inclusion criterion finally led to the selection of 46 articles (**Figure 1**).

## Result

The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the issue of a life-threatening illness, through the prevention and relief of suffering across early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual" (WHO, 2011). Both hospice and palliative care offer relief from the pain and symptoms of serious illness. They also respond to the emotional, social, and spiritual needs of the patients and their families. Hospice is a version of palliative care for individuals whose lives are on the verge of ending. Likewise, in palliative primary care, individualized patient-centered care and joint decision-making are given priority [5].

Previous studies suggested that important hurdles to using palliative care may include inadequate education, training, and perceptions of palliative care, insufficiently trained people in the field, inadequate funding for the treatment, and regulatory barriers[6]. Unfortunately, minimal improvements have been made even in the developed world in converting access to resources for vulnerable groups for palliative care, especially those living in poverty at the margins of society, despite pleas for better resources.

### Access to Palliative Care:

According to the World Health Organization, many terminally ill Europeans died in needless misery and suffering because healthcare systems lack qualified professionals and easily available palliative care treatments (WHO, 2011). Activities to prevent nutritional and pain issues, as well as actions to avoid unnecessarily delaying death

and to remain in control, are all crucial during the end-of-life stage [7]. In recent years, there has been an increase in awareness of the requirements of people dying from non-cancer conditions in terms of palliative care, along with the rise of palliative care teams in hospitals and the community.

Equity of access to services is a core premise driving palliative care policy. The "Korea Declaration" on hospice/palliative care declares that hospice and palliative care must be offered in line with the principles of equity, independent of color, gender, sexual orientation, ethnicity, faith, socioeconomic standing, national origin, or capacity to pay for treatments[8]. According to previous studies, early utilization of palliative care is associated with symptom relief, improved mood, less depressive symptoms, higher quality of life and survival, general satisfaction with treatment outcomes, and reduced costs of care.

The current disparities in access to this crucial service are progressively receiving more attention from policymakers as there is mounting evidence of the advantages of early access to palliative care. Due to the recent use of rights terminology to emphasize the need for palliative care on a global scale, this urgent request for better access to palliative care has received a great deal of support. Brennan (2017) first proposed this idea of palliative care as a right at the end of life in 2007, and it was most recently affirmed in the WHO Global Atlas of Palliative Care 2014[9].

Most people throughout the world are still ignorant of this palliative care, it is not used to its full potential. According to WHO, just 20 of the world's 232 nations (8.6%) have integrated palliative care into their healthcare systems. Furthermore, 80% of low and middle-income countries lacked palliative care services. Unsurprisingly, reviews on palliative care reveals that patients with low socioeconomic status (SES) continue to have limited access to palliative care services and, as a result, suffer worse outcomes [10].

### Access to Specialist Palliative Care (SPC):

Specialist palliative care (SPC) refers to services whose primary function is to provide palliative care. These services often care for patients with complicated and challenging requirements, necessitating a greater degree of education, personnel, and other resources. Specialized services are provided by specialist palliative care for people with complicated conditions that are not properly addressed by conventional treatment choices.

Specialist Palliative Care (SPC) is generally acknowledged and used mostly for cancer patients. It is currently regarded as an accepted practice to provide specialist palliative care to persons suffering from diseases other than cancer. This has been observed in cases of heart failure, chronic obstructive pulmonary disease, renal failure, Alzheimer's disease, liver failure, HIV/AIDS, and a variety of neurodegenerative disorders (Rosenwax, 2006). Furthermore, those with non-cancer conditions are more likely than cancer patients to develop anxiety and depression. For patients and families dealing with non-malignant diseases, accurate and timely information about the condition is just as crucial as comfort and support throughout the disease's course [11].

There is evidence to support the claims that persons with complicated life-limiting non-malignant diseases other than cancer may require an integrated multidisciplinary network of SPC providers to address their requirements and symptoms [12]. Despite projections of their future requirements, there is no information on non-cancer patients getting SPC. While a research from the UK (Addington, 1998)

shows that 17% of patients with non-cancer disorders genuinely needed SPC, and a recent South Australian study (Currow, 2004) suggested that 70% of persons with life-limiting illnesses would benefit from SPC [13].

