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Multidimensional Palliative Care Needs and Perceived Barriers among Adult Patients with Chronic Illnesses: A Descriptive Comparative Study

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Abstract

Background: Adults with chronic illnesses often experience serious health-related suffering that extends beyond physical symptoms and requires multidimensional palliative care. Objective: This study assessed the palliative care needs and perceived barriers among adult patients with chronic illnesses in selected health facilities in Dagupan City. Methods: A descriptive-comparative, cross-sectional design was employed among 56 purposively selected adult patients diagnosed with chronic illnesses for at least six months. Data were collected using an expert-validated structured questionnaire that measured physical, psychological, social, spiritual, informational, and barrier-related needs. Frequency, percentage, weighted mean, independent-samples t-test, and one-way ANOVA were used at the 0.05 level of significance. Results: Respondents were mostly 60–74 years old, female, married or widowed, with elementary or high-school education, and commonly affected by long-term chronic conditions with comorbidities. High needs were observed across all domains: spiritual (M = 4.09), barriers (M = 4.07), social (M = 4.03), physical (M = 4.02), psychological (M = 3.99), and informational (M = 3.99). Financial constraints, limited palliative services, workforce gaps, and cultural reluctance to discuss end-of-life concerns were major barriers. Significant differences were found by age, illness duration, and comorbidity count. Conclusion: Palliative care should be stratified, holistic, culturally sensitive, patient-centered, equitable, and integrated early into clinical practice.

Keywords: *Palliative care; Chronic illness; Serious health-related suffering; Symptom burden; Patient needs; Health literacy; Spiritual care; Barriers to care*

Introduction

Palliative care has shifted from being viewed as end-of-life care for terminal cancer to a broader, needs-based approach for people experiencing serious health-related suffering from severe and chronic illness. Radbruch et al. (2020) defined palliative care as active, holistic care for persons with serious health-related suffering, with the goal of improving the quality of life of patients, families, and caregivers. This reconceptualization is important for adults with chronic illnesses because suffering is often multidimensional, involving pain, fatigue, breathlessness, anxiety, family strain, spiritual distress, and uncertainty about prognosis and treatment choices. The consensus definition by Radbruch et al. is reported in the *Journal of Pain and Symptom Management* with DOI 10.1016/j.jpainsymman.2020.04.027.

Globally, palliative care remains under-accessed despite increasing need. The Lancet Commission emphasized that inadequate access to palliative care and pain relief is a major issue in universal health coverage, particularly in low- and middle-income countries (Knaul et

al., 2018). Etkind et al. (2017) further projected that population aging and trends in chronic disease will substantially increase future demand for palliative care. Meta-analytic evidence also shows that palliative care is associated with improved quality of life, symptom burden, patient satisfaction, and advance care planning outcomes (Kavalieratos et al., 2016). These findings justify early integration of palliative care into chronic illness management rather than limiting it to terminal care. Knaul et al.'s Lancet Commission report carries DOI 10.1016/S0140-6736(17)32513-8, while Etkind et al.'s BMC Medicine article carries DOI 10.1186/s12916-017-0860-2.

In the Philippine and similar LMIC contexts, chronic illness care remains largely biomedical and episodic, with limited systematic assessment of physical, psychosocial, spiritual, informational, and care-access needs. Adults with cancer, cardiovascular disease, chronic respiratory illness, diabetes, kidney disease, and multimorbidity may continue receiving disease-directed treatment while simultaneously experiencing unmanaged distress. This study therefore assessed multidimensional palliative care needs and perceived barriers among adult patients with chronic illnesses, with attention to demographic and illness-related differences.

Methodology

This study employed a descriptive-comparative, cross-sectional design. The respondents were 56 adult patients with chronic illnesses receiving care in selected hospitals, outpatient clinics, and community-based health facilities in Dagupan City. Inclusion criteria required that respondents be 19 years old or older, have been medically diagnosed with a chronic illness for at least 6 months, be aware of their diagnosis, be physically and cognitively capable of answering the questionnaire, and be willing to participate. Patients in acute medical crisis, newly diagnosed patients, those with severe cognitive impairment, and those unable to provide valid consent were excluded.

A structured questionnaire was used to gather demographic and clinical data and to measure palliative care needs across physical, psychological, social, spiritual, informational, and perceived-barrier domains. The instrument was expert-validated by professionals with experience in palliative care, chronic illness nursing, and community health. Responses were rated using Likert-type indicators and interpreted using weighted means. Frequency and percentage described the profile of respondents; weighted mean determined the level of palliative care needs; independent-samples t-test and one-way ANOVA tested differences in needs when grouped according to demographic and illness-related variables at the 0.05 significance level.

Results and Discussion

Demographic and Clinical Profile

The respondents were predominantly older adults, with the largest age group falling within 60–74 years. Most were female, married or widowed, and had an elementary or high-school education. The common chronic illnesses included cancer, heart disease, kidney disease, diabetes, and chronic respiratory conditions. A substantial proportion had been living with illness for more than four years and had one or more comorbidities. This pattern reflects the

global association between ageing, multimorbidity, and increased palliative care need. Barnett et al. (2012) established that multimorbidity increases with age and is associated with greater care complexity, while Etkind et al. (2017) projected rising palliative care demand due to ageing and chronic illness trends. Barnett et al.'s *Lancet* study is indexed with DOI 10.1016/S0140-6736(12)60240-2.

