Equity of access

“‘Equity of access’ has become a popular slogan of many governments concerning the healthcare sector. When such equity of access is applied to palliative care, it is worth examining the phrase in greater detail. This first issue of the *European Journal of Palliative Care* in 2008 is an attempt to do that in several ways.

Specialist palliative care grew out of the care of advanced cancer patients in hospices. This in itself is not an equitable distribution of care by diagnosis. In Western Europe, approximately 25% of deaths are due to cancers, but a further 50% are caused by cardiac and respiratory disease. In the United Kingdom, 90% of hospice deaths, however, are due to cancer. Furthermore, although cancers tend to be diseases of middle age and the elderly, the age distribution of specialist palliative care service is younger than might be expected. It could be argued that a younger age group is associated with more complex symptomatology, and certainly with more complicated psychosocial issues. But there remains a stubborn preponderance of the old and very old who die in the care home sector without their fair share of specialist help. The review of opioid use in the elderly by Natasha Michael (*Pain and the use of opioids in treating elderly patients*, page 6) examines several of these factors that militate against equitable service provision. She suggests mechanisms whereby access to pain relief might become fairer.

Psychological distress at the end of life remains underdiagnosed even in specialist palliative care units. The review of such psychosocial care inequity is provided by Venkateswaran and colleagues (*Making sense of end-of-life distress*, page 17). They highlight the need to distinguish symptoms of adjustment disorders from major depressive illness. They advocate adequate screening and adaptation of psychological techniques, rather than increased routine psychiatric service provision.

Beresford and colleagues (*Is specialist palliative care social work being neglected?*, page 22) report the results of a survey of specialist social work provision in palliative care. They point out how psychosocial care provision can be patchy and has, to date, been somewhat marginalised in national recommended practice and by vagaries of referral patterns. However, users clearly identify the value of equitable social work provision. The case for rectifying the low rate of referral to palliative care services for black and ethnic minority groups is quite clear from this survey.

It is no coincidence that the majority of voluntary hospices in Western Europe are named after Christian saints and tend to be situated in the more affluent areas of population. This is a reflection of the strong moral, religious and compassionate motivation that lay behind their foundation. There have now been many examples, throughout Europe, of extrapolating the philosophy of palliation to the generalist sector of healthcare. The article by Bejjani-Gebara and colleagues (*End-of-life care for Muslims and Christians in Lebanon*, page 38) moves this discussion further by contrasting the various cultural and religious practices prevalent in Lebanon. They emphasise the need to know and understand the Islamic and Christian viewpoints not only of their patients but also of themselves, in order to achieve equitable access to palliative care.

Finally, in the ‘EAPC news and views’ section (page 47), the *Access to pain relief* document published by Help the Hospices last September draws attention to the continuing inequity of analgesic availability across the world. This has been a recurrent issue that has been tackled to some extent by the World Health Organization over many years. However, there remains much work to be done. Clearly, we *palliateurs,* as well as our political masters, have our agenda set for the next few years.”

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Andrew Hoy, *Editor*