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Which public health approach to palliative care? An integrative literature review.

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Abstract

Background: Public health and palliative care are both broad disciplines with blurred boundaries. There is growing support for an alignment of palliative care to public health. Given the novel nature of this alignment and the ambiguity of the parent definitions, there is an understandable lack of clarity around this merged model.

Methods: The aim of this study is to describe the theoretical features of the public health approach to palliative care as articulated in the current research literature. An integrative literature review was conducted using systematic methods to identify qualitative and quantitative studies that expressly support such an approach.

Results: The search identified 18 studies. A thematic synthesis of these studies identified three different paradigms of a public health approach to palliative care within the current empirical research. These were defined as *a health promotion approach* focussed on empowerment at community level, a *World Health Organisation approach* which focussed on systems at country level, and a *population-based approach* which typically viewed palliative care issues from an epidemiological perspective.

Conclusion: This review highlights that the public health approach to palliative care is understood in various ways. It is important that future research studies clarify *which* public health approach they are referring to.

Keywords: palliative care, end of life, public health, health promotion, theory, models, frameworks

Introduction

Although many countries have adopted their own definition of palliative care, most are based upon that proposed in 2002 by the World Health Organisation (WHO), which states that: ‘Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual’.¹ This definition goes on to clarify that palliative care is appropriate early on in the disease, and that it is also applicable to patients with non-cancer diagnoses. Both these points were lacking in the earlier 1990 definition.² Changes such as these have added breadth, and possibly ambiguity to what constitutes palliative care.³ In addition, Pastrana et al.⁴ have eloquently described how changes in terminology over time have negatively influenced the understandings of palliative care in that definitions have grown more diverse, and there now exists a plethora of overlapping terms with diverse meanings.

Similarly to palliative care, many definitions of public health exist. Possibly one of the older, yet enduring definitions originates from Winslow who described public health as, ‘the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health’.⁵ A different take on public health was brought about by the

Ottawa charter in 1986.⁶ The charter heralded what is known as known as the *new public health*, or *health promotion*. This was a movement away from a narrow bio-medical model towards a broader conceptualisation of well-being that acknowledges the influence of the person and their social context.⁷ In general terms, health promotion encompasses a range of interventions that seek to modify behaviour and the environment in order to improve health.⁸

It is therefore hardly surprising that the public health approach to palliative care (PHAPC) which encompasses the ideas and concepts of these two broad, evolving disciplines, poses some challenges for theoretical clarity. Indeed, recently in the editorial for a special edition of articles on community engagement in the journal *Progress in Palliative Care*, Rumbold⁹ acknowledges the, 'breadth and ambiguity of public health frameworks' and Clark¹⁰ has also highlighted this lack of clarity. A public health approach to palliative care, or the linking of the two disciplines has been made in a number of ways. Dzinga and Higginson¹¹ state that the first reference to palliative care being identified with public health was in a paper by Wilkes¹² published in *The Lancet* in 1984. This paper highlighted the fact that chronic conditions were responsible for more deaths than cancer and on this basis argued that palliative care needs to be more integrated into public health services.¹² Clark¹³ identifies the first real linking of palliative care to public health as having occurred within the WHO, and in particular in the work of one time Chief of Cancer, Jan Stjernswärd. Either way, palliative care is now commonly referred to as a public health concern by the WHO who often frame this association in the language of the their Public Health Model which aims to integrate palliative care into all levels of society. Policy, drug availability, education and implementation are key elements of this strategy.¹⁴

A different, but equally important, connection between palliative care and public health is that made by sociologist Allan Kellehear. He proposes a public health model of palliative care that aligns the principles of palliative care with those of health promotion as outlined in the Ottawa Charter.¹⁵ These health promoting ideas are now well known in Australia and the UK in particular. Kellehear is closely associated with the Public Health and Palliative Care International Association (PHPCIA) which defines a public health approach to palliative care as, ‘one that views the community as an equal partner in the long and complex task of providing quality health care at the end of life. Just as health, according to WHO, is “everyone’s responsibility” so too is death, dying, loss and care.’¹⁶ While this definition acknowledges the social aspect of the WHO’s take on health, it makes no overt reference to WHO’s public health strategy for palliative care.

