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Palliative Medicine

The complex relationship between household income of family caregivers, access to palliative care services and place of death: a national household population survey.

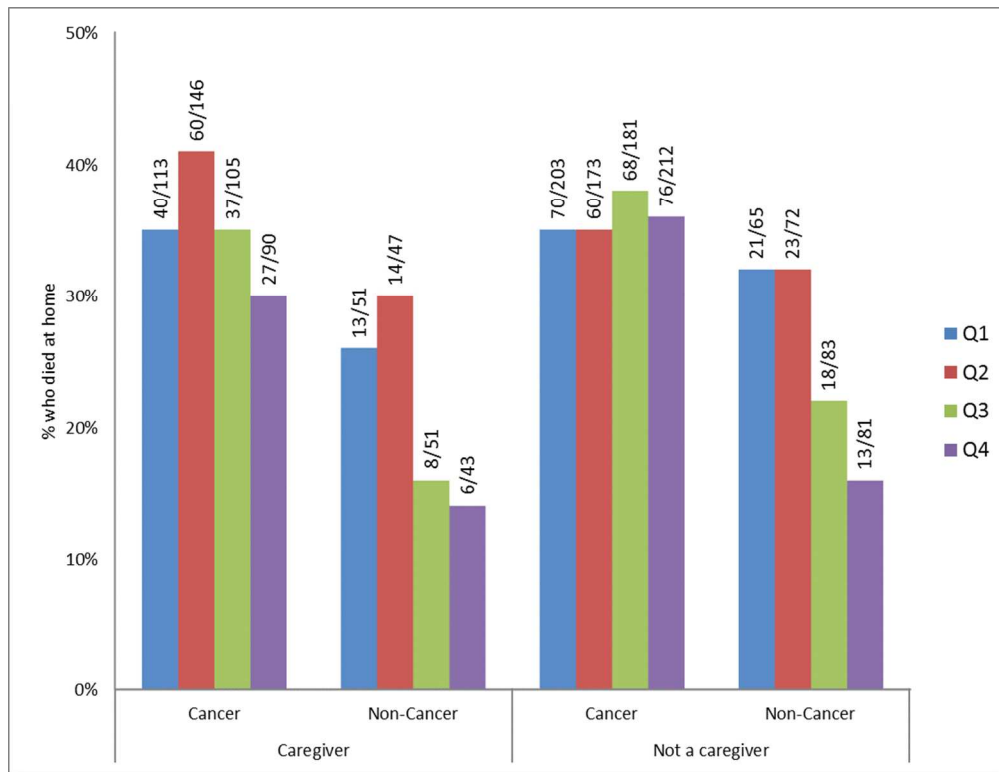
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Keywords:	caregivers, palliative care, socio-economic status, place of death, household income, population survey, carers
Abstract:	<p>Background: Previous work shows that more affluent patients with cancer are more likely to die at home. Whereas those with non-cancer conditions are more likely to die in hospital. Family caregivers are an important factor in determining place of death.</p> <p>Aim: To investigate associations between family caregivers' household income, patients' access to specialist palliative care and place of patients' death, by level of personal end-of-life care.</p> <p>Design: A cross-sectional community household population survey.</p> <p>Setting and participants: Respondents to the Household Survey for England.</p> <p>Results: One third of 1265 bereaved respondents had provided personal end-of-life care (caregivers) (30%). Approximately half (55%) of decedents accessed palliative care services and 15% died in a hospice. Place of death and access to palliative care were strongly related ($p < 0.001$). Palliative care services reduced the proportion of hospital deaths ($p < 0.001$), and decedents accessing palliative care were more likely to die at home ($p < 0.001$). Respondents' income was not associated with palliative care access ($p = 0.233$). Overall, respondents' income and home death were unrelated ($p = 0.106$), but decedents with caregivers in the highest income group were least likely to die at home ($p = 0.069$).</p> <p>Conclusions Decedents' access to palliative care services was associated with fewer deaths in hospital and more home deaths. Bereaved respondents' income was unrelated to decedents' place of death when adjusted for palliative care access. For caregivers only, decedents with more affluent caregivers</p>

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	were the least likely to die at home. Higher income caregivers are likely to be powerful patient advocates; information needs must be addressed with regard aim of care.

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Proportion who died at home by income, for caregivers by cancer death or not.

