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Exploring palliative care debates:
Equitable access and the role of social workers

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ABSTRACT

INTRODUCTION: Equity of access to palliative care for older adults and the role of social work are interwoven as older adults are the largest population group requiring end-of-life care and hospice social workers predominantly work alongside older adults. This article explores the intersections of palliative care policy and practice, older adults' inequitable outcomes, Te Tiriti o Waitangi (1840), and challenges faced by social workers seeking to be effective advocates for older adults.

APPROACH: Undertaking post-graduate study in palliative care allowed for an exploration of the literature and older adults' experiences of inequity observed in practice through a social work lens. Literature reviews completed during post-graduate study foreground the literature search informing this article. The literature search was completed using University of Canterbury Library and CINAHL Health sciences databases focused on palliative and end-of-life care, older adults and caregivers. Keywords used included *literature reviews, palliative or end-of-life, older adults or elderly, caregivers or family, psychosocial, New Zealand, caregiver distress*, and *ageism*. Abstracts of articles were reviewed; literature was chosen based on relevance to the topic. Additional literature was sourced through Google Scholar, Google searches of current proposals/reports, and international databases.

CONCLUSIONS: The current Aotearoa New Zealand Ministry of Health (MoH) (2001) Palliative Care Strategy does not effectively respond to older adults' end-of-life care needs or acknowledge the roles and contributions of social workers within palliative care. Improving older adults' equity of access to palliative care requires interlinking and prioritising older adults' end-of-life care and empowering the contributions of social workers.

Keywords: Literature review, older adults, equity, palliative care, social work

Preserving the philosophy of palliative care, recognising inequity experienced by older adults, and considering the role of social work within these contexts, is a multifaceted journey. The journey begins with the philosophy of palliative care and the future of specialist palliative care services. Palliative care encompasses family/whānau-inclusive, patient-centred healthcare with a focus on comfort and relieving suffering for people with life-limiting and quality-of-life-limiting conditions (Carroll & Quill, 2015; World Health Organisation [WHO], 2022). Palliative care improves quality-of-life and general wellbeing by positively impacting symptom burden,

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including depression, anxiety, nausea, pain and insomnia (Coym et al., 2020; Enguidanos et al., 2014). Specialist services are predicted to drive future development with hospital-based palliative care and hospices working collaboratively alongside primary healthcare services within compassionate community approaches (Carroll & Quill, 2015; Hogan, 2021; Van Den Block, 2015). WHO recognises disparities within specialist services noting that palliative care is more accessible in high-income countries and there is a lack of access within developing countries (Bates et al., 2019). The philosophy of palliative care challenges public health systems worldwide; increasingly impersonal, technology-dependent, and medication-focused care are attributed to cost-saving priorities, growing global populations and subsequent increases in deaths (Jackson & Healthwatch, 2019; Randall & Downie, 2006; Smith et al., 2002).

The purpose of this article is to examine the key debates within palliative care literature in relation to improving older adults' end-of-life experiences within Aotearoa New Zealand and to consider how social workers can provide meaningful contributions within this context. The article has its roots in post-graduate study with literature being sourced from the University of Canterbury Library, CINAHL Health sciences databases as well as Google Scholar. The literature focused on palliative and end-of-life care, older adults and caregivers. The discussion that follows here encompasses the key debates identified within the literature. These debates include palliative care becoming an over-complicated, specialist service that does not prioritise equity of access for older adults; social workers' positionality and capacity to be effective advocates for older adults; medical model dominance within interdisciplinary team approaches and the implications for social work; the effects of ageism and social devaluation of aging New Zealanders; inequity experienced by dementia sufferers and older adults in aged care; as well as Māori older adult perspectives within biculturalism debates. The article concludes with a summary of key points and future pathways to improve equity of access for older adults.

