Palliative care as a fundamental right for older adults in humanitarian crises: closing a persistent inequity gap

Lancet Healthy Longev 2026; 7: 100928

Published Online October 28, 2026
https://doi.org/10.1016/j.lanhl.2026.100928

See Review https://doi.org/10.1016/j.lanhl.2026.100921

See Review https://doi.org/10.1016/j.lanhl.2026.100922

See Review https://doi.org/10.1016/j.lanhl.2026.100927

Older adults remain among the most invisible populations in humanitarian crises. Evidence from *The Lancet Healthy Longevity* Series shows that their health, functional, and psychosocial needs are frequently overlooked, driven by misconceptions about ageing and age-related bias in emergency planning and response, and compounded by intersectional vulnerabilities such as gender, disability, displacement, and poverty.[1] Humanitarian responses often adopt disease-focused, survival-driven models that inadequately address older adults' complex, person-centred and community-centred needs, and their voices are further marginalised through exclusion from policy processes.[2,3] Palliative care has a crucial role here: providing person-centred care, preventing and alleviating suffering, supporting dignity, and strengthening decision making for individuals and families.

Older adults in humanitarian settings face high levels of serious health-related suffering arising from ageing, pre-existing chronic conditions, and acute shocks caused by conflict, displacement, disasters, and health emergencies. The *Lancet* Commission on Palliative Care and Pain Relief estimated that more than 61 million people face serious health-related suffering annually, with older adults bearing a disproportionate burden. Structural barriers, cultural norms, and humanitarian practices that prioritise life-saving interventions over relief of suffering exacerbate this burden, resulting in avoidable serious health-related suffering that could be mitigated through low-cost interventions.[4]

Serious health-related suffering, as defined by the *Lancet* Commission, is suffering associated with illness or injury that cannot be relieved without medical intervention. Palliative care, as defined by WHO, is a holistic approach that improves quality of life for patients and families facing life-threatening illness through prevention and relief of suffering. Palliative care is not restricted to end-of-life care and should be introduced early, alongside curative treatment, without implying therapeutic abandonment.[5]

The COVID-19 pandemic exposed these realities at scale. Oxygen shortages overwhelmed intensive care units, and the isolation of dying patients forced health systems to confront the consequences of neglecting comfort-focused care. Emergency protocols were adapted to include symptom control and anticipatory prescribing, showing that when lifesaving interventions cannot reach all who need them, relief of suffering should not be optional.[6]

Despite WHO guidance and evidence of feasibility and cost-effectiveness, palliative care remains one of the most neglected components of humanitarian health responses. Persistent misconceptions equating palliative care with end of life, inadequate training, restricted access to essential medicines including opioids, and weak policy frameworks contribute to its absence from emergency preparedness and response. Yet, palliative care remains a low-cost, evidence-based intervention that alleviates serious health-related suffering and strengthens caregiver resilience, which is particularly relevant for older adults in crises.

Ageing is associated with physiological changes that reduce functional reserve and increase vulnerability to chronic decline, compounded in crises by acute illness, trauma, and disruption of health and social systems. Older adults are more likely to live with multiple chronic conditions requiring continuity of care, rehabilitation, and caregiver support—all frequently interrupted during emergencies.

Exacerbation of chronic respiratory, cardiometabolic, and cancer conditions often occurs alongside crisis-related illness or injury, and access to diagnostics and specialist care is restricted. Older adults are also disproportionately affected by displacement due to strong attachment to home and community, which might delay evacuation or complicate adaptation after relocation.[7] Scarcity of resources, delayed care-seeking, and exclusion from referral pathways further increase morbidity and mortality, and shortages of health workers, medicines, and psychosocial support intensify suffering for both older adults and caregivers. In these contexts, palliative care should be an indispensable component of humanitarian health care, not an optional add-on.

Misunderstandings about palliative care remain a major barrier in humanitarian settings. Palliative care is frequently equated with terminal care, abandonment, or withdrawal of treatment, generating resistance among clinicians, patients, and families. Cultural norms might

Older adults in humanitarian settings

Older adults are disproportionately affected by humanitarian crises but are often overlooked in health-care planning, preparedness, and response in these settings. In this Series, we aim to highlight these issues and provide a framework for including the health-care needs of older adults in humanitarian crises.

Comment 1: 10.1016/j.lanhl.2026.100923
Comment 2: 10.1016/j.lanhl.2026.100924
Comment 3: 10.1016/j.lanhl.2026.100931
Comment 4: 10.1016/j.lanhl.2026.100928
Series 1: 10.1016/j.lanhl.2026.100921
Series 2: 10.1016/j.lanhl.2026.100927
Series 3: 10.1016/j.lanhl.2026.100922

limit open discussion of prognosis and decline, and expectations of cure, religious beliefs, and fear of distress hinder communication. These attitudes are compounded by humanitarian constraints—staff shortages, insecurity, triage pressures, and high caseloads—and by structural barriers such as weak policy frameworks, restrictive opioid regulations, and inadequate training, together excluding older adults from effective relief of suffering despite the availability of low-cost, feasible interventions.