391x300mm (72 x 72 DPI)

Review

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3 **Title:** The complex relationship between household income of family caregivers, access to
4
5 palliative care services and place of death: a national household population survey.
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8 **Running Title:** Caregiver household income, access to palliative care services and place of
9
10 death.
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49 **Word count 2,871**
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ABSTRACT

Background: Previous work shows that more affluent patients with cancer are more likely to die at home. Whereas those dying from non-cancer conditions are more likely to die in hospital. Family caregivers are an important factor in determining place of death.

Aim: To investigate associations between family caregivers' household income, patients' access to specialist palliative care and place of patients' death, by level of personal end-of-life care.

Design: A cross-sectional community household population survey.

Setting and participants: Respondents to the Household Survey for England.

Results: One third of 1265 bereaved respondents had provided personal end-of-life care (caregivers) (30%). Just over half (55%) of decedents accessed palliative care services and 15% died in a hospice. Place of death and access to palliative care were strongly related ($p < 0.001$). Palliative care services reduced the proportion of deaths in hospital ($p < 0.001$), and decedents accessing palliative care were more likely to die at home than those who did not ($p < 0.001$). Respondents' income was not associated with palliative care access ($p = 0.233$). Overall, respondents' income and home death were not related ($p = 0.106$), but decedents with caregivers in the highest income group were *least* likely to die at home ($p = 0.069$).

Conclusions

For people who had someone close to them die, decedents' access to palliative care services was associated with fewer deaths in hospital and more home deaths. Respondents' income was unrelated to care recipients' place of death when adjusted for palliative care access. When only caregivers were considered, decedents with caregivers from higher income

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2
3 quartiles were the *least* likely to die at home. Family caregivers from higher income brackets
4 are likely to be powerful patient advocates. Caregiver information needs must be addressed
5 especially with regard to stage of disease, aim of care and appropriate interventions at the end
6 of life.
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11
12 **Keywords:** caregivers; palliative care; socio-economic status; place of death; household
13 income; carers; population survey
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18 **Running Title:** Caregiver household income, access to palliative care services and place of
19 death.
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Key Statements

What is already known about the topic?

- More affluent people who die from cancer are more likely to die at home.
- More affluent people who die from non-malignant conditions are more likely to die in hospital.

What this paper adds?

- This study of *those who had someone close die*, (providing personal care or not) found no relationship between the bereaved person's income and decedent's death at home.
- However, if *personal end-of-life care* was provided by those from higher income quartiles, decedents from *any* cause were the *least* likely to die at home.
- Decedents with identified palliative care service use were more likely to die at home.

Implications for practice, theory or policy?

- The interplay between place of care and income is more complex than being able to pay for care.
- Family caregivers from higher income brackets are likely to be powerful patient advocates.
- Caregiver information needs must be addressed especially with regard to stage of disease, aim of care and appropriate interventions at the end of life.

Introduction

Socio-economic factors (education, household income, area of residence) are some of the social determinates of health outcomes including place of death. In the United Kingdom, people who die from cancer are more likely to die at home than an institution if of higher socioeconomic status (SES).[1] However, people of higher SES dying from cardiovascular or respiratory diseases are more likely to die in an institution.[1]

In Australia, access to specialist palliative care services reduces the likelihood of dying in hospital, but not home death.[2] Several groups (older people, people with non-malignant diseases, people with lower SES) are consistently under-referred to specialist palliative care services.[2-7]

The interplay between SES, access to specialist palliative care and place of death is complex. A systematic review of the worldwide literature examined whether access to specialist palliative care modified the effect of patients' SES on place of death for adults with cancer. [8] The review found some evidence to suggest that use of specialist palliative care might modify the unfavourable effect of lower SES on home death. The presence of a family caregiver adds further complexity: another systematic review found that patients without a home caregiver are less likely to access community palliative care services.[9]

In 2013, questions about providing informal care for '*someone close*' at the end of life were included in the Health Survey for England (HSE).[10] The questions were adapted from the South Australia Health Omnibus Survey (HOS), allowing comparisons with different service, funding and social care models in this study.[3] Importantly, these are data about people who did and did not access palliative care services at the end of life, and whether or not the person "*close*" had provided care, irrespective of health service contact.