According to research from Western Australia (Rosenwax, 2006), a significant percentage of persons who passed away during 2.5-years did not get SPC; even those who did had cancer or cancer in conjunction with other non-malignant diseases. SPC was only given to 10% of those with particular non-cancer diseases (Rosenwax, 2006). In addition, people in lower socioeconomic levels are more likely to lack access to specialized palliative care (SPC) than those in higher socioeconomic ones [14].

### **Access to Geriatric Palliative Care:**

Geriatrics and palliative care are two distinct but connected medical specialties. They are both incredibly multi-professional and interdisciplinary fields since they focus on improving the quality of life, personal skills, and social participation of patients and their families [15]. The Geriatric Palliative Care textbook states that palliative care for the elderly "focuses on giving patients with relief from the symptoms, discomfort, and stress of a severe disease, whatever the diagnosis may be.

Lazris revealed that nearly 40% of elderly people pass away in hospitals while receiving expensive, inefficient treatment for illnesses that may be better handled by a compassionate approach (Lazris, 2019). Whilst "less is better" is a proverb in geriatric care [16]. Better quality and quantity of life are frequently associated with fewer drugs, examinations, consultations, treatments, and hospital stays. According to Medicare statistics, the elderly who have greater access to primary care and less access to specialty care are likely to live longer and better.

Changes in end-of-life morbidity and an increase in life expectancy are expected to have significant negative effects on health care. In Europe today, women and men may expect to live an additional 34 and 29 years after turning 50, respectively. However, the predicted absence of morbidity is only expected to last 10 or 9 years, respectively [17]. Therefore, a geriatric approach to care is necessary since the burden of chronic multi-morbidity, functional dependence, frailty, and usually cognitive impairment increases in the latter two decades of most people's lives. Likewise, the causes of death differ, the dying process changes, and the final phases of life develop into a protracted period characterized by difficult therapeutic decisions, difficult symptom management, a wide range of psychological problems, and easily overlooked spiritual sorrow. Thus, it is evident that hospice and palliative care are required, particularly in view of the growing number of people who stay in residential care homes or assisted living facilities as well as the specific needs and conditions that these individuals experience [18].

Stjernsward estimate that there are 58 million fatalities from all causes globally, with 45 million occurring in developing countries and 13 million in developed ones. Palliative care would be helpful for the predicted 60%, or 35 million individuals, who would live with terminal illnesses for a long time before passing away. The largest group to pass away will be the elderly. In many countries, older patients and their caregivers may not have equal access to palliative care as compared to younger patients [19]. This may be somewhat explained by the fact that cancer patients, who tend to be younger, make up the bulk of palliative care patients; nonetheless, age appears to be an independent predictor in both the location of death and accessibility to specialist therapy.

According to demographic trends, the core population of patients receiving palliative care is growing older, as well as an increase in chronic diseases and long-term health problems. There are several barriers to palliative care use among older patients, despite scientific evidence of the benefits of these services. A significant impediment to providing adequate palliative care for the elderly is the difficulty of the first line of healthcare practitioners for the elderly, notably geriatricians, to properly identify their role in terms of duty for giving palliative care [20]. Burt and Raine conducted a comprehensive review of the impact of age on referral to expert palliative care and discovered that "older patients were less likely to be referred to, or to use specialized palliative care." Although direct age discrimination is considerable, the largest concern may be the indirect discrimination that occurs from failing to provide sufficient palliative care to elderly patients in hospitals. According to a European project (ELDCARE), elderly patients, defined as those 65 years of age or older, had considerably worse survival rates than younger persons, particularly one year after diagnosis. The increased disadvantage of aged patients was particularly noticeable in women in general and for gynecological cancers in specific.

Despite strong evidence that people with advanced non-malignant diseases might benefit from this treatment, palliative care services are still inextricably tied to cancer (Gibbs et al., 2002). Nonetheless, because older persons are more likely to die from causes other than cancer, they are at a disadvantage in terms of access to SPC by diagnosis. In a UK-based research, several participants agreed that an older patient with palliative care needs to arouse a different response than a younger patient with identical demands and that this had therapeutic consequences. In the same study, younger persons were found to have more extensive support networks, as well as an advocate who could lobby for the greatest quality treatment on their behalf. The significance of family and support networks in providing access to programs such as SPC was perceived as increasing the shortage of psychological assistance accessible to older persons, particularly those living alone.

Although studies show inequalities in referral to and use of palliative care services for older people, however, the reasons for this are unclear, and some studies also suggest that age is not associated with access to specialist palliative care for patients within the healthcare system.