Palliative care should move beyond conceptual recognition to become an integral part of humanitarian health responses for older adults. Evidence shows that early integration improves quality of life, reduces symptom burden, and enhances caregiver outcomes across conditions, including non-communicable diseases, outbreaks, trauma, and organ failure.[8] These benefits are particularly relevant for older adults, who face disproportionate serious health-related suffering and are often excluded by disease-focused care models that cannot account for the complexity of needs across the life course.

Embedding palliative care requires integrating communication, psychosocial support, care planning, and symptom control into routine practice. This integration of the palliative care approach does not require specialist-only services but depends on training frontline health workers, ensuring access to essential medicines, establishing referral pathways, and integrating palliative care into primary and emergency care systems. When implemented consistently, palliative care is a scalable, cost-effective, and ethically sound approach even in resource-constrained settings.

Palliative care should be recognised as an essential component of all health systems, particularly in humanitarian settings wherein suffering is amplified and system resilience is strained. The WHO Global Reference Package for Palliative Care outlines core services deliverable across community, outpatient, and hospital levels, including in emergencies, and supports planning aligned with local needs.[9]

Integration should also address systemic barriers—gaps in access, quality of care, and age-disaggregated data—and adopt person-centred, participatory approaches that involve older people and their caregivers. The integration process of the palliative care approach should include operational research, monitoring of symptom burden, functional status, caregiver outcomes, and care preferences, to strengthen the evidence base for palliative care in humanitarian settings. Relief of suffering, preservation of dignity, and caregiver support should be core indicators of humanitarian response quality.

As humanitarian crises intensify and populations age, failure to address preventable suffering among older adults undermines both clinical effectiveness and humanitarian principles of equity and impartiality. Palliative care offers a holistic, medically sound, and culturally adaptable response to complex needs in crisis settings. Ensuring its integration across the continuum of care—and recognising older adults and their caregivers not only as beneficiaries but also as active agents within their communities—should become a non-negotiable standard of humanitarian health systems.

MD declares a WHO consultancy on palliative care, honoraria from the McGill Palliative Care National Grand Rounds Programme and the African Palliative Care Association/WHO, and travel support from Aga Khan University, Stanford University, and Global Partners in Care. FK declares travel support from the NIHR Global Health, McGill International Palliative Care Congress, Public Health Palliative Care International Conference, and WHO. JL declares a WHO consultancy and travel support from the European Association for Palliative Care. NG declares a WHO consultancy. FE declares no competing interests.

Copyright © 2026 The Author(s). Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

*Favila Escobio, Megan Doherty, Julie Ling, Nahla Gafer, Farzana Khan

Favila.escobio-consultant@brussels.msf.org

Médecins Sans Frontières, Operational Centre Brussels, Rue de l'Arbre Bénit 46, 1050 Brussels, Belgium (FE); HelpAge International, London, UK (FE); Two Worlds Cancer Collaboration, North Vancouver, Canada (MD); Faculty of Medicine, University of Ottawa, Ottawa, Canada (MD); Children's Hospital of Eastern Ontario, Ottawa, Canada (MD); Palliative Care, WHO Regional Office for Europe, Copenhagen, Denmark (JL); WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt (NG); Palliative care in humanitarian aid situations and emergencies (PallCHASE), South Africa (NG); Fasiuddin Khan Research Foundation, Dhaka, Bangladesh (FK)

1 van Boetzelaer E, Browne JL, Vaid S, et al. Elderly people in humanitarian crises, a forgotten population: a call for action. *PLoS Glob Public Health* 2023; **3:** e0002142.

2 HelpAge International. Age inclusion specialists: promoting and strengthening older age inclusion in humanitarian action. May, 2025. https://www.helpage.org/wp-content/uploads/2025/06/Age-Inclusion-Specialists-Report.pdf (accessed Aug 20, 2026).

3 WHO. World report on ageing and health. Sept 29, 2015. https://www.who.int/publications/i/item/9789241565042 (accessed Aug 20, 2026).

4 Knaul FM, Farmer PE, Krakauer EL, et al. Alleviating the access abyss in palliative care and pain relief -an imperative of universal health coverage: the *Lancet* Commission report. *Lancet* 2018; **391:** 1391–454.

5 WHO. Palliative care. Aug 5, 2020. https://www.who.int/news-room/fact-sheets/detail/palliative-care (accessed Aug 20, 2026).

6 WHO. Clinical management of COVID-19: living guideline. Aug 18, 2023. https://www.who.int/publications/i/item/WHO-2019-nCoV-clinical-2023.2 (accessed Sept 21, 2026).

7 van Boetzelaer E, van de Kamp J, Keating P, et al. Involving older people in the preparedness, response, and recovery phases in humanitarian emergencies: a theoretical framework on ageism, epistemic injustice, and participation. *Lancet Healthy Longev* 2024; **5:** e76–82.

8 Powell RA, Schwartz L, Nouvet E, et al. Palliative care in humanitarian crises: always something to offer. *Lancet* 2017; **389:** 1498–99.

9 WHO. WHO palliative care reference filter. https://uhcc.who.int/uhcpackages/packages/global (accessed May 14, 2026).