Older adults inequity is central within the "over-complicated palliative care debate"; this is evident within fragmented public health systems with inadequate, services that struggle to meet the end-of-life needs of older adults (Clark, 2019; Gott et al., 2017; Morgan et al., 2021; Nicholson & Richardson, 2018; Randall & Downie, 2006). This is oppositional to the origins of palliative care that sat outside traditional medical practices by focusing on comfort, and patient-led care. Clark (2019) maintained there is a growing ambivalence towards normalising death, a feature of hospice care, stating palliative care is increasingly viewed as a new medical/specialist field with a unique clinical territory and compliant patient population.

Palliative care is challenged by being viewed exclusively as a specialist service for "the dying only". Hospice and comfort care are often seen by patients and whānau as medical personnel "giving up on them" (Coym et al., 2020; Firn et al., 2016). The challenge for future palliative care provision is broadening the scope of specialised care while retaining Dame Cecily Saunders' (founder of the modern hospice movement) original vision of achieving a "good death" through person-centred care that prioritises individual preferences (Randall & Downie, 2006). Inequitable resource distribution will marginalise the healthcare needs of older adults, especially people living with dementia, who are predicted to be the main group requiring primary healthcare (Carroll & Quinn, 2015; Kellerhear, 2015; Van Den Block, 2015; Volicer et al., 2015).

Unfortunately, allied healthcare contributions, including social workers, are minimised within palliative care debates that prioritise medical-model services. Worldwide, the need for palliative care exceeds the capacity of hospices and specialist units; this reduces the possibility patients with life-limiting conditions will access specialist care (Coym et al., 2020;

Erlenwein et al., 2014; Etkind et al., 2017; Hess et al., 2014; Luckett et al., 2014). Observations within practice reflect this; older adults are less likely to receive no-cost inpatient specialist care and more likely to access asset-tested aged residential care (ARC).

The medical model's dominance is evident within evolving palliative care approaches. Coym et al.'s (2020) qualitative study showed incorporating inpatient palliative care consultation (IPCC) within hospital practices improved patient care. IPCC improves patients' and family/whānau mental/emotional wellbeing by incorporating spiritual care, and high-quality communication (Coym et al., 2020). Holistic care was shown to be secondary to requests for pain and symptom management, IPCCs primary source of referral. The broader scope of palliative care is underutilised, especially those that social workers provide including: psychosocial and communication support for patients and family/whānau, trauma-informed care, and information to assist with decision-making (Erlenwein et al., 2014; Gaertner et al., 2012; Sasahara et al., 2010). Older adults are more likely to be detrimentally impacted by end-of-life care that does not prioritise age-attuned communication and psychosocial assessments, an over-emphasis on treating symptoms encourages reductionism and reduces social workers' input. Policy development plays an important role within these contexts by defining palliative care services and providing an outline of resource allocation to improve service delivery and address inequity.

Aotearoa New Zealand context

Policy outlining future palliative care practices within Aotearoa New Zealand include an outdated Ministry of Health [MoH] Strategy (2001) and recent review, MoH (2017). These documents express a commitment to providing palliative care as a unique philosophy that ensures everyone can have a "good death" conversant with individual needs and aspirations. Providing sustainable service provision, and equitable access to palliative care is endorsed as everyone's concern with a commitment to providing community-attuned service delivery.

Compassionate community and public health approaches are recommended throughout palliative care research; collective responses to death, dying, bereavement and aging are encouraged as they affect everyone and have widespread consequences throughout society including detrimental mental health outcomes, such as suicide, social withdrawal, job loss, discrimination and stigma (Carroll & Quinn, 2015; Kellerhear, 2015; Van Den Block, 2015).

The MoH (2012) recommends providing one level of specialist palliative care throughout the public health system utilising a hub-and-spoke approach. This involves one site (hub) providing a base for services to support satellite sites (spokes). This is indicative of compassionate community approaches; hospice services could become repositories of knowledge and specialist skills and provide support through collaborations with community organisations and primary healthcare providers. Hub-and-spoke models could perpetuate older adults' marginalisation if current deficits are not addressed. The MoH (2012) aspiration to ensure everyone can access "all components of specialist palliative care" is problematic if existing resource deficits persist. The MoH (2012) stated when specialist palliative care cannot be provided, existing resources will compensate. This potentially perpetuates rural service delivery deficits observed within practice, especially rural older adults lacking access to no-cost hospice supports and funded in-home care.