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3 The aim of this study is to investigate whether access to specialist palliative care services
4 ameliorates the effects of respondents' SES on decedents' place of death. The null hypothesis
5 was that there was no relationship between these three variables by level of respondents'
6 care.
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11 12 13 14 15 16 17 **Methods**

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20 A population-based, observational study was conducted. Detailed methods of the Health
21 Survey for England (HSE) are described elsewhere.[11] In summary, it is an annual, face-to-
22 face, cross-sectional survey measuring health and health-related behaviours. Core socio-
23 demographic data are included yearly and specific topics added by researchers buying 'space'
24 to incorporate researchers' questions. Consolidated de-identified data are supplied to
25 researchers of core data and researchers' specific data.
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35 HSE is commissioned by the NHS Information Centre for Health and Social Care for the
36 Department of Health. Addresses were issued between January and December, 2013, and
37 fieldwork completed in March 2014. A random probability sample of households (9,408
38 addresses in 588 postcode sectors) was surveyed. Adults (age 16 or over) and children were
39 interviewed at households identified at the selected addresses followed by a visit from a
40 specially trained nurse for those consenting. Data were weighted by HSE weights with the
41 aim of the weighting to reduce non-response bias resulting from differential non-response at
42 the household level. [11] The dataset included 10,980 respondents, of whom 2,165 (20%)
43 stated *that someone close to them had died of a terminal illness in last five years* (hereafter
44 referred to as 'respondents) and, as a subsequent question so as not to pre-empt questions
45 about care, whether or not they had accessed palliative care services. The HSE included the
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3 question set in their ethics approval processes (including consent) for the 2013 survey,
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5 obtained from the Oxford A Research Ethics Committee (reference 12/SC/0317).
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11 **Measure of socioeconomic status**

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16 In this current study, household income was used as the surrogate measure of SES. Income in
17
18 the Australian dataset was grouped into four \$20,000 income bands. In the HSE dataset the
19
20 variable used was derived equivalised income. Equivalised income adjusts household income
21
22 to take account of the number of persons in the household. It should be noted that in the HSE
23
24 dataset around 19% of adults live in households where no information is provided on income,
25
26 and are therefore excluded from the breakdown by equivalised household income. This was
27
28 summarised into quartiles based on the quartiles from this equivalised income: 25%=
29
30 £14,701, 50%=£24,700, 75% =£44,094.
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37 **Provision of care**

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41 In the Australian HOS, respondents were asked if they had provided “hands on care” and its
42
43 level. In the HSE question, this was phrased as “personal care”, and defined as “things like
44
45 helping with washing, dressing, going to the toilet, or eating.” In the HSE, respondents were
46
47 also asked if they had provided company, errands, laundry, shopping, giving lifts, taking to
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49 appointments or out for recreation.
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56 **Palliative Care Services**

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3 In both surveys, the question “Was a palliative care service used?” was asked alongside an
4 explanation from the interviewer that a palliative care service aims to comfort, not to cure, to
5 relieve pain and distress for people who are dying and to support patients, families and
6 friends in approaching death and coping with grief.” Examples of service providers were
7 given in the English survey.
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18 **Place of death**

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22 The deceased’s place of death was reported as home, hospital, hospice, residential aged care
23 facility, or ‘other’.
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32 **Statistical analysis**

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35 The main analysis conducted was a comparison of survey respondents who stated *that*
36 *someone close to them had died of a terminal illness in the last five years* and whether or not
37 they had access to palliative care services (hereinafter referred to as respondents).
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44 Demographic characteristics of the respondents and place of death of the deceased were
45 described. Univariate analyses were undertaken comparing groups using a Chi-square test for
46 categorical data and a t-test for continuous data.
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53 Logistic regression was undertaken to explore the relationship between home death and SES,
54 adjusting for access to palliative care, age, gender and educational and marital status. A
55 Hosmer and Lemeshow Test was used to assess model fit. **In view of the relationship between**
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2
3 educational level and SES, findings were adjusted for educational status. Sensitivity analyses
4
5 quantified the effect of dying at home by income, adjusting for access to palliative care with
6
7 the exclusion of non-cancer patients. This analysis was repeated substituting the provision of
8
9 personal care by the respondent. Analyses were undertaken using SPSS (v.22, SPSS Inc.,
10
11 Chicago, IL).
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16 Findings were reported in accordance with the STrengthening the Reporting of OBservational
17
18 (STROBe) studies in Epidemiology statement.[13]
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21 22 23 24 **Results**

