

have access to palliative care than members of the White population, who makes up the majority of the population, and they also tend to favour aggressive care over palliative care when it comes to the end of life [15-17]. Studies have also indicated that minorities are less likely to be happy with the level of care, communication, and pain control when they do receive palliative care [16]. Numerous variables have been identified as contributing to this gap by a recent scoping review of the literature. Economic instability and a lack of proper insurance, cultural and spiritual views on health and medicine, and geographic location were listed as the key contributing variables in the review. Palliative care is often hampered by communication issues and prejudice on the part of medical professionals [18]. These results highlight the importance of 'cultural and spiritual values' as well as 'difficulties in communicating' since they demonstrate that obstacles to palliative treatment are not just due to economic issues but also have cultural and social roots. Disparities in healthcare and in terms of health still exist in India. People who belong to scheduled castes, scheduled tribes, or other backward castes are more likely to have poorer health outcomes and less access to treatment, and these gaps have also been linked to poverty, rural living, and social class or caste [19,20]. Subgroups of the Indian population might not have equitable access to palliative treatment as a result. Even if more information is required on this subject, such inequalities are a problem for public health. Since the country's first palliative care programmes were founded in the 1980s, palliative care in India has undergone enormous improvement. Sadly, due to a lack of funding, the current schemes cannot offer palliative care to all patients who would benefit from it [21,22]. The problem of fair and equal access to palliative care is especially important given India's low palliative care resources. What can be done to ensure that the population is divided fairly among the little palliative care resources that are available? is the issue that has to be answered. Even though India's healthcare inequalities are mostly caused by poverty, expanding palliative care facilities and offering free palliative care may not be sufficient to eliminate them. Health and healthcare disparities are not merely a financial problem, as has been demonstrated above. Numerous proposals have been put up in the US to solve the problem of unequal access to healthcare. A key component of these strategies is the growth of cultural competency. Palliative care programmes naturally incorporate some attention to cultural concerns into their services since palliative care offers a comprehensive response to pain and suffering brought on by life-threatening disease. According to the WHO, palliative care includes consideration of "psychosocial or spiritual problems" [23]. There are cultural aspects to these issues. For

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these attitudes into practise in patient care. Palliative care professionals cannot learn from patients without cultural competence. Providers of palliative care need to be skilled in determining what patients' illnesses and diseases mean to them, how they interact with the outside world, and how they wish to be treated. Patients will be given more authority to participate completely in the decision-making process about their treatment via the use of cultural humility and expertise. Due to the widely held cultural presumption that people in India must be sheltered from the suffering that bad news might bring, patients are frequently excluded from the decision-making process. In India, medical professionals frequently agree to pleas from the patient's family to withhold the diagnosis and prognosis.

Palliative care professionals will become aware of the limitations of such cultural practises and beliefs and may discover they may not apply to all patients as a result of their cultural humility. Research among cancer patients in India has frequently demonstrated that many of them desire to learn more about their condition and participate in decisions about their care, but are unable to do so. Healthcare professionals that are culturally competent are able to deal ethically with circumstances where the patient's information demands may conflict with the family's desire to shield the patient from damage that they believe would be brought on by the very same knowledge. Patients from various cultural origins will more readily find their way to the palliative care service when cultural competency is included into palliative care programming through cultural knowledge, attitudes, and abilities. Patients will be more compliant with treatment suggestions since they and their loved ones will be happier, return for therapy, and do so. In this approach, cultural competency will aid in enhancing palliative care access and health outcomes in India.

Conclusion

When palliative care services are provided in a country with a diverse population, like India, cultural competency is a crucial instrument for their growth. Cultural competency will likely increase patient satisfaction and, more crucially, lessen inequalities in access and health outcomes in palliative care if it is effectively implemented and tailored to the Indian palliative care setting. The biggest benefit of cultural competency is that it might potentially assist patients greatly while without necessarily significantly raising the expenditures associated with running palliative care initiatives. Although it is necessary to include cultural competency into daily operations and education, doing so does not call for a huge financial outlay. Programmes for palliative care need to begin considering how they might inventively include cultural competency into their operations.

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Conflict of Interest

There are no conflicts of interest.

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