### **Implications of socioeconomic status on access to palliative care:**

Socioeconomic status is defined as an individual's or group's position on the socioeconomic scale, which is determined by a combination of social and economic factors such as income, amount and type of education, occupation type and prestige, place of residence, and—in some societies or parts of society—ethnic origin or religious background (APA Dictionary). Whereas examining socioeconomic status frequently reveals discrepancies in resource access and concerns of privilege, power, and control.

The majority of medical expenses are incurred through hospital services. Choosing the right combination of therapies with curative and palliative goals and avoiding inappropriate treatments or transitions not only benefits patients and families, but also improves healthcare policy and costs. Yi conducted a review and discovered that hospital treatment accounts for more than 80% of total health and social care costs, despite the fact that community and palliative care expenditures are modest, ranging from 6%-16% and 1%-15%, respectively. According to Aldridge and Kelley, 13% of the US\$1.6 trillion was spent on healthcare for persons in their final year of life, which was

attributable to a small group of exceptionally costly patients. According to a recent Medicare cost analysis, 20% of expenses are spent in the final year of life, with expenditures rising in patients' final days, particularly when they are in the hospital.

According to Koffman, among socially and financially wealthy patients, there is a high correlation between socioeconomic status and understanding of palliative care. People from lower socioeconomic backgrounds may also have various communication requirements and confront extra hurdles as they approach the end of their lives, such as issues with insufficient housing (Rowley, 2021), fuel poverty, and lack of income (Gardiner, 2020; Lewis, 2011). Studies have also shown that patients with lower socioeconomic positions, especially those with poor educational attainment, and men are less likely to get palliative care (PC) or hospice care and more likely to undergo "curative" chemotherapy weeks before death.

Consequently, the influence of some key socioeconomic status variables on palliative care based on empirical facts is discussed below,

**Income:** Income capacity is a significant indicator of socioeconomic status. Several studies from various countries have found a substantial link between access to palliative care and a person's or family's ability to earn money. McCarthy observed that patients with higher median earnings were more likely to seek hospice care services than patients with lower family incomes. Another study found that those with low income who sought care in urban medical institutions were less likely to receive adequate help.

On the other side, Burge et al. (2008) found that people were less likely to be enrolled in a palliative care program (PCP) if they lived in medium and lower-middle-income areas. Patients in lower-middle or middle-income regions might not have access to or be eligible for social programs that provide the majority of the financial support required for treatment. Patients with higher earnings could have access to more resources that allow for the use of PCP treatment, particularly at home, such the ability to afford pricey medications and equipment.

**Education:** Although education significantly impacts socioeconomic status and other life determinants, it is recognized that it may not be sufficient to significantly change any culture. When the relationship between educational attainment and access to palliative care was examined, it was shown that persons with higher levels of education use hospice/palliative services more frequently. Similarly, Kumar observed that patients with lower levels of education accessed palliative and supportive care services less frequently.

**Occupation:** Occupation is described as whatever individuals do to keep themselves occupied, and it is deemed meaningful when it achieves a purpose or objective that is personally or culturally significant. In a British cross-sectional study, Kessler discovered that those in the lowest socioeconomic class (unskilled occupations) were less likely to die in hospice/palliative settings than those in professional employment.

However, there were also observations that, alongside unskilled professionals, several patients from semi-skilled jobs felt unable to request a hospice bed when palliative care was required.

**Place of residence:** Prior studies consistently found that patients living in urban rather than rural areas were more likely to utilize palliative care. Rural residents may have access problems and distance limitations that hinder their use of the amenities, which might account for the lower utilization rate (Parajuli 2020). According to a review, hospice/palliative care utilization was 11 times more prevalent in urban

than in rural areas. Additionally, women who lived in low-income areas with less education had a lower likelihood of getting hospice care services.

However, on the other side, Burge discovered that palliative care program (PCP) registration among people living in low-income neighborhoods did not differ substantially from registration among people living in high-income neighborhoods.

