

Relieving Suffering as a Health System Responsibility: Governance and Global Inequities in Palliative Care [†]

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Abstract

Palliative care evolved through recognition of subjectively experienced suffering, yet its availability depends on how societies recognize, prioritize and act. This paper presents a narrative, conceptually oriented synthesis of interdisciplinary literature from social science, bioethics and global health policy to examine how concepts of consciousness and suffering shape the governance and distribution of palliative care within health systems, particularly between high-income and low- and middle-income countries. These disparities are mediated by resources, as well as regulatory regimes, financing structures, workforce authority, and political prioritization. Relieving suffering is a health system responsibility that requires policy coherence, proportionate regulation and accountability in addressing global inequities.

Keywords: global health; health inequities; palliative care; social institutions; suffering

1. Introduction

The recognition of human suffering at the end of life is a defining feature of palliative care. However, the capacity to perceive suffering, rooted in consciousness and subjective experience, does not automatically translate into systematic action to relieve it. Every year, more than 61 million people globally experience approximately 6 billion days of serious health-related suffering that could be alleviated with access to palliative care and pain relief [1]. Yet, access remains limited, with only 12% of the 40 million people requiring palliative care annually receiving it, most of whom reside in high-income countries [2]. These figures highlight a fundamental paradox: while suffering is universally experienced, its relief is unevenly institutionalized.

The provision of palliative care is not only a clinical challenge but fundamentally one of governance. Suffering becomes addressable at scale only when it is recognized, prioritized and operationalized through social institutions, including health systems, regulatory frameworks, financing mechanisms and professional structures. Global inequities in palliative care access reflect differences in how societies value and respond to suffering. The poorest 50% of the global population receive only 1% of opioid analgesics, while the richest 10% receive nearly 90% [1]. These disparities are not explained by resource constraints alone, reflecting deeper institutional and policy issues.



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This paper presents a narrative, conceptually oriented synthesis of interdisciplinary literature examining how concepts of consciousness and suffering shape the governance and distribution of palliative care within health systems, with particular attention to global inequities between high-income countries (HICs) and low- and middle-income countries (LMICs). The analysis draws on peer-reviewed publications, international policy documents and selected grey literature from palliative care, social science, bioethics, and global health policy to analyze why palliative care remains unevenly integrated despite strong international commitments, and explores institutional arrangements that have successfully expanded access in resource-constrained settings. The literature was selected purposively, prioritizing influential conceptual papers and illustrative examples relating to governance, institutional arrangements and global inequities in order to integrate diverse perspectives to develop a coherent conceptual analysis of palliative care as a health system responsibility.

2. Theoretical Framework: From Consciousness and Suffering to Institutional Responsibility

Palliative care is grounded in the recognition of subjectively experienced suffering, encompassing physical, psychological, social, and existential dimensions. This perspective, aligned with humanistic philosophy and person-centered care, situates consciousness as the locus through which individuals experience and interpret suffering. It represents a shift from biomedical models focused solely on disease to more holistic approaches that acknowledge lived experiences [3].

Several complementary conceptual perspectives have informed discussions of palliative care, including human rights approaches, the capability approach and broader health equity frameworks. The present paper adopts the lens of consciousness and suffering because it provides a conceptual bridge between individual lived experience and institutional responses required to address suffering at the population level.

However, using this conceptual lens, individual recognition of suffering does not address it at the population level. For suffering to be systematically alleviated, it must be institutionalized and embedded within the structures, norms, and practices of social systems. Thus, palliative care is a social institution and reflects how societies organize responses to suffering.

Institutionalization requires several key elements: normative recognition, resource allocation, enabling regulatory frameworks, workforce capacity, and accountability mechanisms [4]. Where these elements are weak or absent, even strong ethical commitments may fail to translate into effective service delivery. This helps explain persistent global inequities despite widespread endorsement of palliative care within frameworks such as universal health coverage.

3. Global Inequities: Comparative Analysis Between HICs and LMICs

Global disparities in palliative care mirror broader patterns of health inequality, manifesting across coverage, access to essential medicines, workforce capacity, and system integration.

3.1. Coverage and Access

Approximately 19 million people require palliative care annually, with nearly 78% residing in LMICs [5]. Of the estimated 21 million children globally requiring access to pediatric palliative care, 97% reside in LMICs [6]. However, service availability is disproportionately concentrated in HICs. In many LMICs, palliative care infrastructure remains minimal or non-existent, despite a higher need.

3.2. Opioid Access

Inequities in opioid distribution represent the most visible disparity. Globally, only 1% of opioid analgesics are distributed to low-income countries despite a disproportionate burden of need [7]. For example, India, accounting for a substantial proportion of untreated pain-related deaths, reported morphine consumption far below global averages. Importantly, multivariate analyses suggest that governance and health system characteristics explain much of this variation, indicating that access is partly determined by institutional design, rather than economic capacity alone.

