What Leaders Need to Know About the Design and Delivery of Equity-Oriented Palliative Care

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Key Takeaways

- Individuals experiencing structural inequities often have more complex health needs, yet face significant barriers to accessing care, including palliative care.
- Healthcare leaders are uniquely positioned to improve health equity in palliative care in their role as decision makers, through shaping policy, allocating funding and setting priorities in the design and delivery of care.
- Inequities in care can be reduced by embedding an equity lens which can improve both access and outcomes.

Abstract

Social and structural inequities disproportionately affect individuals who are experiencing homelessness or vulnerable housing, leading to poorer health outcomes and barriers to equitable, timely access to care. Building on lessons learned from the Improving Equity in Access to Palliative Care collaborative focused on this vulnerable population, this article encourages healthcare leaders to drive system-level change in palliative care by prioritizing and adopting an equity lens to build a more inclusive and effective healthcare system for those experiencing homelessness or vulnerable housing. Specifically, key considerations for the design and delivery of equity-oriented palliative care and implications for healthcare leaders are explored.

Background on Inequities Impacting Health

It is well established that people facing social and structural inequities, such as those experiencing homelessness or vulnerable housing, systematic discrimination and mental health or substance use challenges, experience persistent barriers to healthcare access and poorer health outcomes (McNeil and Guirguis-Younger 2012; Reilly et al. 2022; Roerig et al. 2024; Stajduhar et al. 2019). Individual experiences of inequity are considered social and structural because of ongoing and deeply embedded disadvantages within societal structures, institutions and policies that create unequal outcomes for certain groups of people compared with others (Reimer-Kirkham et al. 2016; Weinstein et al. 2017). Instead of positioning ill health as a consequence of individual-level circumstances, the concept of health equity, and by extension, inequity, acknowledges that individuals are nested within larger social, institutional, economic, historical and political structures that predispose them to negative health outcomes (Nixon 2019; Reimer-Kirkham et al. 2016; Sítima et al. 2024). The "cure" for inequities in health, therefore, lies in removing obstacles to health such as poverty, discrimination and deep-seated social and systemic barriers that prevent certain groups from accessing healthcare and other essential resources that promote health and well-being (Braveman et al. 2018, p. 3).

Structural inequities accelerate aging-related health conditions, leading to disproportionately higher rates of cancer and other chronic diseases (Bourgeois et al. 2023; Santos Salas et al. 2023), especially among First Nations, Inuit and Métis (Browne et al. 2016; Nguyen et al. 2020). Despite their complex health needs, people who experience inequities encounter significant challenges in accessing healthcare, including at the end of life (Hudson et al. 2016; Shulman et al. 2018; Stajduhar et al. 2019). Palliative care aims to improve quality of life for individuals with serious illnesses and has a longstanding history of providing person-centred care that prioritizes the unique needs, values and preferences of

individuals living with life-limiting conditions (Reason and Paltser 2023). Grounded in a holistic approach, palliative care has been instrumental in improving quality of life, enhancing symptom management and ensuring dignity at the end of life. Through its integration into mainstream healthcare systems, palliative care has contributed to the development of networks of support that engage families, healthcare providers and broader social structures in care. This approach has led to improved healthcare experiences, more appropriate utilization of services and overall reductions in healthcare costs by preventing unnecessary hospitalizations and ensuring that care is delivered in the most appropriate settings (CIHI 2023).

Palliative Care in the Context of Structural Vulnerabilities

Palliative care in Canada has made significant strides in improving the quality of life for individuals with serious illnesses. These advances have strengthened healthcare systems and fostered the development of compassionate communities and care teams that can support improved person-centred care experiences at the end of life for Canadians who are able to receive such services.

While palliative care has been highly effective in meeting the needs of mainstream populations, it has, to a large degree, not equitably serviced individuals facing structural inequities. People experiencing poverty, homelessness or vulnerable housing, racial discrimination and geographic barriers – such as those living in rural and remote communities – continue to encounter significant challenges in accessing high-quality palliative care (Stajduhar et al. 2020b). Structural vulnerabilities, including inadequate housing, lack of culturally safe care and systemic biases within healthcare institutions, mean that many people facing inequities do not receive the same level of person-centred, compassionate care as others (Purkey and MacKenzie 2019). While substantial attention has been directed toward addressing health inequities at the population health and systems levels across Canada, until now, little progress has been made in identifying approaches to reduce health inequities in the context of palliative and end-of-life care.