Primary palliative care is mainly provided by Aged Residential Care (ARC), Primary Health Organisations (PHOs), General Practitioners (GPs), and district nursing. Integrated specialist support within primary care is required to ensure everyone has access to comprehensive care (McLeod & Atkinson, 2019; MoH, 2012). McLeod and Atkinson (2019) maintained the hub-and-spoke model can potentially meet current and future needs, including an expected 50% increase in deaths by 2038. The authors recommend measuring the extent of indirect support required and improving national data collection related to specialist palliative care provision. For hub-and-spoke models to be effective, allied health and medical practitioners will be required to work collaboratively within interdisciplinary teams (IDT).

Palliative care and interdisciplinary team approaches

Older adults are the largest population group dying globally with deaths predicted to increase significantly by 2034 due to increased growth of elderly populations. Specialist hospice services will not be able to meet growing demand for older adults' end-of-life care unless government investment and the availability of specialist practitioners is increased (Jackson & Healthwatch, 2019; McLeod & Atkinson, 2019; Van Den Block, 2015; Volicer et al., 2015). Funding pressures will enable medical-model dominance, especially if medical services are prioritised over other services (Allied Health Work Group [AHWG], 2022; Cheyne et al, 2011; Hogan, 2021; Payne, 2014).

Ageism and devaluing of older adults is exacerbated when limited IDT integration between gerontologists and palliative care specialists occurs; incorporating theoretical frameworks responsive to older adults' specific needs, perspectives, and aspirations is encouraged (Gott et al., 2011; Nicholson & Richardson, 2018). Within Aotearoa New Zealand 38.5% of deaths receive specialist palliative care from accredited expert-level practitioners; non-specialists provide most primary care (McLeod & Atkinson, 2019; MoH, 2015). Integrated public health systems can ensure specialist palliative care is available throughout primary care (McLeod & Atkinson, 2019; MoH, 2012). Research shows older adults benefit from specialist palliative care across an illness trajectory, including bereavement support, education, and information for caregivers (Frey et al., 2020: Murray et al., 2017). Gerontologists and palliative care specialists recommend compassionate community approaches that incorporate geriatric nursing, primary care, and allied health collaborations (Cardona-Morell et al., 2016; Gjerberg et al., 2015; Gott et al., 2011; Motamedi et al., 2021; Rodríguez-Prat et al., 2017; Rosa et al., 2022).

Compassionate community responses and IDT approaches incorporating public health systems, acute care, ARC, and primary care can address deficits (Motamedi et al., 2021; Tarter et al., 2016). Simplifying palliative care, normalising death and dying, increasing practitioner education and understanding the effects of fragility and comorbidities within age-related illnesses is encouraged throughout the literature (Devik et al., 2015; Motamedi et al., 2021; Tarter et al., 2016).

Older adults' inequity

Older adults are the disadvantaged dying within palliative care. There is a global need for advocacy and increased awareness of older adults' inequitable outcomes (Castelli Dransart et al., 2021; Gott & Ingleton, 2011; Gott et al., 2011; Lilley & Reid, 2023). Gott et al.'s (2011) study of ageism within palliative care included a survey of 2,074 bereaved carers. The study showed those aged over 85 are almost three times less likely to receive inpatient hospice care than those less than 75 years old. Gott et al. (2017) and Smith et al. (2002) concur; these studies show those of advanced age, defined by gerontologists as 85 years old and older, experience the highest levels of inequity.