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27 Household survey participation was 64%. Demographic characteristics of the respondents
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29 who stated that ‘*someone close to them had died of a terminal illness in last 5 years*’, by
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31 access to palliative care services are shown (Table 1) together with the characteristics
32
33 associated with patients’ access to palliative care. Of interest, respondents’ household income
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35 associated with patients’ access to palliative care. Of interest, respondents’ household income
36
37 was not associated with access to palliative care ($p=0.233$). Household income was missing
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39 for 402 of respondents and 52% of those had access to palliative care. As a quality check,
40
41 there was no significant difference in the proportion who had access to palliative care
42
43 compared to those who had income recorded ($p=0.164$).
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47 Age and gender of respondents were similar between groups. Hands-on care was provided by
48
49 30% of the bereaved (hereon referred to as “caregivers”), one half of decedents (55%) had
50
51 accessed palliative care services and 15% died in a hospice. The majority died from cancer
52
53 (72%).
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55 56 57 **Access to palliative care and place of death**

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3 Decedents who accessed palliative care services were less likely to die in hospital (31%
4 without, 61% with; $p < 0.001$). (Table 1) The proportion of people dying in hospices *and* at
5 home increased and those who accessed palliative care services were more likely to die at
6 home (36%, 26%, $p < 0.001$).
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11 <<insert Table 1 about here>>
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13 14 15 16 **Respondent's income and decedent's place of death** 17

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19 There was no statistically significant difference between income groups regarding place of
20 death ($p = 0.099$), nor any relationship between household income and dying at home
21 ($p = 0.106$; Table 2).
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26 <<insert Table 2 about here>>
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29 This finding stands even when adjusted for access to palliative care and, separately,
30 excluding non-cancer patients in sensitive analyses (Table 3).
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34 <<insert Table 3 about here>>
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37 38 **Analysis of data from those who had provided care (caregiver)** 39

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41 The intensity of hands-on care provided by the caregiver was associated with access to
42 palliative care ($p < 0.001$). One third of people who accessed palliative care services had
43 provided hands-on care, compared to one quarter of those who had not.
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49 For caregivers, income and place of death were associated ($p = 0.147$) and income and death at
50 home compared with elsewhere ($p = 0.069$; Table 4).
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53 <<insert Table 4 about here>>
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Caregivers in the highest income group were *least* likely to provide care for someone who died at home (25%), although this did not reach statistical significance ($p=0.069$) even after adjusting for diagnosis (0.108). For those who had died from a non-cancer condition ($p=0.180$) and cancer ($p=0.378$), those with caregivers in the highest income group were *least* likely to die at home (Figure 1).

<<insert Fig 1 about here>>

Discussion

Main findings

Decedents who died from *any cause* with identified access to palliative care services were least likely to die in hospital ($p<0.001$), and were more likely to die at home. This study found no relationship between the *respondent's* income and *decedent's* death at home once adjusted for palliative care service access. However, people with *caregivers* from higher income quartiles were the *least* likely to die at home irrespective of identified access to palliative care services.

How does this compare with other findings?

This survey found a reduction in hospital deaths in people with identified access to palliative care services and an increase in home deaths. In contrast, in Australia, with access to palliative care services, the deaths moved from hospital to hospice but did not change levels of death in the community.[2] This may be due to a variety of factors including the wide cultural diversity and extreme rurality in Australia coupled with a community expectation to go to hospital. However, although in both countries palliative care services are provided at no