3.3. Within- and Between-Country Variation

Disparities exist within countries and regions. In Latin America, inequities in cancer and palliative care access are widespread. In India, state-level differences, such as the relatively advanced system in Kerala, illustrate how subnational policies influence access.

4. Institutional Mechanisms: Regulation, Financing, and Workforce

The persistent inequities in palliative care access are mediated by several interrelated institutional mechanisms, which are summarized in Table 1. Regulatory frameworks governing opioid use represent a significant barrier, particularly in LMICs. While international conventions aim to balance access and control, national implementations can be excessively restrictive, imposing administrative and prescribing constraints that limit clinical availability. Evidence from India's amendment of the Narcotic Drugs and Psychotropic Substances Act demonstrates that regulatory simplification can significantly improve access to pain relief [8].

Table 1. Institutional determinants of palliative care inequity.

Domain	Key Barrier	Impact
Regulation	Restrictive opioid laws	Limited pain relief access
Financing	Low public funding	High out-of-pocket burden
Workforce	Limited prescribing authority	Service bottlenecks
Governance	Low political priority	Poor system integration

Health financing structures also play a critical role. In many LMICs, low public health expenditure and reliance on out-of-pocket payments restrict access to palliative care services. Even where palliative care is formally included in national policies, inadequate reimbursement mechanisms may render services financially unsustainable. For example, in Kazakhstan, existing insurance mechanisms have not translated into equitable access [2].

Workforce constraints also compound these barriers. Limited training opportunities, lack of formal recognition of palliative care as a specialty, and restrictive prescribing authority contribute to service bottlenecks. The concentration of opioid prescribing authority among specialist physicians is particularly problematic in settings with workforce shortages, limiting service delivery in both rural and community settings [9].

Finally, political prioritization remains a decisive factor. Despite international recognition of palliative care as a component of universal health coverage, many countries have not incorporated it meaningfully into national health strategies. The absence of monitoring systems and accountability mechanisms allows these gaps to persist, reflecting broader challenges in health system governance.

5. Alternative Institutional Arrangements

Despite these constraints, several models demonstrate that institutional redesign can expand access to palliative care in resource-limited settings. The Kerala model in India provides a prominent example of community-based care that integrates volunteer networks, primary care services, and supportive regulatory frameworks. By leveraging social capital and embedding palliative care within local communities, this model has achieved broader coverage despite limited resources. This Kerala model has been widely cited as a scalable innovation [10].

Task-shifting is another important strategy. Expanding prescribing authority to trained non-physician providers, such as nurses and clinical officers, has been shown to improve access to pain relief in settings with limited physician availability. When supported by appropriate training, supervision, and regulatory reform, task-shifting can address workforce bottlenecks while maintaining quality of care.

Mobile and home-based care models are additional adaptive approaches to service delivery. In Kazakhstan, the introduction of mobile palliative care teams has improved access for patients who are unable to attend facility-based services due to illness severity or geographic barriers. Similarly, non-governmental organizations have played a complementary role in extending services, particularly for vulnerable populations such as children with life-limiting conditions [11].

Together, these models demonstrate that in addition to resource availability, institutional flexibility is also a key determinant of access to palliative care.

6. Policy Implications and Health System Obligations

The findings of this analysis indicate that global inequities in palliative care are modifiable institutional arrangements. First, palliative care should be recognized as a core health system responsibility instead of an optional service. This requires explicit inclusion in national health policies, integration into essential health benefit packages, and allocation of dedicated resources.

Second, regulatory frameworks governing opioid use must be recalibrated towards proportionality. Many countries maintain restrictions that exceed international requirements, effectively prioritizing control over access. Reform should focus on simplifying prescribing procedures, expanding the pool of authorized prescribers, and ensuring reliable supply chains.

Third, sustainable financing mechanisms are essential to ensure equitable access. Integrating palliative care into national insurance schemes and ensuring adequate reimbursement can reduce financial barriers and support service provision across different care models, including home-based and community-based services.

Fourth, workforce development is critical. Expanding training opportunities and revising scope-of-practice regulations to support task-shifting can increase service capacity, particularly in underserved areas. This requires coordinated policy reform alongside investments in education and supervision systems.

Finally, global governance mechanisms should be strengthened to support accountability. International organizations can play a key role in monitoring progress, providing technical assistance, and advocating for the inclusion of palliative care within universal health coverage frameworks [12].

7. Conclusions

Palliative care originates from the recognition of human suffering, yet its effective delivery depends on how societies institutionalize responses to that suffering. While global inequities reflect differences in economic resources, other factors including governance, regulatory frameworks, financing structures, and political prioritization also play a key role.

Evidence from alternative models demonstrates that these barriers can be overcome through institutional reform. Expanding access requires policy coherence, proportionate regulation, sustainable financing, and workforce strategies that align with local contexts. Ultimately, ensuring equitable access to palliative care is both a technical and moral imperative, requiring health systems to recognize relief of suffering as a fundamental responsibility.

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Abbreviations

The following abbreviations are used in this manuscript:

HICs	High-income countries
LMICs	Low- and middle- income countries

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