These variations in theoretical frameworks for understanding the interface between public health and palliative care form the backdrop and impetus for this review of the current research literature. The aim of the review was to identify studies that explicitly claim to support a PHAPC in order to explore variations in theoretical understandings of what such an approach actually constitutes.

Methods

The review follows the framework put forward by Whittemore and Knafel¹⁷ for rigorous integrative literature reviews, allowing for the inclusion of qualitative and quantitative data.

The search was carried out by C.D. with the help of a specialist librarian at Auckland University during December 2015. The databases Cinhal, Medline and Psychinfo were searched using combinations of the following search terms: palliative care, hospice, terminal care, end-of-life care, public health, health promotion, community engagement, community development, compassionate communities, social capital and social networking. The search was limited to empirical studies, published between 2005 and 2015, written in English, and that expressly acknowledged their study as sitting within the framework of a public health or health promoting approach to palliative care.

Details of the selection process are outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) chart.¹⁸

(Insert figure 1 near here)

Data evaluation stage

Integrative literature reviews do not lend themselves to evaluating the quality of data, due to the challenge of applying uniform quality criteria to such a diversity of research designs.¹⁷ Furthermore, the focus of this review was not the research findings, but the conceptual framework adopted and therefore quality was less relevant than in a traditional systematic review. Therefore, the studies included in the review were not assessed for quality before analysis.

Data analysis stage

The analysis of the data from the literature took place over three stages, and was based on the flexible method for thematic analysis suggested by Braun and Clarke.¹⁹ Firstly,

to aid with data familiarisation a basic literature chart was developed to sort and organise the data, and then a thorough reading of each study was undertaken. A table summarising the included studies may be found in the appendix. Secondly the data were coded based upon the words the authors associated with a PHAPC. Braun and Clarke¹⁹ refer to this as, ‘coding to identify a particular feature of the data set’. In order to do this, text that included the search terms and their surrounding context were extracted. These data extracts were then used to generate codes. Thirdly, the codes were analysed for patterns in content or meaning, as suggested by Saldana.²⁰ These were grouped together into bigger sub-themes and themes. Themes were reviewed by both C.D. and M.G. until consensus was reached.

Results

Of the eighteen articles identified by the search, four were mixed methods, five were quantitative, and nine were qualitative. Of the mixed methods studies, two were evaluation studies. The dominant method for data collection in the qualitative studies was interviews (n=7). Amongst the quantitative studies, the use of surveys (n=4) was most prevalent.

(Insert Figure 2 near here)

Social or caring networks were the subject of three of the studies. Bereavement, place of death and public awareness were each the subject of two studies. The remaining topics were each the subject of one study: service delivery through community groups, service delivery through home care services, palliative care professionals, the uptake of a PHAPC, education, opioid availability and existential issues.

Three overarching themes were created which relate to how a PHAPC was conceptualised by the authors of the studies. These are now discussed:

Theme 1 - Health promotion approach

This theme, namely a *health promotion approach* captures how twelve²¹⁻³² of the articles articulated a PHAPC, and this was the dominant theme in the literature. Eleven of these studies used the actual words, 'health promotion' to frame their study, and the one²⁷ study that did not, referenced the works of Kellehear on health promotion as the theoretical underpinning of a PHAPC.

Three sub-themes were identified within this theme. The first was that of *community*. Many of these studies referred to the importance of community in their descriptions of a PHAPC. Four^{21,24,25,29} studies promoted the use of community as providers of care over the further development of formal services. Horsfall et al.²³ advocated for a move away from traditional health promotion, where community members might be the passive recipients of education, to a more active model where they are agents of care provision through informal networks. Likewise, Paul and Sallnow³⁰ argue for a move away from traditional public health methods towards a community engagement approach where the community are active in their own care. The use and growth of social networks in end-of-life care was seen as a demonstration of a community development model in the study by Leonard et al.²⁴ In all the studies, the term 'community' appeared to refer to people or places or both. While Mills et al.²⁹, Leonard et al.²⁴ and Horsfall et al.²³ all acknowledged the challenge of actually defining community, only Mills et al.²⁹ stated their particular definition in the context of their study. They write, 'in this context,

communities are represented by existing or potential networks of individuals and groups that either share or have the potential to share common concerns or goals'.^{29(p219)}

