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Introduction

Palliative care, as de ned, is the active and comprehensive treatment provided to individuals, irrespective of age, who are grappling with severe illnesses and are in close proximity to the end of life. is approach emphasizes prevention, early detection, thorough assessment, and management of medical concerns, encompassing pain, psychological distress, spiritual discomfort, and social needs. e goal is to enhance comfort and quality of life for both the patient and family caregivers. e World Health Organization advocates for the early integration of palliative care, starting from the identi cation of life-threatening conditions to achieve these objectives. e evolution of investments in palliative care stems from the merging of clinical and palliative care, responding to people's needs and expectations. Notably, palliative care gains prominence when diseases prove unresponsive to curative or control treatments [1,2]. However, in low- and middle-income countries, palliative care is o en insu cient and precarious due to a lack of knowledge among health professionals and the public, inadequate resources, and shortcomings in public-private health systems, hindering the delivery of quality and safe palliative care [3,4]. Dying individuals in these regions frequently experience agony and neglect, as palliative care is not consistently provided. Di erent paradigms, such as the biological perspective, suggest that treatment failures for cure should not be accepted, palliative care patients should be identi ed later, and optimistic prognoses should be avoided. Given these constraints, palliative care is more embraced among cancer patients than among those with prolonged illnesses and poor prognoses, justifying the focus on oncology in this review [5,6]. Especially in the oncology eld, clinical instability and worsening symptoms in advanced cancer patients can lead to the use of urgencies and emergencies, as well as prolonged hospital admissions, when treatment is not integrated with a professional palliative care team for di cult cases. e absence of in-hospital teams, transitional care, home palliative care, or a structured network for managing individuals with palliative care needs results in substantial nancial expenses in hospital-based models [7,8]. Many developed nations invest in well-organized palliative care services, primarily managed by primary care, to address the escalating costs associated with chronic illnesses. is investment is driven by the recognition of the intrinsic link between palliative care and primary care, both guided by shared values such as equity, solidarity, social justice, universal access to services, multisectoral activity, decentralization, and community participation. Evolving end-of-life care practices, including the shi of hospice care from hospitals to homes, are integral components of the palliative care strategy within primary care [9,10]. Home care serves as the primary delivery method for palliative care, aligning with bioethical values like patient autonomy and expanding access to a broader population.

e success of home palliative care hinges on the presence of a family caregiver o ering care under professional supervision. e health team, responding to demand, conducts home consultations, with nurses o en playing a pivotal role within a multidisciplinary team. Primary

it is anticipated that 90% of the 480,000 annual fatalities by 2056 could be treatable with palliative care. e objective of palliative care is to improve the quality of life for patients and their families by preventing

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