Palliative care policy development and service delivery for older adults is influenced by philosophical and political agendas. Older adults' societal value determines the level of care they receive (Frey et al., 2020:

Gott et al., 2017: Jackson & Healthwatch, 2019: Motamedi et al., 2021; Murray et al., 2017; Rodríguez-Prat et al., 2017; Rosa et al., 2022). A lack of societal value was noted within media coverage and policy responses during the Covid-19 pandemic. Ageism and devaluing older adults was evident, older adults were described as frail, passive and unworthy of social investment, the cost to society was prioritised with an emphasis on implementing cost-saving strategies (Cheyne et al., 2011; Gott et al., 2017; Morgan et al., 2021). Ageism observed within practice is reflected within the literature, particularly age-related practices that restrict funded care options.

Population growth amongst older adults will affect Aotearoa New Zealand's health system; 1.2 million people are expected to be aged 65 years or older by 2034, almost 180,000 older adults will be 85 years old or older, older adults are predicted to constitute over a fifth of the total population (Jackson & Healthwatch, 2019). Although older adults are predicted to be the largest population group requiring end-of-life care, funding and resourcing for older adults are lacking within policy (McLeod & Atkinson, 2019; MoH, 2002, 2017).

Limited social investment in older adults' healthcare increases the care load and financial cost to caregivers (Belasco et al., 2006: Gott et al., 2017; Schoenmakers et al., 2010; Wong et al., 2022). Caregivers can experience social isolation, depression, anxiety, fatigue, and deterioration of family relationships (Belasco et al., 2006: Gott et al., 2011; Gott et al., 2017; Maidment & Beddoe, 2016; Schoenmakers et al., 2010; Wong et al., 2022). This is a significant issue as family/unpaid caregivers are estimated to provide 75-90% of in-home end-of-life care (Dunbrack, 2005). Specialist palliative care is shown to reduce caregiver distress and increase positive experiences for older adults, caregivers and family/whānau by providing information about illness trajectories, care and comfort support (Wong et al., 2022; Yang et al., 2012). Current funding shortfalls are predicted to increase, increasing the burden of unpaid caregivers. Third-way policies favour unpaid family support where "family is best" is viewed as "family is cheapest" (Cheyne et al., 2011; Payne 2014). Gott et al. (2015) recommended prioritising quantifying the social, financial, and personal costs experienced by family caregivers as community-based palliative care increases globally. Identifying and quantifying the cumulative cost to unpaid caregivers is an important step towards increasing government funding and the availability of funded care.

Older adults fear being a burden and will decline whanaungatanga (reciprocity), including receiving unpaid care from family/whānau. 'Te Puawaitangi O Nga Tapuwae Kia Ora Tonu, Life and Living in Advanced Age,' study shows Māori and non-Māori participants prioritise not being a burden to family above all other end-of-life care concerns, including dying at home (Gott et al., 2017). Older adults' concern they are a burden is observed in practice and can lead to pre-emptive admissions to ARC and older adults considering assisted dying. Assisted dying research shows negative self-perception can be an underlying factor for requesting a quicker death (Castelli Dransart et al., 2021; Coyle & Sculco, 2004; Kelly et al., 2002; Rodríguez-Prat et al., 2017). The MoH (2001) strategy is committed to supporting home-based deaths, claiming 50-70% of people prefer dying at home. Gott et al. (2017) challenged the view that older adults prefer to die at home, an outcome that can require high levels of unpaid care and older adults perceiving themselves as a burden. The authors state older adults do not prefer home-based death, and reliance on family members to provide care, challenging national and international policy development that states home death is essential to a good death.

Older adults in the end stages of chronic illness are susceptible to overtreatment and can receive aggressive, and potentially harmful, medical interventions, that do not improve quality-of-life (Cardona-Morell et al., 2016; Motamedi et al., 2021). Randall and Downie (2006) maintained "letting dying happen" challenges overtreatment. They state accepting death as a natural part of disease progression ethically encompasses the philosophy of palliative care by withholding or withdrawing life-prolonging treatments when risk and harm outweigh potential benefits. Listening to the goals and values of patients and family/whānau, providing information about the impacts of treatment, and prioritising quality-of-life as a lived experience instead of focusing on prolonging living can prevent overtreatment—this is particularly relevant for those living with neurological deterioration and older adults in ARC (Randall & Downie, 2006).