Level of Palliative Care Needs

Domain	Overall Mean	Interpretation
Informational needs	4.13	Needed
Spiritual needs	4.09	Needed
Perceived barriers	4.07	Major barrier
Social support needs	4.03	Needed
Physical care needs	4.02	Needed
Psychological needs	3.99	Needed

The highest need was informational (M = 4.13), particularly regarding clear explanation of diagnosis, treatment options, home symptom management, prognosis, and decision-making guidance. This suggests that patients need clearer, more compassionate, and culturally sensitive communication from healthcare professionals. Early palliative care improves understanding of illness and supports decision-making, as shown in major palliative care trials and systematic reviews (Kavalieratos et al., 2016; Temel et al., 2010).

Spiritual needs were also high (M = 4.09), with respondents reporting a need for religious guidance, hope, inner peace, meaning-making, and assistance in dealing with existential concerns. This finding is particularly relevant in the Philippine context, where religious faith and family-centered coping strongly influence illness experience. Contemporary literature emphasizes spiritual care as a necessary component of whole-person palliative care rather than an optional addition (Best et al., 2023; Radbruch et al., 2020).

Physical care needs were high (M = 4.02), with pain relief, breathlessness management, fatigue control, sleep support, mobility assistance, nutrition support, and general symptom control identified as important needs. This is consistent with Solano et al. (2006), who found pain, breathlessness, and fatigue to be common across advanced cancer, AIDS, heart disease, COPD, and renal disease. The findings indicate that symptom assessment and management should be routine for adults with chronic illnesses, regardless of diagnosis.

Psychological needs were high (M = 3.99), particularly anxiety management, emotional support, coping with uncertainty, sadness, fear, and access to counseling. Chronic illness often creates uncertainty about disease progression, treatment response, family responsibilities, and financial stability. Palliative care interventions have been associated with improvements in quality of life and symptom burden, although effects vary by study quality and setting (Kavalieratos et al., 2016). The JAMA meta-analysis by Kavalieratos et al. (DOI 10.1001/jama.2016.16840) found evidence of improvements in patient quality of life and symptom burden.

Social support needs were high (M = 4.03), especially family support, assistance with daily activities, transportation, financial help, and communication within the family. In family-centered health systems, relatives often function as primary caregivers, yet they may lack financial, emotional, and technical support. These findings imply that palliative care plans should include family assessment, caregiver preparation, social work referral, transport assistance, and financial navigation.

Perceived Barriers to Palliative Care

The overall barrier score was high (M = 4.07), indicating that respondents perceived major obstacles to receiving adequate palliative care. The strongest barriers were financial constraints (M = 4.25), limited access to palliative services (M = 4.10), lack of trained personnel (M = 4.05), cultural reluctance to discuss end-of-life concerns (M = 4.00), and inadequate information (M = 3.95). These barriers show that unmet palliative needs are not purely clinical; they are also economic, institutional, educational, and cultural.

The findings align with global evidence that access to palliative care is constrained by workforce shortages, low service integration, limited access to medicines, weak referral systems, and inadequate public awareness, especially in LMICs (Knaul et al., 2018; Sleeman et al., 2019). Thus, improving palliative care requires more than individual patient counseling. It requires institutional protocols, workforce development, referral networks, community education, and financial protection mechanisms.

Differences in Palliative Care Needs

Significant differences in palliative care needs were found according to age group ($p = .041$), illness duration ($p = .038$), and comorbidity count ($p = .025$). No significant differences were found by sex ($p = .081$) or educational level ($p = .067$). These results suggest that disease burden, duration, and multimorbidity are stronger determinants of palliative care need than sex or educational attainment in this sample.

Older adults, patients with longer illness duration, and those with more comorbidities reported higher levels of need. This is consistent with Barnett et al. (2012), who linked multimorbidity to increased healthcare complexity, and Etkind et al. (2017), who identified aging and chronic progressive illness as major drivers of future palliative care demand. Practically, this means that palliative screening should prioritize patients with multiple chronic conditions, prolonged disease trajectories, recurrent admissions, functional decline, or repeated symptom complaints.

Conclusions

The study concludes that adult patients with chronic illnesses experience substantial multidimensional palliative care needs. Informational, spiritual, social, physical, and psychological domains were all rated as needed, while financial, service-access, workforce, communication, and cultural barriers were identified as major obstacles. Significant differences by age, illness duration, and comorbidity count indicate that palliative care should be stratified according to clinical risk and disease burden.

Healthcare institutions should integrate routine palliative care screening into chronic illness management, strengthen symptom-control protocols, expand patient and family education, provide psychosocial and spiritual support, and establish referral pathways to

specialized palliative services. Policy and institutional responses should also address affordability, workforce training, culturally sensitive communication, and continuity of care. A holistic, early, and patient-centered palliative care model is necessary to reduce suffering and improve quality of life among adults living with chronic illness.

AI DECLARATION STATEMENT

AI tools were used only for grammar refinement, formatting, and manuscript organization. The data, analysis, interpretation, and conclusions remain the sole responsibility of the author.

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