The second sub-theme identified was *assets*. The codes that informed the development of this sub-theme all described asset-based rather than deficit-based thinking. For example, in Benzein and Savemans'²² descriptions of health promoting conversations, the authors highlighted the need for acknowledging resources and wellness as opposed to deficits and illness. Three²³⁻²⁵ of these studies, all Australian, were concerned with social capital, which Lewis et al. describe as a 'relational resource'.^{25(p2)} It was reasoned that social capital in the form of caring networks furthers public good by meeting wider needs²³, contributes towards a de-medicalisation of death²⁴, helps care for disadvantaged populations, and adds to greater sustainability²⁵. One³² study considered health promotion as an empowering model that decreased dependence on statutory services.

The third sub-theme had to do with the described *benefits* of a health promotion approach. The background to Lindqvist and Tishelman's²⁶ study describes how using opportunities to reflect on death and dying helps to break down taboos and increase awareness of end of life issues. These two benefits, along with improving access to palliative care, are identified as the outcomes of a PHAPC by McIlfatrick et al.²⁷ Paul and Sallnow³⁰ also cite examples of how community engagement methods have improved access to palliative care services. Two studies^{30,31} mentioned holistic care as an intended outcome of health promoting palliative care. Other benefits mentioned included achieving a 'good death'³¹ and positive changes in knowledge, attitudes and

behaviours.²⁸ Additional benefits of recognising and developing social capital have been described in the sub-theme *assets*.

Theme 2 – World Health Organisation (WHO) approach

All three studies³³⁻³⁵ that contributed codes towards this theme expressly acknowledge the use of WHO guiding documents and strategies related to palliative care. Two^{34,35} of the articles reported evaluation studies using mixed methods, and were based in African countries. The other study³³ was an international study that used epidemiological methods to determine variables that might be associated with opioid availability. All three studies considered their topic from a national perspective and all three spoke of integration into the existing public health systems as being a goal to strive towards. Integration was also spoken of in terms of palliative care being incorporated into national policy.³⁴ Two studies^{34,35} made reference to the national burden of palliative needs, and also articulated the need for better reach of service provision. Equitable service provision and the development of programmes were described by Grant et al.³⁴ as being necessary and important. In Logies' study³⁵, the issue of funding and sustainability was raised in terms of palliative care service provision.

One study²⁷ fitted into both themes of the *WHO approach* and *Health promotion approach*. This study advocated for incorporating elements from both paradigms, arguing, 'the need for a parallel approach ensuring that palliative care is more integrated into health service systems alongside a continued public health approach to palliative care in order to eradicate social taboos and ensure services are sought out when required'.^{27(p6)} This was the only study that acknowledged dichotomous models, and

from this extract it is implied that one approach is socially orientated and the other systems orientated.

Theme 3 – Population-based approach

Three studies³⁶⁻³⁸ did not fit comfortably into either of the first two themes. Of these three studies, two made very limited reference to the WHO strategic documents related to palliative care (in comparison to those allocated to the *WHO approach* theme), and one made no mention of the WHO at all. Neither did these three studies fit into the first theme *health promotion approach* since they made no reference to health promotion. Thus the third theme, a *population-based approach* was generated using the codes from these three articles. A valuing of population level data was evident in all three studies; one³⁸ was a population-based survey, one³⁷ expressly advocated a population based approach, and the third³⁶ was a pilot survey that recommended the results be tested in a larger population-based study. Foundational elements of traditional public health namely epidemiology, research and policy are described by Lupu et al.³⁷ as the tools of public health necessary for a PHAPC. In the study by Wilson et al.³⁸ which considered public preferences regarding the place for end-of-life care, epidemiological concepts were considered and a good home death was described as the desirable outcome of public health interventions at the end of life. The developments of service provision options, as well as the development of community capacity, are acknowledged in the study by Aoun et al.³⁶ This study also recognised the importance of cost savings and equity in allocating resources in the context of a public health model.