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2
3 cost to the patient, there are also important differences in Australian and English primary care
4
5 with regard to caring for the dying. In England there is widespread implementation of
6
7 systems of care such as Gold Standards Framework, the palliative care register as part of the
8
9 Quality Outcomes Framework which embeds this into their system of remuneration, and the
10
11 maintenance of a clinical culture of visiting the patient in their own homes. The quality of
12
13 primary care is known to be crucially important with regard to supporting people to die at
14
15 home if that is their wish across a variety of countries [14] and responsibility for community
16
17 palliative care supported by early integration with specialist teams[15] and home visits by the
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19 family practitioner have been highlighted as important factors.[16, 17] However, in Australia,
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21 home visits are less frequent and there is variable practice with regard to the composition of
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23 the multi-disciplinary primary and palliative care teams across settings and the level of
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25 integration with palliative care teams.
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33 The intensity of hands on care provided by the caregiver was associated with increased access
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35 to palliative care ($p < 0.001$). Those referred to palliative care services may be those assumed
36
37 to have sufficient support to sustain home care. Family and friends involved in providing care
38
39 may more effectively advocate for additional help. A recent mortality follow-back study of
40
41 place of death in people with cancer found that patients' and relatives' preferences, home
42
43 palliative care, and district/community nursing explained over 90% of home deaths.[18]
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49 Although there was no association between respondents' household income and care
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51 recipients' place of death, when only those who had provided hands on, personal care were
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53 considered, income did play a part. Those with caregivers from higher income quartiles were
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55 the *least* likely to die at home. This is consistent with the National End of Life Care
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57 Intelligence Network (NEoLCIN) 2012 report for people dying of *non-cancer* disease but in
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1
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3 contrast to the data regarding death due to cancer.[19] The NEOLCIN data are mainly sourced
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5 from NHS and social care *patient* data. The HSE caregiver dataset is therefore not directly
6
7 comparable with NEOLCIN data as household income of patient and caregivers before and
8
9 after the death may be different. Gomes *et al* found that people with cancer were more likely
10
11 to die at home if family members were aware that the disease was no longer curable, and
12
13 preferences for place of care had been discussed with patients and families.[18] However, as
14
15 more educated, higher income caregivers are likely to be effective using their health literacy
16
17 to advocate for those for whom they care,[20] then if the caregiver believes that best care is
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19 hospital, even in very advanced disease, then this might help to explain the caregiver income
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21 effect on home deaths.[18] However, we did not have data on the caregivers' employment
22
23 status. These caregivers may be those in employment and may be less able to increase the
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25 level of personal care around the time of death, especially if they have used leave entitlement
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27 prior to this point.
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34 With non-cancer conditions there are particular challenges of a disease trajectory with
35
36 episodic deteriorations and periods of recovery, poorer professional skills in determining and
37
38 communicating prognosis reflected in lower rates of advance care planning.[21, 22] There is
39
40 poorer public understanding of the terminal nature of such conditions and conversations
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42 about prognosis are less likely than for cancer.[23] This issue is complicated by the fact that
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44 for people with advanced non-cancer conditions, hospital admission may be beneficial during
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46 deteriorations, any of which may lead to death. As there is emerging evidence that a palliative
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48 approach alongside appropriate disease-modifying treatment does not appear to shorten
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50 survival[24, 25] and may even prolong it,[26] our findings may indicate clinically important
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52 disadvantage to patients.
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3 There is a need for clear communication with patients *and* their caregivers about the
4 implications of advanced disease and the need for advance care planning including informed
5 preferences for place of death. There is increasing emphasis on the importance of advanced
6 care discussions between clinicians and *patients* to encourage a realistic understanding of
7 their stage of disease. However, there is no systematic approach to ensure patients' family
8 caregivers have an up-to-date understanding of the stage of disease, aim of care and viable
9 treatment options. The family member or friend usually seen with the patient in the clinic, or
10 at home, or visiting in hospital may not be the person who is the most health literate or
11 strongest patient advocate. If information is not passed accurately on by the patient or
12 accompanying person, or expressly communicated by clinical staff then the family
13 member/friend acting as the main patient advocate may influence place of care and
14 interventions from a basis of incomplete understanding.
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32 The issue of providing care for *someone close* at the end of life and the relationship with
33 socioeconomic status is therefore complex and not simply a matter of being able to pay for
34 help in the home.
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41 **Limitations**

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44 As the numbers with a spousal relationship were small, there is no sub-group analysis.
45 Spousal household income is a measure that may change with the death of the spouse but this
46 paper focuses on *respondents' (not decedent)* household income acknowledging that this may
47 be different to the patients'. Previous work with caregivers more broadly showed people with
48 lower household incomes were more likely to become caregivers, to carry a higher caregiver
49 burden and experience poorer health. This work found that caregivers who are less deprived
50 are likely to have greater health, knowledge and skills, and greater material resources with
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3 which to support the care recipient.[27] Findings were adjusted for educational status but our
4
5 lack of data regarding employment status limits our ability to draw conclusions, given the
6
7 issues highlighted above. SES is more complex than household income alone, each aspect
8
9 highlighting differing aspects of access to health services.
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11 12 13 14 15 16 **Implications for policy and practice**

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19 Despite government policy urging more care in the community, in part driven by a desire to
20
21 save hospital costs, good care of the dying at home requires excellent (and costly) nursing,
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23 medical and social supports, without accounting for the care provided by family and friends.
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25 Dying at home is perceived by bereaved caregivers as having poorer symptom control than
26
27 inpatient care suggesting that community care is still sub-optimal.[28]
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29