A key priority in Canada's Action Plan for Palliative Care (Health Canada 2019) is to foster improved access to palliative care for underserved populations. One mechanism for addressing this key priority has been through the establishment of the Improving Equity in Access to Palliative Care collaborative, a partnership between Healthcare Excellence Canada and the Canadian Partnership Against Cancer (detailed further in IEAPC Delivery Team 2026a and IEAPC Delivery Team 2026b).

This article shares key considerations for delivering equity-oriented palliative care and engaging healthcare leaders to build a more inclusive and effective healthcare system for those experiencing homelessness or vulnerable housing. We hope that this article can inspire others to embark upon or continue their own improvement journeys to make palliative care more accessible to every person, including those who experience greater inequity in access to care.

Key Considerations for the Design and Delivery of Equity-Oriented Palliative Care

Over the years, extensive research has identified the key components of high-quality palliative care, including effective symptom management, integrating family members into the care circle, ensuring that individuals can die in their preferred setting – most often at home – and taking into account emotional, psychosocial and spiritual aspects of care that are aligned with a person's needs and wishes. Palliative care is unique in its focus not only on care of the person as they are living and dying, but also on the family through recognition of the importance of support through grief and bereavement (Giesbrecht et al. 2023). These principles have shaped mainstream approaches to palliative care and have contributed to improved end-of-life experiences for many. However, for individuals facing structural inequities, these ideals are often out of reach due to systemic barriers such as inadequate access to culturally safe care, financial instability, housing insecurity and experiences of discrimination within the healthcare system (Klop et al. 2018; Sítima et al. 2024; Stajduhar et al. 2020a). Equity-oriented palliative care requires a shift beyond conventional models to actively recognize these key challenges and barriers to care while also understanding that the current ideals set forth within palliative care services require contextualization and adaptation if we are to realize equity in palliative care.

Key considerations include the following:

1. Recognizing that palliative care services and the potential benefits of palliative care are largely unknown to people who experience inequities and the sectors (i.e., housing, harm reduction, outreach, mental health and addictions services, etc.) that commonly support them (Henry et al. 2017; Roerig et al. 2024; Stajduhar et al. 2019).
2. Understanding that, in the context of inequity, addressing the social determinants of health is a key palliative care intervention that must be prioritized (Henry et al. 2017; Horvick and Dias 2024).
3. Appreciating that the need to prioritize daily survival (for food and shelter) often makes accessing palliative care services a low priority for many people who experience structural inequities (Stajduhar et al. 2019, 2024).
4. Acknowledging that most healthcare and palliative care services are not designed for populations experiencing inequities (Giesbrecht et al. 2018; Stajduhar et al. 2019; West et al. 2020).
5. Realizing that significant gaps exist between healthcare,

social services and mental health and addictions services, leaving vulnerable individuals without proper support when they are on a palliative trajectory (McNeil and Guirguis-Younger 2012; Stajduhar et al. 2020a; Stajduhar et al. 2020b; Webb et al. 2024).

6. Identifying those who could benefit from palliative care is complex in high-risk communities where many are at risk of dying (Stajduhar et al. 2020a; Stajduhar et al. 2020b).
7. Recognizing that family caregivers – those who provide most of the care in the community and of which palliative care services are dependent upon – are not often present for people who experience structural inequities (Mollison et al. 2025; Rosenwohl-Mack et al. 2019; Stajduhar et al. 2020b).
8. Realizing that community service workers providing care act as de facto family members and experience profound but unrecognized grief because of their care work (Giesbrecht et al. 2023; Stajduhar et al. 2020a). See article by Black and Laing in this issue for a detailed commentary on this topic (Black et al. 2026).
9. Understanding that there exists a lack of knowledge related to integrating palliative approaches to care among community service workers and tools to support them in their work, while at the same time recognizing that much of the work associated with care of the dying lies outside the scope of their workplace roles (Stajduhar et al. 2020a, 2024).
10. Acknowledging the need to shift our care approaches and models to "meet people where they are at," including supporting outreach, bed-based and community models as key promising practices for the design and delivery of equitable access to palliative care (Johnson et al. 2024; Robinson et al. 2022; Stajduhar et al. 2024) that recognizes the need for trauma- and violence-informed approaches to care, promotion of substance use health and implementation of culturally safe care practices (Ko et al. 2015; Quinn et al. 2024).