(Insert Figure 3 near here)

Discussion

The three themes identified in this literature review may be thought of as three different paradigms of a PHAPC. The *health promotion approach* is the dominant articulation of a PHAPC in the current literature. Noteworthy is the prevalence of the term *social capital* in the articles that contributed to the *health promotion approach* theme. Social capital is a concept growing in popularity within the social science literature.³⁹ It has also been proposed as a potential model to support well-being in palliative care.⁴⁰ The term neatly covers a range of beneficial social links within groups, between groups and across hierarchies. However, as a concept, it has been criticised on a number of points including its' lack of clear definition; the simplistic use of the term to cover an extensive range of phenomena; its inability to recognise cross-cutting links of gender, ethnicity and class; and the implied meaning of the word 'capital' being that it only generates positive outcomes.³⁹ These criticisms have not been addressed within the palliative care literature, indicating a need for palliative care to more fully engage with literature in other disciplines where the theoretical foundations of key concepts drawn upon in health promoting palliative care have been widely critiqued.

The second paradigm identified by the review was the *WHO approach* which reflects the ideas of the WHO Public Health Strategy for Palliative Care.¹⁴ As mentioned earlier, this strategy highlights four essential pillars for improving and integrating palliative services into country health systems, namely policy, drug availability, education and implementation. These features, specifically integration, a health systems focus, the importance of policy and opioid availability were clearly associated with a PHAPC in the three studies linked to this theme. It appeared that taking a public health approach meant measuring palliative care success in terms of how well integrated

it was into the mainstream health systems, how significantly it was reflected in policy, and how widely available opioids were.

These first two paradigms appear to have different goals. Those studies reflecting the *WHO approach* are concerned with integrating palliative care into health systems, at country level predominantly, and therefore reach and service provision are core concerns. The studies linked to a *health promotion approach* talk much about social empowerment and the de-medicalisation of death, and this seemingly at a community level. However, while this does show different emphases, it cannot be said that these two themes are mutually exclusive, because arguably the goals of one would support the goals of the other being achieved. Community empowerment and mobilisation would certainly improve reach, as has been demonstrated elsewhere.⁴¹ Also, it must be acknowledged, that although not made clear in the studies included in this review, social participation and community ownership is unambiguously upheld in the WHO Public Health Strategy for Palliative Care and therefore this is shared ground between these two approaches.

The third way in which palliative care issues were associated with public health in the literature was simply from a population perspective, often relying on the science of epidemiology for evidence. This paradigm may be described as a *population-based approach*. Public health has been called a population science in that it is concerned with issues affecting groups of people rather than individuals. Perhaps a population perspective aligns palliative care issues with public health simply because they affect a significant number of people. The studies that reflected this conceptualisation made no explicit link to health promotion or the Ottawa charter, and none to the WHO public

health strategy for palliative care. Again, this does not mean that this approach sits in isolation of the first two. Indeed a population approach and the use of epidemiology may be employed and upheld by proponents of all three paradigms.

Limitations

Whilst rigorous and systematic methods were used to conduct this review, certain limitations must be acknowledged. Due to resource constraints we were only able to include papers written in English and the search was limited to the published literature contained in the included databases. It is also acknowledged that the breadth of the topics under consideration might have limited the sensitivity of the search.

Conclusion

This integrative literature review makes an important contribution to current understandings of the integration of a public health approach into palliative care research. We identified eighteen research papers that expressly identified their studies as nested within a PHAPC. A thematic analysis of the texts has shown that a PHAPC was conceptualised by the authors of these studies in three different ways. The dominant theme was that of a *health promotion approach*, the other two less dominant themes were labelled a *WHO approach* and a *population-based approach*. It must be acknowledged that these three themes share significant common ground which in itself can add to the confusion. In addition, key concepts adopted from the discipline of public health, notably ‘community’ and ‘social capital’ are rarely defined, pointing to an urgent need for further engagement by palliative care researchers with the theoretical underpinnings of public health approaches. The need to pin down these understandings is important not only for the sake of clarity, but also for the future growth and

application of these ideas within palliative care. In light of this, we recommend that authors make clear which PHAPC they are drawing on to inform their research.

Disclaimer statements

Contributors C.D is the main author and takes responsibility for the content of this article. All data collection and analysis was guided by M.G and completed by C.D. The manuscript was critically revised by both authors. This study forms a part of a master's thesis for which M.G. is supervisor.