30
31 Caregivers can play a powerful advocacy role for the care recipient and their own needs,
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33 especially when the patient is too sick to convey their own wishes. If the caregiver believes
34
35 that the best place of care is hospital, especially if due to a lack clear explanation and honest
36
37 discussion regarding treatment futility, then health literate caregivers will continue to push
38
39 for hospital admission.
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46 47 **Conclusions**

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49
50 This study examined data concerning people in England who had *someone close* to them die.
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52 For study respondents, access by the decedent to palliative care services was strongly
53
54 associated with a reduction in deaths in hospital and an increase in home deaths.
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56 Respondents' household income and decedents' place of death were not associated when
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3 adjusted for palliative care use. However, when only caregivers were considered, decedents
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5 with caregivers from higher income quartiles were the *least* likely to die at home.
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8 There is a complex relationship between caregivers' SES, ability to provide personal care,
9
10 and health literacy that is likely to have an impact on a patient's place of death. Further
11
12 research is needed to help interpret these findings, inform tailored and relevant support, and
13
14 provide appropriate resources for caregivers for someone at the end of life.
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21 22 **Declarations**

23
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25
26
27 **Ethics approval and consent to participate:** The HSE included the question set in their
28
29 ethics approval processes (including consent) for the 2013 survey, obtained from the Oxford
30
31 A Research Ethics Committee (reference 12/SC/0317). For the elements involved in this
32
33 report, verbal consent only was sought. Verbal consent was not recorded assuming that those
34
35 who took part in the survey, and provided data had consented to do so.
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40 **Consent to publish**

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42 This article does not publish individual participant data.
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47 **Availability of data:** The HSE data used in this analysis are available at the UK Data Archive:
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49 NatCen Social Research and University College London. Department of Epidemiology and
50
51 Public Health, Health Survey for England, 2013 [computer file]. Colchester, Essex: UK Data
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3 **Figure legend.**
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7 **Figure 1: Proportion who died at home by income, for caregivers**
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10 **by cancer death or not.**
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Table 1: Demographic characteristics of respondents who stated that *someone close to them had died of a terminal illness in last 5 years by access to palliative care*

	HSE respondents			
	Access to pall care missing for 3 responders			
	Total n=2165	PCS n=1190	No PCS n=975	p-value
Age (Mean (sd)) (n=2165)	47.7 (18.6)	47.0 (18.0)	48.6 (19.3)	0.042
Sex (n=2165)				0.147
Female	1174 (54%)	662 (56%)	512 (53%)	
Male	991 (46%)	528 (44%)	463 (47%)	
Marital Status (n=2163)				0.018
Single	478 (22%)	280 (24%)	198 (20%)	
Married	1032 (48%)	555 (47%)	477 (49%)	
Co-habiting	286 (13%)	162 (14%)	123 (13%)	
Separated/Divorced	182 (8%)	104 (9%)	78 (8%)	
Widowed	186 (9%)	88 (7%)	98 (10%)	
Household Income* (n=1763)				0.233
Q1	440 (25%)	254 (26%)	186 (24%)	
Q2	447 (25%)	250 (26%)	197 (25%)	
Q3	436 (25%)	225 (23%)	211 (27%)	
Q4	440 (25%)	253 (26%)	187 (24%)	
Qualifications† (n=2160)				0.050
No qualifications	462 (21%)	241 (20%)	221 (23%)	
Trade qualification,/certificate/diploma	1138 (53%)	616 (52%)	522 (54%)	
Degree	560 (26%)	332 (28%)	228 (23%)	
Relationship to deceased (n=2164)				0.033
Spouse/Partner	133 (6%)	72 (6%)	61 (6%)	
Parent	425 (20%)	226 (19%)	199 (20%)	
Child	73 (3%)	42 (4%)	31 (3%)	
Sibling	209 (10%)	100 (8%)	109 (11%)	

