



End-of-life care and the social contract: A European reckoning?

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ABSTRACT

End-of-life (EOL) care is a universal yet deeply unequal experience across Europe, revealing persistent gaps between people's preferences and health system delivery. Despite strong evidence that most individuals wish to die at home or in familiar surroundings, EOL care remains overly medicalised, hospital-centred, and socially stratified, with significant socioeconomic inequalities in access to palliative care that have widened since the COVID-19 pandemic. This commentary argues that EOL care constitutes a critical test of the social contract and should be understood as a core health system issue rather than a marginal or purely clinical concern. Drawing on European policy debates, comparative evidence, and examples of public health and democratic innovations—including Compassionate Communities and citizen deliberation processes—we frame EOL care as a systemic, relational, and societal challenge. We highlight the importance of death literacy, community engagement, and participatory governance in rebalancing responsibility for dying between health systems, communities, and society at large. We conclude by identifying key policy priorities for integrating EOL care across health systems, strengthening equity and solidarity, and reframing EOL care as a shared societal obligation grounded in dignity, compassion, and collective responsibility.

Everyone will face the end of life. Whether through personal experience or that of a loved one, end-of-life (EOL) care is a universal concern. The quality of dying is an integral component of wellbeing, dignity and healthy ageing, and is increasingly recognised as a part of the right to health (World Health Organization, 2014). While variability across communities, cultures, and historical contexts must be acknowledged, the World Health Organ

ization proposes that the quality of dying should be understood as the extent to which an individual dies in a manner aligned with their values and preferences, taking into account their cultural background, personal goals, expectations, relationships, and concerns related to life and death (Harwood et al., 2025).

Yet across Europe, EOL care remains deeply unequal, overly medicalised and reflective of both health system shortcomings and fractures

in our social contract (OECD, 2023). Any European reckoning must begin by acknowledging profound contextual diversity: differences in welfare regimes, health-system models, and historical trajectories of palliative-care development mean countries face distinct pressures and starting points. The reckoning is therefore not uniform; it unfolds asynchronously across contexts.

A recent session on EOL care at the European Health Forum Gastein reframed EOL as a stress test of the social contract, exposing a profound mismatch between what people want and what systems deliver. In many ways, EOL care exposes several core dimensions of the social contract—its *redistributive* (financing, access, coverage), *relational* (dignity, trust, recognition) and *participatory* (voice, deliberation, democratic engagement) promises—and where these break down.

Across many European countries, more than half of deaths still occur

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in hospitals, despite widespread preferences for dying at home (OECD, 2023, 2024). Only 40% of those who would benefit from palliative EOL care actually receive it (OECD, 2019). Within countries, disparities have widened since COVID-19; people facing financial difficulties are significantly less likely to access palliative care, with a marked post-pandemic decline across 28 countries (Sillitti, 2025).

From a systems perspective, these pressures emerge where hospital-centric delivery coexists with limited home- and community-care capacity, uneven palliative-care training, fragile primary care, and stretched informal caregiving—and directly shape outcomes. While specialised services have expanded over the past decade, access remains highly uneven: in some countries such services are almost non-existent, while others exceed the European Association for Palliative Care's threshold of two services per 100,000 inhabitants; only around one third of countries report good system-level embedding (Garralda et al., 2025; Tripodoro et al., 2025).

As the Lancet Commission on the Value of Death argues, death is both a personal and collective experience shaped by dignity, autonomy, and solidarity (Sallnow et al., 2022). Yet current “death systems” are paradoxical: some people are over-treated in hospitals, while others die without basic care. These contradictions mirror broader social inequities and, crucially, relational fragility in the social contract—where trust, recognition and the moral fabric of care are secondary to throughput and institution-centred routines. They also reveal how EOL care can reproduce inequality when responsibility is shifted into families without adequate support, raising fundamental social justice questions about who carries the emotional and economic load of dying. This burden is not evenly distributed: informal caregiving responsibilities disproportionately fall on women, making EOL care a critical site of gender inequality and reinforcing broader patterns of inequity within the social contract.

Across Europe, dying has largely disappeared from everyday life. It has been relocated to hospitals, professionalized, and disconnected from social experience. Many citizens lack the knowledge, confidence, and shared language needed to engage with EOL choices. Strengthening death literacy¹ is not a peripheral task: it is both a public health priority and a civic one (Rosenberg et al., 2021; Rumbold et al., 2020).

Death literacy refers to the knowledge and capabilities that help individuals and communities understand end-of-life issues, communicate about them, navigate care systems, and mobilise support (Noonan et al., 2016). Importantly, it is not merely an individual awareness but a collective resource—a form of social capital that enables communities to share responsibility, recognise vulnerability and participate meaningfully in decisions about care (Rosenberg et al., 2021; Rumbold et al., 2020). In this sense, death literacy reinforces the relational dimension of the social contract: it helps rebuild the trust, recognition, and mutual obligation that underpins humane care.

