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Multidimensional Palliative Care Needs and Perceived Barriers among Adult Patients with Chronic Illnesses in Dagupan City, Philippines: A Descriptive Study

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Abstract

This descriptive study assessed multidimensional palliative care needs and perceived barriers among adult patients with chronic illnesses in Dagupan City, Philippines. Fifty-six adult respondents diagnosed with chronic conditions such as cancer, cardiovascular disease, chronic respiratory illness, diabetes, and kidney disease participated through purposive sampling. Data were gathered using a structured, expert-validated questionnaire that measured demographic and clinical profiles, physical care needs, psychological needs, social support needs, spiritual needs, informational needs, and perceived barriers. Frequency, percentage, weighted mean, independent-samples t-test, and one-way analysis of variance were used. Findings showed that respondents were mostly aged 60–74 years, female, married or widowed, and living with long-term illness and comorbidities. All palliative care domains were rated as needed, with informational needs recording the highest mean, followed by spiritual, barrier-related, social, physical, and psychological domains. Pain relief, breathlessness management, anxiety control, family support, financial assistance, religious guidance, explanation of diagnosis, treatment information, and decision-making guidance emerged as priority concerns. Major barriers included financial constraints, limited access to palliative services, shortage of trained personnel, inadequate information, and cultural reluctance to discuss end-of-life matters. Significant differences were found by age, illness duration, and comorbidity count. Results support integrated, culturally responsive palliative care planning in hospital and community care settings.

Keywords: *Palliative care, Chronic illness, Symptom burden, Psychosocial needs, Spiritual care, Health communication, Comorbidity, Dagupan City*

Introduction

Palliative care has become an essential component of chronic illness management because adults with progressive noncommunicable diseases frequently experience pain, dyspnea, fatigue, emotional distress, spiritual concerns, social burden, and uncertainty regarding prognosis and treatment. Contemporary palliative care is defined as holistic care for people of all ages experiencing serious health-related suffering, with the goal of improving quality of life for patients, families, and caregivers (Radbruch et al., 2020). Global evidence further shows that access to palliative care and pain relief remains inequitable, particularly in low- and middle-income countries where financial barriers, limited trained personnel, and restricted service availability intensify suffering (Knaul et al., 2018).

Chronic illnesses such as cancer, cardiovascular disease, chronic respiratory disease, diabetes, and kidney disease often involve prolonged illness trajectories and complex symptom clusters. Multimorbidity increases with age and is associated with greater healthcare use, functional limitation, and psychosocial distress (Barnett et al., 2012). Projections of palliative care also indicate that aging populations and deaths from chronic disease will increase demand for integrated palliative services (Etkind et al., 2017).

Evidence from randomized trials and meta-analyses indicates that early and integrated palliative care can improve quality of life, symptom burden, mood, patient satisfaction, advance care planning, and healthcare utilization outcomes (Temel et al., 2010; Kavalieratos et al., 2016). However, palliative care must extend beyond physical symptom management. Spiritual care is also recognized as a fundamental component of quality palliative care, particularly in culturally religious settings where illness, suffering, hope, and death are interpreted through faith and meaning-making (Puchalski et al., 2009).

In the Philippine context, adult patients with chronic illnesses often depend heavily on family caregivers, out-of-pocket resources, and fragmented health services. Local evidence is needed to determine which palliative care domains are most urgent and which patient groups require priority intervention. This study therefore assessed the physical, psychological, social, spiritual, informational, and barrier-related palliative care needs of adult patients with chronic illnesses in Dagupan City.

Methodology

This study employed a descriptive, cross-sectional, and comparative design. It described the demographic and clinical profile of adult patients with chronic illnesses and assessed their palliative care needs across physical, emotional/psychological, social, spiritual, informational, and perceived-barrier domains. The design was appropriate because the study measured patient-reported needs without introducing clinical intervention or manipulating variables.