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Conflicts of interest The authors declare no conflicts of interest.

Ethics approval Ethics approval was not deemed necessary for this literature review, however the thesis of which forms a part has been approved by the University of Auckland Human Participants Ethics Committee reference number 016999.

Appendix

(Insert table 1 near here).

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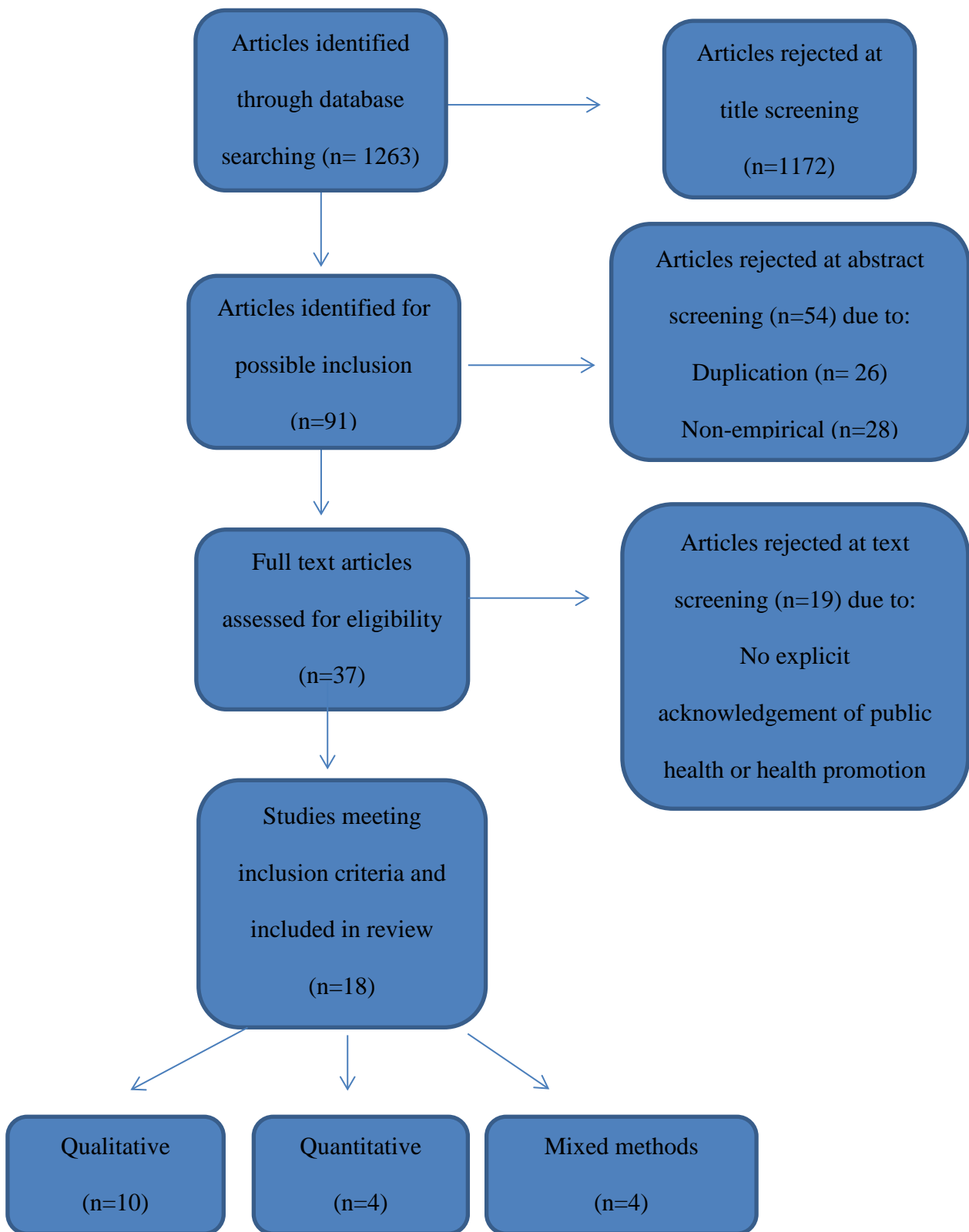