Other relative	1009 (47%)	551 (46%)	458 (47%)	
Friend	275 (13%)	173 (45%)	102 (11%)	
Other	40 (2%)	26 (2%)	14 (1%)	
Provided hands on care (n=2141)				<0.001
Daily	306 (14%)	197 (17%)	109 (11%)	
Intermittent	251 (12%)	154 (13%)	97 (10%)	
Rare	87 (4%)	52 (4%)	35 (4%)	
No care	1497 (70%)	773 (66%)	724 (75%)	
Place of death (n=2153)				<0.001
Home	686 (32%)	432 (36%)	254 (26%)	
Hospital	952 (44%)	369 (31%)	583 (61%)	
Hospice	316 (15%)	284 (24%)	32 (3%)	
Residential, hostel or other	199 (9%)	104 (9%)	95 (10%)	
Place of death (Home) (n=2153)	686 (32%)	432 (36%)	254 (26%)	<0.001
Cause of death (Cancer) (n=2165)	1552 (72%)	997 (84%)	555 (57%)	<0.001

PCS –palliative care services; HSE – Health Survey for England: *NB *respondent's* household income. Figures represent income quartiles: 25%= £14,701, 50%=£24,700, 75% =£44,094. † Trade qualification, certificate, diploma or higher = Below degree or NVQ4/NVQ5

Table 2: Household income quartiles and place of death

Place of death	Income Quartiles†			
	Q1	Q2	Q3	Q4
Home	147 (34%)	160 (36%)	137 (31%)	124 (28%)
Hospital	196 (45%)	189 (42%)	194 (45%)	187 (43%)
Hospice	60 (14%)	65 (15%)	62 (14%)	69 (16%)
Residential, hostel or other	35 (8%)	32 (7%)	42 (10%)	57 (13%)

† Figures represent income quartiles: 25%= £14,701, 50%=£24,700, 75% =£44,094.

Table 3: Logistic regression for odds of dying at home compared to elsewhere

	Unadjusted Odds Ratio (95% CI)	p-value	Adjusted Odds* Ratio (95% CI)	p-value
	All patients (Unadjusted model: n=1791, Adjusted model: n=1790)			
Palliative care (Yes)	1.52 (1.24, 1.87)	<0.001	1.52 (1.24, 1.87)	<0.001
Income		0.102		0.055
Q1	1.28 (0.96, 1.71)	0.095	1.35 (0.98, 1.86)	0.065
Q2	1.43 (1.07, 1.90)	0.015	1.53 (1.13, 2.08)	0.006
Q3	1.19 (0.89, 1.60)	0.235	1.25 (0.93, 1.68)	0.148
Q4	1.00		1.00	
	Cancer only patients (Unadjusted model: n=1283, Adjusted model: n=1283)			
Palliative care (Yes)	1.66 (1.29, 2.13)	<0.001	1.68 (1.31, 2.17)	<0.001
Income		0.639		0.386
Q1	1.06 (0.76, 1.47)	0.734	1.16 (0.81, 1.68)	0.418
Q2	1.20 (0.86, 1.66)	0.284	1.32 (0.93, 1.88)	0.118
Q3	1.19 (0.85, 1.67)	0.300	1.28 (0.91, 1.81)	0.155
Q4	1.00		1.00	

*Adjusted for age, gender, marital status and educational status

Table 4: Income and place of death for those who provided personal care

Caregiver n=648, p=0.147	Q1	Q2	Q3	Q4
Home	53 (32%)	73 (38%)	46 (29%)	33 (25%)
Hospital	74 (45%)	78 (41%)	64 (41%)	58 (43%)
Hospice	25 (15%)	25 (13%)	27 (17%)	22 (16%)
Residential, hostel or other	12 (8%)	16 (8%)	21 (13%)	21 (16%)

There was an association for the caregivers ($p=0.069$) between place of death and income, after adjusting for access to palliative care. (Table 5) The Hosmer and Lemeshow Test demonstrated a good model fit and was not seen for non-caregivers.

Table 5: Logistic regression for odds of dying at home compared to elsewhere by caring status

	Odds ratio (95% CI)	p-value
Caregiver (n=682)		
Palliative care (Yes)	2.39 (1.65, 3.47)	<0.001
Income		0.069
Q1	1.53 (0.91, 2.57)	0.111
Q2	1.91 (1.16, 3.15)	0.011
Q3	1.31 (0.77, 2.22)	0.323
Q4	1.00	
Not a caregiver (n=1066)		
Palliative care (Yes)	1.23 (0.95, 1.60)	0.110
Income		0.778
Q1	1.17 (0.82, 1.67)	0.389
Q2	1.19 (0.83, 1.71)	0.353
Q3	1.13 (0.79, 1.62)	0.510
Q4	1.00	