Dementia and ARC inequity

Another key debate are people living with dementia, they are often excluded from palliative care although there are no effective treatments; sufferers lose their independence and, eventually, their lives (Honinx et al., 2019; Van Den Block, 2015; Volicer et al., 2015; Wang & Wang, 2020). Future projections show dementia care and care for adults of advanced age will significantly increase within the next 10 years (Jackson & Healthwatch, 2019; McLeod & Atkinson, 2019; Van Den Block, 2015; Volicer et al., 2015). McLeod and Atkinson's (2019) data analysis showed the number of people dying with dementia is greater than previously known. Total deaths in 2015 within Aotearoa New Zealand reveal a pattern determined by age that strongly indicates the number of people with dementia will continue to increase within our ageing population.

The MoH (2001) strategy does not recognise dementia care or older adults in ARC specific needs or aspirations, including access to holistic treatments or support to maintain family connections and relationships. Over 43.8% of total deaths in 2015 within Aotearoa New Zealand occurred in ARC or had a residential care subsidy. McLeod and Atkinson (2019) challenge assumptions that older adults stay in ARC for extended periods prior to dying, or that ARC is like home. The authors state 24.3% of people were first admitted to ARC within the last three months of life, with 43.7% dying in ARC less than a year after admission. Older adults increasingly access ARC for short stays and are presenting with increased fragility and complex needs (Boyd et al., 2011; Connolly et al., 2014; Phillips & Currow, 2017).

The Covid-19 pandemic intensified pre-existing oppression and showed inequity of access to palliative care for older adults living with dementia is a worldwide public health priority (Gilissen et al., 2020; Pivodic et al., 2018; WHO, 2020). Access to palliative care enhances quality-of-life and supports symptom relief for Alzheimer's and progressive dementias, including vascular, frontotemporal, and dementia with Lewy bodies, as it does not exclude curative treatments and interventions for other conditions that occur during disease progression (Van Den Block, 2015; Volicer et al, 2015). Older adults with dementia are more likely to be asset-tested and experience restricted access to funded care (Jackson & Healthwatch, 2019; McLeod & Atkinson, 2019). Ageist policies marginalise financial implications experienced by older adults and prioritise societal costs, reflecting third-way political agendas that suggest older adults are less worthy of social investment (Cheyne et al., 2011; Gott et al., 2011; Payne, 2014).

Māori perspectives

Māori experience persistent inequitable outcomes across all health and wellbeing indicators, including palliative care. Māori disadvantage is recognised within strategic planning, empowering te Māoritanga perspectives is required to achieve positive outcomes (MoH, 2001, 2017). Durie's (2011) Te Whare Tapa Wha wellbeing model is widely utilised as an indigenous healthcare initiative; whole-person/whānau wellbeing conceptualised as achieving balance within four walls of a whare (house), representing mental health, family/whānau, physical, emotional and spiritual wellness, that is connected to whenua or a place of belonging. Concepts of whenua are particularly relevant as Māori are recognised as Tangata Whenua or belonging to the land.

Aotearoa New Zealand is a bicultural nation, an equal partnership between Māori and the British Crown and achieving meaningful equality is essential to achieving equitable access to quality end-of-life care for Māori. Boulton et al. (2020) stated biculturalism requires authentic power-sharing at structural levels. Bevin et al.'s (2023) investigation of Aotearoa New Zealand 2019/2020 healthcare plans shows Te Tiriti o Waitangi (1840) principles are disempowered within constrained options. Te Pae Tata (2022) interim health plan marginalises the palliative care needs of older Māori and non-Māori adults. Mason et al. (2019) maintained rising deaths amongst older Māori requires increased government investment into improving culturally appropriate end-of-life care. The authors state Māori whānau provide the bulk of end-of-life care whilst experiencing high levels of socioeconomic disadvantage.