Recognizing and responding to the social determinants of health, integrating community-based and culturally relevant supports and ensuring flexible, person-centred approaches that prioritize the needs and voices of structurally marginalized populations is key to realizing equity in palliative care. Without these considerations, palliative care risks reinforcing inequities rather than alleviating them.

Implications of These Key Considerations for Healthcare Leadership

Healthcare leaders must recognize that not all populations have equitable access to high-quality palliative care. Without an intentional focus on equity, palliative care can unintentionally reinforce these disparities, leaving the most marginalized individuals without the support they need at the end of life. An equity-oriented approach to palliative care requires addressing these systemic barriers by integrating culturally responsive care, reducing logistical and financial obstacles and ensuring that policies and programs are designed with the needs of structurally vulnerable populations in mind. Unpublished pilot data also suggest cost-saving to the healthcare system by the implementation of equity-oriented models of palliative care. For example, in a preliminary analysis of healthcare utilization data from Victoria's mobile Palliative Outreach Resource Team (PORT) in its first year of operations, 71% of emergency room and 57% of hospital admissions were avoided. Applying the key considerations described in this article, Medavie Community Paramedicine in Moose Jaw, Saskatchewan (part of the Improving Equity in Access to Palliative Care collaborative) has launched community-based palliative wellness clinics in familiar settings such as the John Howard Society. Staffed with advanced care/community paramedics, these clinics deliver vital-sign monitoring, wound assessments and seamless referrals to health and social support services and increased access to care. Between April 2023 and March 2024, they received over 412 initial referrals and conducted more than 1,072 follow-up visits, averting an estimated 595 emergency department visits and hospital admissions by providing timely care within a trusted community environment. These data, while preliminary, suggest that programs and services such as these not only improve care outcomes but also have the potential to avoid healthcare utilization costs.

Beyond policy and resource allocation, healthcare leaders also play a critical role in fostering a culture of equity within their institutions.

Healthcare leaders are uniquely positioned to advance equity in palliative care. Leaders have the influence, resources and strategic oversight needed to drive meaningful change. As decision makers in health systems, leaders shape policies, allocate funding and set priorities that determine who receives care and how it is delivered. By embedding equity into their organizational mandates, leaders can ensure that palliative care services are accessible, culturally responsive and tailored to the needs of people who face structural inequities.

Beyond policy and resource allocation, healthcare leaders also play a critical role in fostering a culture of equity within their institutions. Specifically, healthcare leaders can support policy and service redesign that prioritizes structurally vulnerable populations facing end of life, promote cross-sector collaboration to reduce silos in care, implement training opportunities for healthcare providers and community workers

to support high-risk communities in accessing equity-oriented palliative approaches to care and encourage innovative and scalable models of care to enhance accessibility. They also have the authority to implement workforce training that enhances cultural humility, advocate for care delivery models that integrate the social determinants of health and establish partnerships with community organizations that serve underserved populations. Leaders can also champion research and data collection that highlight gaps in palliative care access, using this evidence to advocate for system-wide reforms. Ultimately, healthcare leaders have a responsibility to ensure that the principles of high-quality palliative care – dignity, choice and comfort – are available to all, regardless of socioeconomic status, race, geography or other factors. By prioritizing equity, leaders can help create a healthcare system where every person receives the compassionate, person-centred care they deserve at the end of life.