Figure1 PRISMA flow diagram detailing selection of articles

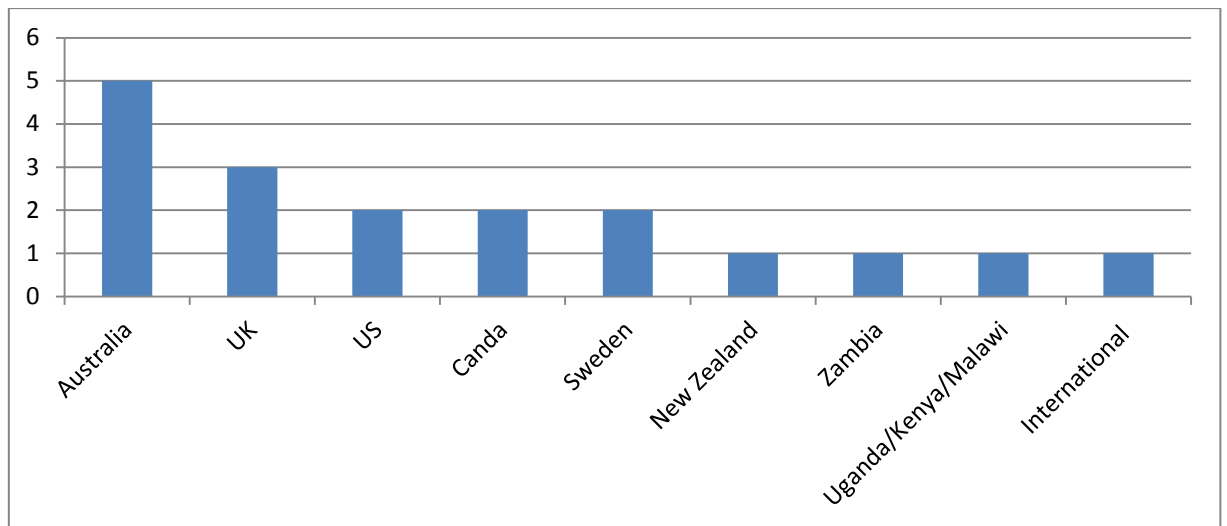


Figure 2 Chart showing the geographical origins of included studies

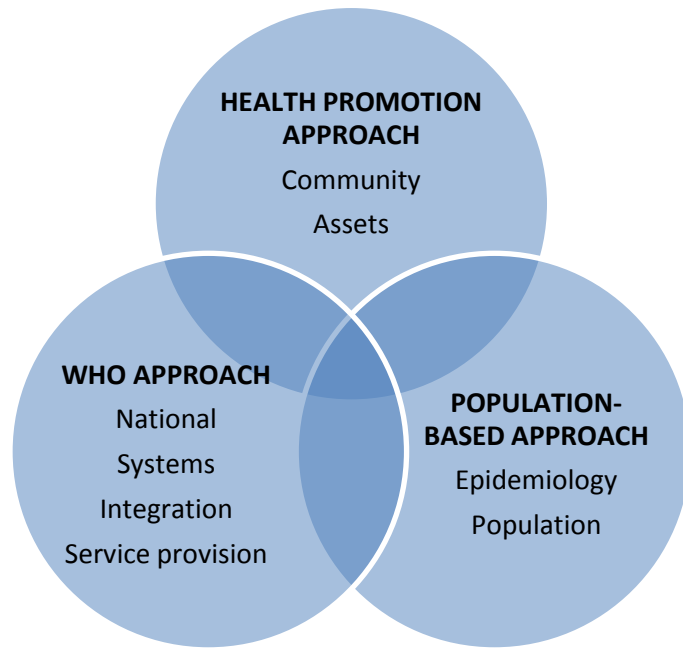


Figure 3 Themes: The articulation of a PHAPC in the literature

Table 1 Literature Chart of all included studies

Author, Year, Country	Aim of Study	Participants/ sample	Study Design and Method	Key Findings	Link to PHAPC	Theme
Aoun et al., 2014 Australia	To pilot test a survey associated with a theoretical public health model for bereavement support	23 clients from 3 funeral providers 6-24 months post bereavement	Quantitative and qualitative data from a postal survey	Empirical support for the survey and the model was gained	The bereavement model proposed here is population based – different levels of interventions target different populations	Classic public health approach
Bellamy et al., 2014 New Zealand	To explore older peoples experiences around bereavement support	28 bereaved older adults from 3 different regions	Qualitative Telephone interviews	Family and friends play a pivotal supportive role in bereavement, as do community based organisations. The need for formal bereavement services was questioned by the majority of participants	The use of existing community supports in bereavement care is highlighted and there is explicit linking to the work of Kellehear	Health promotion approach
Benzein	To	6 couples,	Qualitative	Health	Health	Health

<p>& Savema, 2008</p> <p>Sweden</p>	<p>describe couples experiences of taking part in nurse-initiated health promoting conversations about existential issues</p>	<p>where one of them had advanced cancer and was receiving care from a palliative care home team</p>	<p>e Semi-structured interviews</p>	<p>promoting conversations about hope and suffering were found to be beneficial</p>	<p>promotion in palliative care was central to this study and explicitly referred to</p>	<p>promotion approach</p>
<p>Gilson et al., 2013</p> <p>International</p>	<p>To examine the influence of governments and health systems on opioid availability</p>	<p>177 countries consumption of opioids in relation to other variables such as human development index, palliative care infrastructure, health system resources and expenditure</p>	<p>Quantitative Multivariate regression</p>	<p>Few predictor variables can explain opioid consumption, although a high human development index was associated with higher opioid consumption</p>	<p>Specific reference is made to the “WHO public health approach to developing palliative care”. Opioid availability is a key pillar of the WHO strategy</p>	<p>WHO approach</p>
<p>Grant et al., 2011</p> <p>Uganda, Kenya, Malawi</p>	<p>To describe local perspectives on the impact of three community-based palliative care</p>	<p>33 patients, 27 family carers, 36 staff, 25 volunteers and 29 community leaders Uganda,</p>	<p>Evaluation study using interviews, observations and routine statistical data</p>	<p>Holistic care was delivered effectively and “good” deaths were achieved at home. Mobile</p>	<p>Key points in the discussion included access to oral morphine, and the impact of health systems on programme delivery. The</p>	<p>WHO approach</p>