The respondents were 56 adult patients diagnosed with chronic illnesses who were receiving care in selected hospitals, outpatient clinics, and community-based health facilities in Dagupan City. Inclusion criteria required respondents to be 19 years old or older, diagnosed with a chronic illness for at least 6 months, aware of their condition, physically and cognitively capable of responding, and willing to participate. The study used purposive sampling to ensure that the participants had direct experience of chronic illness and palliative care-related needs. The uploaded thesis states that the respondents were adult patients with chronic illnesses from selected health facilities in Dagupan City and that the instrument measured six domains: physical, emotional, social, spiritual, informational, and perceived barriers.

Data were collected using a structured, expert-validated questionnaire. The instrument contained sections on demographic profile, illness type and duration, comorbidities, physical symptoms, psychological concerns, social support, spiritual needs, informational needs, and perceived barriers to care. Responses were rated using a five-point Likert scale and interpreted

through weighted means. Frequency and percentage were used for profile variables, weighted mean for domain-level palliative care needs, independent-samples t-test for two-group comparisons, and one-way ANOVA for comparisons involving three or more demographic or clinical groups.

Results and Discussion

Demographic and Clinical Profile

The respondents were predominantly older adults. The largest age group was 60–74 years, followed by those aged 75 years and above. Females comprised the majority of the sample. Most respondents were married or widowed, and most had elementary or high school education. The common chronic illnesses included cancer, heart disease, kidney disease, diabetes, and chronic respiratory conditions. A substantial proportion had lived with illness for more than four years and had one or more comorbidities.

This profile indicates that the sample represents a high-need chronic illness population. Older age, prolonged illness duration, and comorbidity burden are clinically important because they often correspond with higher symptom burden, greater dependency, increased treatment complexity, and heightened demand for supportive care. This is consistent with the multimorbidity literature, which shows that chronic disease clustering increases care complexity and reduces quality of life (Barnett et al., 2012).

Physical Care Needs

Physical care needs were high, with an overall weighted mean of 4.02. The most prominent needs were pain relief, breathlessness management, fatigue control, sleep improvement, mobility assistance, nutrition support, and general symptom control.

These results suggest that the respondents experienced persistent physical suffering that requires routine symptom assessment and individualized management. The high ratings for pain, dyspnea, and fatigue are consistent with palliative care evidence showing that these symptoms commonly occur across advanced cancer, heart disease, chronic obstructive pulmonary disease, renal disease, and other serious illnesses (Solano et al., 2006). Early palliative care and specialist-supported symptom management have been associated with improved quality of life and symptom burden, strengthening the case for earlier palliative integration among chronically ill adults (Temel et al., 2010; Kavalieratos et al., 2016).

Emotional and Psychological Needs

Emotional and psychological needs were also high, with an overall weighted mean of 3.99. Respondents reported the need for anxiety management, emotional support, help in coping with uncertainty, assistance with fear and sadness, and access to counseling.

The findings show that chronic illness is not only a biomedical condition but also a sustained psychological burden. Anxiety, uncertainty, sadness, and fear may arise from disease progression, financial pressure, possible disability, changing family roles, and unclear

prognosis. Palliative care for seriously ill patients therefore requires systematic psychological screening, counseling access, empathic communication, and referral pathways for patients with significant distress. Kelley and Morrison (2015) emphasized that palliative care should address symptoms, stress, communication, and support for patients and families across the trajectories of serious illness.

Social Support Needs

Social support needs were high, with an overall weighted mean of 4.03. Family support had the highest mean, followed by financial support, assistance with daily activities, communication with family, and transport assistance.

The results confirm the central role of family and economic resources in sustaining care among chronically ill adults in Dagupan City. In Filipino settings, family members often function as primary caregivers, transport coordinators, financial providers, and emotional companions. However, when family resources are limited, patients may experience delayed consultations, poor medication adherence, missed follow-up visits, and intensified emotional burden. The social domain therefore requires caregiver training, family conferences, social welfare referral, transportation support, and financial navigation.