Conclusion

Healthcare systems can unintentionally deepen health inequities, particularly for people who often face stigma, discrimination and systemic barriers when seeking care. By prioritizing equity in palliative care, healthcare leaders can drive system-level change that improves outcomes for the most underserved populations. Building on lessons learned from the Improving Equity in Access to Palliative Care collaborative and over a decade of Canadian research on equity-oriented palliative care, Canada is well positioned to improve timely access to high-quality palliative care through an equity lens. For healthcare leaders, adopting this lens is not only a matter of social justice but also a crucial step toward building a more inclusive and effective healthcare system. HQ

References

Black, J., S. Laing, R. Carter, S. Landry, J.R. Graham and E. Hassan. 2026. Grief and Bereavement in the Context of Homelessness: Sharing Experiences and Learnings From British Columbia. *Healthcare Quarterly 29*(Special Issue): 22–28. doi:10.12927/hcq.2026.27967.

Bourgeois, A., T.C. Horrill, A. Mollison, L.K. Lambert and K.I. Stajduhar. 2023. Barriers to Cancer Treatment and Care for People Experiencing Structural Vulnerability: A Secondary Analysis of Ethnographic Data. *International Journal for Equity in Health* 22(1): 58. doi:10.1186/s12939-023-01860-3.

Braveman, P., E. Arkin, T. Orleans, D. Proctor, J. Acker and A. Plough. 2018. What Is Health Equity? *Behavioral Science & Policy* 4(1): 1–14. doi:10.1353/bsp.2018.0000.

Browne, A.J., C. Varcoe, J. Lavoie, V. Smye, S.T. Wong, M. Krause et al. 2016. Enhancing Health Care Equity With Indigenous Populations: Evidence-Based Strategies From an Ethnographic Study. *BMC Health Services Research* 16(1): 544. doi:10.1186/s12913-016-1707-9.

Canadian Institute for Health Information (CIHI). 2023. *Access to Palliative Care in Canada*. Retrieved May 08, 2025. <https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf>.

Giesbrecht, M., A. Mollison, K. Whitlock and K.I. Stajduhar. 2023. "Once You Open That Door, It's a Floodgate": Exploring Work-Related Grief Among Community Service Workers Providing Care for Structurally Vulnerable Populations at the End of Life Through Participatory Action Research. *Palliative Medicine* 37(4): 558–66. doi:10.1177/02692163221139727.

Giesbrecht, M., K.I. Stajduhar, A. Mollison, B. Pauly, S. Reimer-Kirkham, R. McNeil et al. 2018. Hospitals, Clinics, and Palliative Care Units: Place-Based Experiences of Formal Healthcare Settings by People Experiencing Structural Vulnerability at the End-of-Life. *Health & Place* 53: 43–51. doi:10.1016/j.healthplace.2018.06.005.

Health Canada. 2019, October. *Action Plan on Palliative Care: Building on the Framework on Palliative Care in Canada.* Retrieved May 08, 2025. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care/action-plan-palliative-care-eng.pdf>.

Henry, B., N. Dosani, L. Huynh and N. Amirault. 2017. Palliative Care as a Public Health Issue: Understanding Disparities in Access to Palliative Care for the Homeless Population Living in Toronto, Based on a Policy Analysis. *Current Oncology* 24(3): 187–91. doi:10.3747/co.24.3129.

Horvick, S. and N. Dias. 2024. Palliative Care Providers' and Administrators' Perspectives on Integrating Community-Based Palliative Care Using the Social Determinants of Health Framework. *Palliative Medicine Reports* 5(1): 81–85. doi:10.1089/pmr.2023.0048.

Hudson, B.F., K. Flemming, C. Shulman and B. Candy. 2016. Challenges to Access and Provision of Palliative Care for People Who Are Homeless: A Systematic Review of Qualitative Research. *BMC Palliative Care* 15(1): 96. doi:10.1186/s12904-016-0168-6.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026b. Improving Equity in Access to Palliative Care for Communities Experiencing Homelessness or Vulnerable Housing. *Healthcare Quarterly* 29(Special Issue): 5–10. doi:10.12927/hcq.2026.27970.