Social workers are committed to empowering Te Tiriti o Waitangi (1840), especially te Tiriti articles that encompass concepts of sovereignty, land, and rights, this includes responding to loss of rights, land, and culture, and the impacts of historical Māori oppression and trauma across the lifespan (Aotearoa New Zealand Association of Social Workers [ANZASW], 2019; Durie, 2011; Egan & Maidment, 2016; International Federation of Social Workers, 2024; Kidd et al., 2021; Maidment & Beddoe, 2016; Pihama, Smith, Evans-Campbell et al., 2017; Pihama, Smith, Cameron et al., 2020; Social Workers Registration Board [SWRB], 2024; Roberts, 2016; Zambas & Wright, 2016). Palliative care practitioners, hospices and healthcare providers will be challenged by persistent Māori marginalisation until meaningful biculturalism is achieved.

Social work perspectives

Social work practice empowers equitable outcomes for older adults; practitioners are guided by codes of conduct and research-informed care that prioritises patient and family/whānau holistic wellbeing and participation in decision-making (Maidment & Beddoe, 2015; Payne, 2004, 2014). Social work skills, values and knowledgebases reflect age-attuned policy development, including care coordination, continuity of care, and holistic psychosocial assessments (Connolly & Harms, 2015; Egan & Maidment, 2016; Golden, 2019; Nicholson & Richardson, 2018).

Social workers are an integral part of hospice whakapapa (history), Dame Cicely Saunders' vision of holistic palliative care reflected her training as a physician, nurse, and social worker. The origins of hospice care incorporate allied health alongside medical care (Reese, 2013). Palliative care social workers are informed by comprehensive, evidence-based practice, and specialist knowledge, including trauma-informed care and approaches responsive to grief and loss experienced across the lifespan (AHWG, 2022; Altilio & Otis-Green, 2011; ANZASW, 2018, 2019; Gamondi et al., 2013a; Gamondi et al., 2013b; Golden, 2019; Hunt et al., 2016; Payne, 2004, 2014; Reese, 2013; SWRB, 2024). Social workers are ideally situated to provide age-attuned care for older adults (Connolly & Harms, 2015; Egan & Maidment, 2016; Nicholson & Richardson, 2018; Reese, 2013; Taels et al., 2021). Yet social work perspectives are often marginalised throughout palliative care policy and practice (Golden, 2019; Taels et al., 2021).

Social workers are committed to seeking social justice for disadvantaged populations, and providing strengths-based care underpinned by anti-oppressive theoretical frameworks. Social workers often utilise systems theory to analyse and critique social systems and policies to identify oppressive forces within human systems; including the interconnections between palliative care policy development and older adults' inequity (Cheyne et al., 2011; Connolly & Harms, 2015; Devik et al., 2015; Egan & Maidment, 2016, Motamedi et al., 2021; Payne, 2014; Tarter et al., 2016). Systems theory informs solution-focused practice and reduces practitioner dominance as people in adversity are viewed as having unlimited potential to identify goals and resolve challenges (Connolly & Harms, 2015; Maidment & Beddoe, 2016; Payne, 2014; Reese, 2013). Social workers utilising systems theory approaches can challenge over-professionalisation of palliative care and problem-focused practice that view patients and whānau as sites of disease (AHWG, 2022; Giles, 2016; Payne, 2014; Randall & Downie, 2006; Reese, 2013; Thompson, 2016). Reductionist pathology and medical-model dominance can be disrupted by effective social workers (Agnew et al., 2011; Brandsen, 2005; Cadell et al., 2010; Chambers et al., 2013; Golden, 2019; Hogan, 2021; Motamedi et al., 2021; Wang & Wang, 2020).