Public-health palliative-care frameworks show that strengthening death literacy requires embedding it across everyday social institutions—schools, universities, workplaces, neighbourhood organisations, and local public-health initiatives (Bollig and Rosenberg, 2023). The aim is not to “teach death” in a narrow curricular sense but to normalise supportive conversations, reduce stigma, and build community capacity. Educational settings are one example among many: when they host age-appropriate storytelling or supportive activities, they help children, families, and educators engage with loss in constructive ways (Blake et al., 2020). Universities likewise help prepare future professionals and community leaders to approach end-of-life issues with competence and compassion (Bollig and Rosenberg, 2023).

The broader point is that multiple community institutions can contribute – incrementally but meaningfully – to restoring social

familiarity with dying. Without this cultural grounding, policy reforms risk becoming technical fixes to what is fundamentally a relational and societal challenge.

The Compassionate Communities model illustrates what a more integrated approach can look like. Such initiatives are intended to complement adequately resourced health systems and must not substitute for public responsibility or sustained investment in formal care services. Rooted in public health principles, these initiatives mobilise local residents, organisations, and services to support people through dying, caregiving, and bereavement (Mills et al., 2024). By strengthening “death literacy” and community participation, they make EOL care a shared civic practice rather than a strictly medical event. Evidence shows such approaches can improve wellbeing, reduce hospitalisations, and better align care with people's values (Aoun et al., 2022; Peeler et al., 2023; Sallnow et al., 2016; Abel et al., 2018).

Democratic innovation also matters. The French Citizen Convention on End-of-Life Care offers another promising example. Bringing together 184 randomly selected citizens, the Convention produced a nuanced, well-informed report that fed directly into parliamentary discussions. Its conclusions highlighted the need to improve EOL care and, within this specific deliberative context, suggested that assisted dying could be considered as part of a continuum of care. This position reflects the outcome of a structured citizens' deliberation and remains context- and jurisdiction-dependent, rather than constituting a normative claim of this paper. Importantly, the Convention demonstrated that when given time, information, and space, citizens can engage meaningfully with complex ethical issues (Convention citoyenne sur la fin de vie, 2023).

Such participatory mechanisms are essential to ensuring diverse perspectives—patients, caregivers, communities, people approaching EOL, policy-makers, and health professionals—inform a broader, non-medicalised and societal debate. As highlighted in Gastein, end-of-life is increasingly a prolonged trajectory rather than a brief clinical episode. It requires integrated care pathways, emotional and spiritual support, and recognition of the paramount role of families and informal caregivers. These relational, community and spiritual dimensions cannot be delegated solely to specialist medical services (Sallnow, 2022). They must be embedded within communities.

Viewed in this light, several policy priorities emerge:

First, establish and maintain public dialogue and social participation platforms, in health and otherwise, such as the French Citizen Convention, to build legitimacy and trust.

Second, leverage these platforms to define what “dying well” means and can be achieved in different cultural and community contexts (Harwood et al., 2025). This includes embedding death literacy in education, workplaces, and civic spaces to strengthen the relational basis of care (Harding et al., 2024).

Third, invest in home-based and community care models that honour people's preferences, close redistributive gaps, and serve as a complement to existing health system structures. Evidence from 20 OECD countries showed that increasing home-based long-term care spending by 1% is associated with more home deaths and fewer hospital deaths, whereas expanding non-home-based services is associated with more institutional deaths (Casanova et al., 2024).

Fourth, integrate EOL care across the health system—anchored in primary care, community settings, and coordinated pathways rather than siloed in specialist services alone. In Croatia, for example, palliative care has been intentionally developed as an integrated model within the broader health system, with reforms focused on new organizational structures, stakeholder empowerment, and coordination across levels of care, supporting a more continuous and patient-centred approach (Vočanec et al., 2022; Lončarek et al., 2018).

Finally, shift the narrative. EOL care is not a marginal issue but a reflection of our collective values.

Reframing EOL care as a universal societal obligation—rooted in dignity, compassion, and solidarity—can help renew Europe's social contract. By strengthening its redistributive, relational, and

¹ Death literacy is the collective ability to understand, plan for, and participate in the processes of dying, caregiving, and bereavement. (Noonan et al., 2016)

participatory foundations, health systems can better respond to a shared human reality: that we will all experience the end of life, and that care should reflect the values by which we choose to live — and to die.

CRedit authorship contribution statement

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Declaration of Competing Interest

We, the undersigned authors of the manuscript entitled, “**End-of-life care and the social contract: A European reckoning?**”, declare that we have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

This work was conducted independently and reflects the authors’ academic and professional perspectives. No external funding or institutional influence has affected the content, analysis, or conclusions presented in the manuscript.

All authors confirm the accuracy of this declaration.

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