Improving Equity in Access to Palliative Care (IEAPC) Program Delivery Team. 2026. The Power of the Collective: Lessons Learned From Pan-Canadian Efforts to Improve Access to More Equitable Palliative Care. *Healthcare Quarterly* 29(Special Issue): 36–45. doi:10.12927/hcq.2026.27962.

Johnson, I.M., A.C. Traver and M.A. Light. 2024. Resident Care in the "In-Between Time": Cross-Sector Perspectives on Enhancing Synergy Between Palliative Care and Permanent Supportive Housing. *Journal of Health and Human Services Administration* 47(3–4): 76–88. doi:10.1177/10793739241253222.

Klop, H.T., A.J.E. de Veer, S.I. van Dongen, A.L. Francke, J.A.C. Rietjens and B.D. Onwuteaka-Philipsen. 2018. Palliative Care for Homeless People: A Systematic Review of the Concerns, Care Needs and Preferences, and the Barriers and Facilitators for Providing Palliative Care. *BMC Palliative Care* 17(1): 67. doi:10.1186/s12904-018-0320-6.

Ko, E., J. Kwak and H. Nelson-Becker. 2015. What Constitutes a Good and Bad Death?: Perspectives of Homeless Older Adults. *Death Studies* 39(7): 422–32. doi:10.1080/07481187.2014.958629.

McNeil, R. and M. Guirguis-Younger. 2012. Illicit Drug Use as a Challenge to the Delivery of End-of-Life Care Services to Homeless Persons: Perceptions of Health and Social Services Professionals. *Palliative Medicine* 26(4): 350–59. doi:10.1177/0269216311402713.

Mollison, A., M. Gagnon, R. McNeil, A. Stewart, M. Giesbrecht, A. Bourgeois et al. 2025. "None of It Turned Out the Way She Wanted, so It Left a Hole in Me": Informal Caregiving at the End of Life in Contexts of Inequity. *Health & Social Care in the Community* 2025: 8788241. doi:10.1155/hsc/8788241.

Nguyen, N.H., F.B. Subhan, K. Williams and C.B. Chan. 2020. Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review. *Healthcare* 8(2): 112. doi:10.3390/healthcare8020112.

Nixon, S.A. 2019. The Coin Model of Privilege and Critical Allyship: Implications for Health. *BMC Public Health* 19(1): 1637. doi:10.1186/s12889-019-7884-9.

Purkey, E. and M. MacKenzie. 2019. Experience of Healthcare Among the Homeless and Vulnerably Housed a Qualitative Study: Opportunities for Equity-Oriented Health Care. *International Journal for Equity in Health* 18(1): 101. doi:10.1186/s12939-019-1004-4.

Quinn, S., L. Ferguson, D. Read and N. Richards. 2024. "The Great Escape": How an Incident of Elopement Gave Rise to Trauma Informed Palliative Care for a Patient Experiencing Multiple Disadvantage. *BMC Palliative Care* 23(1): 61. doi:10.1186/s12904-024-01374-x.

Reason, B. and G. Paltser. 2023. Access to Palliative Care in Canada. *Healthcare Quarterly* 26(2): 6–8. doi:10.12927/hcq.2023.27140.

Reilly, J., I. Ho and A. Williamson. 2022. A Systematic Review of the Effect of Stigma on the Health of People Experiencing Homelessness. *Health & Social Care in the Community* 30(6): 2128–41. doi:10.1111/hsc.13884.

Reimer-Kirkham, S., K. Stajduhar, B. Pauly, M. Giesbrecht, A. Mollison, R. McNeil et al. 2016. Death is a Social Justice Issue: Perspectives on Equity-Informed Palliative Care. *Advances in Nursing Science* 39(4): 293–307. doi:10.1097/ANS.0000000000000146.

Robinson, L., L. Trevors Babici, A. Tedesco, D. Spaner, T. Morey and N. Dosani. 2022. Assessing the Impact of a Health Navigator on Improving Access to Care and Addressing the Social Needs of Palliative Care Patients Experiencing Homelessness: A Service Evaluation. *Palliative Medicine* 37(4): 646–51. doi:10.1177/02692163221146812.