	interventions	Kenya, Malawi		phones facilitated access to clinical and social support networks	conclusion recommended a “public health approach” to more effectively meet national needs	
Horsfall et al., 2012 Australia	Nature, quality and effect of social networks i.e. how they function	94 carers representing 17 caring networks in New South Wales	Qualitative creative methods (photo voice, network mapping and interviews)	Carers can successfully mobilise informal networks of supports to care for the dying at home	Social networks were described in terms of social models of care, social capital and community development. The background to the study referenced the work of Rumbold and Kellehear	Health promotion approach
Leonard et al., 2015 Australia	To analyse the caring networks of people with a terminal illness and identify changes over the time of caring	77 people (in 9 focus groups) from the caring networks of 9 patients	Qualitative and quantitative (Social network mapping in focus groups)	Social networks were shown to increase in size, and the ties between members to strengthen over time. Core and peripheral networks were identified, and there was a diverse	End of life caring was articulated as contributing towards social capital, and explicit links were made to Kellehear, community participation and development	Health promotion approach

				contribution to care		
Lewis et al., 2014 Australia	To explore the nature of caring networks in lower socioeconomic populations	16 patients and 6 informal carers in Western Sydney	Qualitative Semi-structured interviews	Identified networks were mostly inadequate to meet needs for care	Caring networks were described in terms of social capital and health promotion was used to frame the study in the discussion	Health promotion approach
Lindqvist & Tishelman, 2015 Sweden/ international	To explore the preferences for the surroundings in which death takes place	Visitors to a museum exhibition yielded 512 responses from 46 countries	Qualitative Questionnaire Single question, open-ended	Eight categories of preferred death surroundings are identified: familiar death, larger than life death, lone death, mediated death, calm and peaceful death, sensuous death, green death, distanced death	Health promoting palliative care was explicitly acknowledged as the framework for this study, and the exhibition was to “promote public awareness” around death and dying	Health promotion approach
Logie, 2012 Zambia	To evaluate the implementation of an advocacy	8 palliative care organisations	Evaluation study Multiple methods (desk surveys, interviews)	The four pillars of WHO’s public health strategy are vital to	The initiative under evaluation aimed to achieve country level improvement	WHO approach