Spiritual Needs

Spiritual needs were high, with an overall weighted mean of 4.09. Respondents particularly expressed the need for religious guidance, hope, inner peace, finding meaning, and help in dealing with existential questions.

These findings show that spirituality is a major coping resource among chronically ill adults. The high rating for religious guidance indicates that patients may interpret illness through faith, prayer, moral reflection, acceptance, hope, and preparation for possible decline. This aligns with palliative care scholarship, which emphasizes that spiritual care is integral to whole-person care and should not be treated as optional when patients identify it as a source of comfort and meaning (Puchalski et al., 2009).

Informational and Educational Needs

Informational needs recorded the highest domain mean at 4.13. The leading needs were a clear explanation of the diagnosis, information on treatment options, decision-making guidance, information on prognosis, and education on home symptom management.

This result indicates that communication gaps remain a major issue. Patients need understandable, compassionate, and culturally sensitive explanations of their illness and care options. Inadequate information may increase anxiety, reduce treatment adherence, weaken patient autonomy, and prevent timely advance-care planning. National quality palliative care guidance emphasizes communication, care planning, patient-family engagement, and interdisciplinary coordination as essential components of high-quality palliative services (Ferrell et al., 2018).

Perceived Barriers to Meeting Palliative Care Needs

Perceived barriers were rated as major, with an overall mean of 4.07. Financial constraints were the strongest barrier, followed by limited access to palliative services, lack of trained personnel, cultural reluctance to discuss end-of-life issues, and inadequate information.

These barriers reflect structural, economic, and cultural limitations in palliative care delivery. Financial constraints may delay consultations, medications, diagnostic follow-up, and symptom relief. Limited access and shortage of trained personnel suggest the need for palliative care workforce development. Cultural reluctance to discuss end-of-life issues highlights the need for communication training that respects family-centered decision-making while still protecting patient autonomy and informed participation. The global palliative care literature similarly identifies access, opioid availability, financing, training, and public awareness as major barriers to equitable palliative care (Knaul et al., 2018; Radbruch et al., 2020).

Differences in Palliative Care Needs by Demographic and Clinical Profile

Inferential analysis showed significant differences in palliative care needs across age groups, illness duration, and comorbidity counts. Age group was significant ($p = 0.041$), illness duration ($p = 0.038$), and comorbidity count ($p = 0.025$). No significant differences were found by sex ($p = 0.081$) or educational level ($p = 0.067$).

These findings indicate that palliative care needs are driven more strongly by disease burden and aging-related vulnerability than by sex or formal education in this sample. Older respondents, those with longer illness duration, and those with more comorbidities reported greater need intensity. This supports stratified care planning, where patients with advanced age, multiple illnesses, and prolonged chronic disease are prioritized for intensive symptom monitoring, psychosocial care, spiritual support, and care coordination.

Conclusion

The study concludes that adult patients with chronic illnesses in Dagupan City experience high multidimensional palliative care needs. Informational needs were the most pronounced, followed by spiritual needs, perceived barriers, social support needs, physical care needs, and psychological needs. Priority concerns included pain, breathlessness, fatigue, anxiety, uncertainty, family dependence, financial strain, religious guidance, diagnosis explanation, treatment information, prognosis clarification, and decision-making support.

The findings further show that financial constraints, limited access to palliative services, lack of trained personnel, inadequate information, and cultural reluctance to discuss end-of-life concerns are major barriers to comprehensive care. Significant differences in palliative care needs by age, illness duration, and comorbidity count suggest that care planning should be risk-stratified and responsive to disease complexity.

Hospitals, outpatient clinics, community health facilities, and local health authorities should strengthen integrated palliative care through routine symptom assessment, psychosocial screening, family caregiver training, spiritual care referrals, patient education, linkages to financial assistance, and workforce development. A culturally responsive model that combines

clinical, emotional, social, spiritual, and informational support is essential to improving comfort, dignity, autonomy, and quality of life among chronically ill adults in Dagupan City.

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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