Roerig, M., M. Albert, H. Marani and S. Allin. 2024, May. *Supporting Equitable Access to Health and Social Services for People Experiencing Homelessness in Ontario*. North American Observatory on Health Systems and Policies. Retrieved May 08, 2025. <https://naohealthobservatory.ca/wp-content/uploads/2024/08/NAO-Rapid-Review-44_EN.pdf>.

Rosenwohl-Mack, S., M. Kushel, C. Ramsey, M. Handley and K.R. Knight. 2019. "We Really Help, Taking Care of Each Other": Older Homeless Adults as Caregivers. *Gerontology and Geriatric Medicine* 5: 2333721419894765. doi:10.1177/2333721419894765.

Santos Salas, A., C. Bablitz, H. Morris, L. Vaughn, O. Bardales, J. Easaw et al. 2023. Improving Access to Palliative Care for People Experiencing Socioeconomic Inequities: Findings From a Community-Based Pilot Research Study. *Chronic Diseases in Canada* 43(8): 365–74. doi:10.24095/hpcdp.43.8.02.

Shulman, C., B.F. Hudson, J. Low, N. Hewett, J. Daley, P. Kennedy et al. 2018. End-of-Life Care for Homeless People: A Qualitative Analysis Exploring the Challenges to Access and Provision of Palliative Care. *Palliative Medicine* 32(1): 36–45. doi:10.1177/0269216317717101.

Sítima, G., C. Galhardo-Branco and P. Reis-Pina. 2024. Equity of Access to Palliative Care: A Scoping Review. *International Journal for Equity in Health* 23(1): 248. doi:10.1186/s12939-024-02321-1.

Stajduhar, K.I., A. Mollison, M. Giesbrecht, R. McNeil, B. Pauly, S. Reimer-Kirkham et al. 2019. "Just Too Busy Living in the Moment and Surviving": Barriers to Accessing Health Care for Structurally Vulnerable Populations at End-of-Life. *BMC Palliative Care* 18(1): 11. doi:10.1186/s12904-019-0396-7.

Stajduhar, K.I., M. Giesbrecht, A. Mollison, K. Whitlock, P. Burek, F. Black et al. 2024. "You Can't Die Here": An Exploration of the Barriers to Dying-in-Place for Structurally Vulnerable Populations in an Urban Centre in British Columbia, Canada. *BMC Palliative Care* 23(1): 12. doi:10.1186/s12904-024-01340-7.

Stajduhar, K.I., M. Giesbrecht, A. Mollison and M. d'Archangelo. 2020a. "Everybody in This Community is at Risk of Dying": An Ethnographic Exploration on the Potential of Integrating a Palliative Approach to Care Among Workers in Inner-City Settings. *Palliative & Supportive Care* 18(6): 670–75. doi:10.1017/S1478951520000280.

Stajduhar, K.I., M. Giesbrecht, A. Mollison, N. Dosani and R. McNeil. 2020b. Caregiving at the Margins: An Ethnographic Exploration of Family Caregivers Experiences Providing Care for Structurally Vulnerable Populations at the End-of-Life. *Palliative Medicine* 34(7): 946–53. doi:10.1177/0269216320917875.

Webb, L., G. Yarwood, G. Witham, S. Wright and S. Galvani. 2024. Providing Holistic End-of-Life Care for People With a History of Problem Substance Use: A Mixed Methods Cohort Study of Interdisciplinary Service Provision and Integrated Care. *BMC Palliative Care* 23(1): 86. doi:10.1186/s12904-024-01416-4.

Weinstein, N.J., A. Baciu, A. Geller and Y. Negussie. 2017. The Root Causes of Health Inequity. In *Communities in Action: Pathways to Health Equity* A. Baciu, Y. Negussie, A. Geller, and J.N. Weinstein (Eds.) (pp. 99–184). National Academies Press.

West, K.J., B. Wrobel, S. Pallotta and A. Coatsworth. 2020. Bearing Witness: Exploring the End-of-Life Needs of Homeless Persons and Barriers to Appropriate Care. *Omega: Journal of Death and Dying* 82(1): 63–91. doi:10.1177/0030222818801150.

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