**Ethnicity:** Most studies found that racial minorities (i.e. Black, Asian, and Pacific Islanders) were less likely than Whites to use hospice care services. According to one study, being a racial minority was related to a higher likelihood of obtaining palliative care. US National Home and Hospice Care Survey 1996 estimated that only 10% of hospice patients were not white. According to Colon, African Americans' use of hospice/palliative care has decreased while whites' use has grown during the same time period whereas Hispanics and Asians/Pacific Islanders are said to use hospice care less frequently than whites. Similarly, in an Australian study (Koffman, 2007), comprehension of palliative care was found to differ substantially between different demographic groupings. It was highest among females and younger respondents, as well as those who identified as Australian-born residents or UK/Irish-born, those with degrees, and those with higher incomes.

Although there is enough evidence suggesting a correlation between race/ethnicity and access to palliative care, two other substitute studies found no significant association between race/ethnicity and frequency of palliative/hospice care usage.

### **Implications of socioeconomic status on access to geriatric palliative care:**

The concept of healthy aging is based on the prevention and management of disease and disability, the retention of great physical and cognitive performance, and the adoption of active lifestyles and healthful activities. Healthy aging is prioritized in modern medicine, especially when it comes to geriatric care. Even if programs are being implemented to promote healthy aging as "the new normal", a percentage of the growing older adult population have financial challenges, which have an adverse impact on resource allocation and health outcomes.

Socioeconomic position influences elderly people's perceived or real access to healthcare. Different healthcare access may be to blame for differences in healthy aging based on economic status: wealthier older people have better access to care. Longer latencies are associated with poorer socioeconomic status in countries with centralized healthcare systems. Income-related treatment disparities exist when older people with low socioeconomic status are not always provided with the same level of care as older individuals with higher incomes. For example, a Chinese study found that self-reported low access to healthcare among the elderly was substantially associated with higher rates of disability, cognitive decline, and total mortality, particularly in rural areas.

According to studies older age may be a barrier to receiving specialist palliative care (Kite, 2006). As with access to general geriatric healthcare, there are also indications of a lack of availability and usage of geriatric palliative care. Disparities in access to palliative care have frequently been the subject of socioeconomic disparities studies as people get older. Patients' readiness to seek palliative care services may be impacted by their gender, education level, age, race, sickness severity, financial difficulties, religion, and marital status, among other things. Regarding social support, palliative care usage among older cancer patients was significantly correlated with main caregiver

support, and patients in rural locations used it at a lower rate than those in urban areas. According to a recent review of the literature on whether age affects cancer patients' access to specialist palliative care services, older individuals continue to be disadvantaged. Another study of the problems and concerns connected with accessing competent palliative care indicated that age, money, and ethnicity are some of the most important issues.

A worldwide public health goal has been set as making palliative care more accessible to older people and their very complex and co-existing needs (WHO, 2004). Nations are stepping forward to ensure access to geriatric palliative care, for example, palliative care is no longer associated with death, especially in nations like the United States and Australia and especially for old people. However, there is still disagreement exists over why age is a factor to access palliative care, whether the disparity in access to care necessarily indicates inequity in treatment, and a lack of understanding regarding how people's socioeconomic circumstances influence their symptoms and worries about obtaining the end-of-life care.

## Conclusion

The tragedy for the majority of the world's population is that palliative care is not easily accessible, despite the fact that we have the knowledge and expertise to significantly alleviate suffering and reduce pain. Various studies from all around the globe suggested that access to seek palliative care services may be impacted by socioeconomic and demographic factors like age, gender, education level, race, disease type and severity, financial ability, religion, and marital status. Additionally, two-thirds of individuals in need of palliative care live in developing nations with the fewest healthcare resources, where it is mainly needed. The early utilization of palliative care and continued palliation are necessary, especially for improving end-of-life experiences. Cultural change is also required in order to eliminate ageist perspectives and replace them with the greatest palliative care accessible not only to older patients but also to all the people in need. There is evidence that reducing financial barriers to healthcare access, such as universal healthcare coverage in Europe or Medicare in the United States, can enhance health outcomes. Addressing these needs requires a coherent global and national public health approach. Regional or country-based problem identification and proper implementation of the World Health Organization's (WHO) palliative care policies can be a solution to reduce the socioeconomic barriers to accessing palliative and geriatric palliative care services.

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## List of abbreviations:

APA: American psychological association

CDC: Center for Disease Control

HC: Hospice Care

PC: Palliative Care

PCP: Palliative Care Program

SES: Socio-economic Status

SPC: Specialist Palliative Care

US: United States of America

UK: United Kingdom

WHO: World Health Organization

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