Patient-centred planning, comprehensive psychosocial assessments, collaborative networking skills, age-attuned care and compassionate community responses underpin palliative care social work (ANZASW, 2019; Cardona-Morell et al., 2016; Connolly & Harms, 2015; Gjerberg et al., 2015; Golden, 2019; Motamedi et al., 2021; Reese, 2013). Social workers' specialist skills and contributions are pivotal to achieving meaningful change (Altilio & Otis-Green, 2011; ANZASW, 2019; Connolly & Harms, 2015; Egan & Maidment, 2016; Gamondi et al., 2013a; Gamondi et al., 2013b; Hunt et al., 2016; Payne, 2004; Reese, 2013; SWRB, 2024). Hogan (2021) highlighted challenges faced by allied health workers, including the privileging of medical practitioners throughout Aotearoa New Zealand healthcare, and recommends providing direct access to social workers. Social workers' roles and contributions are unrecognised within the MoH (2001) strategy and national policy development (AHWG, 2022; Hogan, 2021). Allied health professionals' qualifications are not prioritised or incentivised; hospices are shown to discourage upskilling of non-medical personnel (AHWG, 2022, Hogan, 2021). If entrenched IDT practitioner-inequity continues, there is a risk social workers will be assimilated into nursing teams, losing their uniqueness and ability to make meaningful contributions (Coym et al., 2020; Reese, 2013; Wang & Wang, 2020).

Improving future outcomes

Older adults are disadvantaged throughout palliative care research, dementia care and ARC inequity are a significant public health concern (McLeod & Atkinson, 2019). Improving equity involves empathetic, age-attuned care planning, and education that balances normalising death and dying with responding appropriately to age-related illnesses, comorbidities, and fragility (Devik et al., 2015; Motamedi et al., 2021; Tarter et al., 2016). Continuous contact and communication with palliative care specialists is shown to reduce to overtreatment (Cardona-Morell et al., 2016; Gjerberg et al., 2015; Motamedi et al., 2021). Research shows equitable outcomes require IDT approaches, holistic models of care, and information and support provided to family/whānau and caregivers to prevent caregiver distress (Lewis et al., 2019; Motamedi et al., 2021; Tarter et al., 2016).

The literature shows reducing medical-model dominance and 'problem-focused' practice will improve older adults' outcomes (Agnew et al., 2011; Chambers et al., 2013; Golden, 2019; Giles, 2016; Gott et al., 2011; Hogan, 2021; Motamedi et al., 2021; Payne, 2014; Reese & Sontag, 2001; Thompson; 2016; Wang & Wang, 2020). Social workers can disrupt inequity in palliative care and are committed to challenging systems and social structures that disadvantage marginalised population groups (ANZASW, 2019; AHWG, 2022; Connolly & Harms, 2015; Egan & Maidment, 2016; IFSW, 2021; Payne, 2004, 2014).

Preventing practitioner burnout is fundamental, particularly dissatisfaction when social workers' contributions are undervalued by other professionals, and practitioners are unable to function autonomously (AHWG, 2022: Blacker et al., 2016; Marmo & Berkman, 2020; Taels et al., 2021). Collective advocacy within the social work profession is indicated as research shows disempowerment is pre-existing, this challenges practitioners' capacity to self-advocate, raise awareness and maintain relationships with peers and colleagues (AHWG, 2022; Giles, 2016; Hogan, 2021; Payne, 2014; Randall & Downie, 2006; Reese, 2013).

Conclusion

Improving equity of access to quality end-of-life care for older adults is contested with conflicting views on the evolution of palliative care throughout the literature. Currently, increasing education and specialisation of the field is challenged by concern that palliative care is over-professionalised and death and dying have become over-complicated. Integrated, compassionate community collaborations, involving social workers and allied health practitioners within IDT approaches can improve older adults' equity. Social workers capacity to make meaningful contributions and older adults' inequity are interwoven and susceptible to being marginalised within larger palliative care debates. Robust policy development that prioritises empowering age-attuned care for older adults and the role of social work is required to achieve positive outcomes.

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