	strategy to improve palliative care in Zambia		, field trips)	success. Ongoing financial support is needed to maintain palliative care infrastructure	s in access to palliative care, explicitly based upon the WHO palliative care public health strategy	
Lupu et al., 2013 U.S.	To quantify the courses available that teach palliative care from a public health perspective	Schools of Public Health in the U.S.	Quantitative Survey of the web	Only 6 out of 49 schools included palliative care content in their curricula	A public health approach to palliative care is explicitly mentioned, and is defined as a “population based view” employing the tools of public health discipline (ie epidemiology , policy analysis)	Classic public health approach
McIlfatrick et al., 2013 Ireland	To establish current awareness and attitudes of palliative care among the general public	600 responses from members of the public	Quantitative Cross-sectional survey Structured questionnaire	Poor awareness of palliative care was found, especially among those with no previous exposure to hospice services	The study makes explicit links to a “public health palliative care or health-promoting palliative care” referencing the work of Kellehear	Health promotion approach
McIlfatrick et al., 2014 Ireland	To explore public perceptions of palliative	50 members of a community scheme	Qualitative Semi-structured telephone	Experience generates understanding and	Specific reference is made to Kellehear’s health	Health promotion approach

	care in light of health promoting palliative care requiring more public ownership	in Northern Ireland	interviews	targeted educational strategies are required	promoting palliative care, and how low levels of public awareness are a challenge to the goals of a PHAPC	
Mills et al., 2015 Australia	To explore community-based activities around end of life care that might link in with the philosophy of health promoting palliative care	10 representatives from 8 local community groups with an interest in EOL issues in the Australian Capital Territory	Qualitative In depth semi-structures interviews and field notes	Themes identified from this study were practical support, respect and responsiveness, connection and empowerment. These were especially evident in groups where socialisation, peer support and normalisation were promoted.	It was clearly articulated that this study was concerned with health promoting palliative care and building community capacity in end-of-life care	Health promotion approach
Paul & Sallnow, 2013 U.K.	To scope if the public health approach to EOL care is a priority for UK	146 services from four UK countries	Quantitative (one open-ended question) Online survey	A public health approach to palliative care is a priority for the	This study was explicitly about exploring the uptake of the public health approach to palliative care	Health promotion approach

	hospices			majority of UK hospices, and a range of work is being undertaken in this area.	in the UK. This approach was seen as synonymous with the terms <i>compassionate communities</i> , and <i>health-promoting palliative care</i>	
Pizzi, 2014 U.S.	To determine what professionals think about their work, and how does this thinking shape their practice	12 hospice professionals from 4 disciplines and different organisations	Qualitative In-depth interviews	Promoting a good death was the overarching theme	The conceptual framework for this study made specific mention of the Ottawa charter and discussed the links between health promotion and palliative care	Health promotion approach
Stajduhar et al., 2011 Canada	To examine the interpretation of family empowerment by home care services	13 leaders from 3 health care agencies in British Columbia	Qualitative In-depth semi-structured interviews	Empowerment was seen as the long term goal of client/family self-care	Empowerment was articulated as a principle of health promotion. The work of Kellehear was referenced and specific mention of health promoting palliative care	Health promotion approach
Wilson et al., 2013 Canada	To determine public preferences for final days of life	1203 adults living in Alberta Representative	Quantitative Survey by telephone	Home is the preferred place for end-of-life care for most	This study was framed as taking a “public health perspective” on end-of-life care.	Classic public health approach

		populatio n-based sample		people living in Alberta.	Importance was placed on gaining a representativ e population based sample	
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List captions for figures and tables:

Figure 1 PRISMA flow diagram detailing selection of articles

Figure 2 Chart showing the geographical origins of included studies

Figure 3 Themes: The articulation of a PHAPC in the literature

Table 1 Literature Chart of all included studies