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Integrating Palliative Care into Primary Health Care: strategies for a comprehensive approach

Integração dos Cuidados Paliativos à Atenção Primária à Saúde: estratégias para uma abordagem integral

Integración de los cuidados paliativos en la atención primaria de salud: estrategias para un enfoque integral

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Abstract:
Objective: to identify publications on palliative care within Primary Health Care. **Methods:** an integrative review was conducted in which articles were selected from the PubMed, Elsevier, and Virtual Health Library databases. They were analyzed using the Patient, Intervention, Comparison, and Outcomes strategy, with the guiding question: "What strategies can be adopted to integrate palliative care into the core of primary health care?" The review was conducted between July and August 2024 and covers the period 2009–2024. **Results:** of the 30,872 initial publications, 11 (only two Brazilian) were selected, demonstrating that the integration of palliative care into primary care improves patient quality of life, significantly reduces hospitalization rates, lowers financial costs, and increases the efficiency of health professionals. The heterogeneity of the global population also poses a complex challenge, hindering the consolidation of an effective model, both in terms of financial viability and applicability in training. In Brazil, although Primary Health Care has extensive coverage and is a strategic location for comprehensive care, Palliative Care remains marginalized. This is due to issues such as gaps in professional training, limited team structure for this approach, and a lack of public policies to ensure its full integration. **Conclusion:** Primary Health Care is a powerful asset in Brazil given its coverage; however, it is necessary to include Palliative Care, as well as further studies on the topic.
Keywords: Palliative care; Primary Health Care; Death; Medical Oncology; Terminal care.

Resumo:
Objetivo: identificar publicações acerca de cuidados paliativos no âmbito da Atenção Primária à Saúde. **Método**: revisão integrativa em que foram selecionados artigos nas bases de dados PubMed, Elsevier e Biblioteca Virtual em Saúde, analisados por meio da estratégia *Patient, Intervention, Comparison e Outcomes*, com a seguinte questão norteadora: “Quais estratégias podem ser adotadas para integrar os cuidados paliativos na essência da atenção primária à saúde?”. A busca considerou o período de 2009 a 2024 e foi realizada entre julho e agosto de 2024. **Resultados**: das 30.872 publicações iniciais, foram selecionadas 11 produções (das quais apenas duas brasileiras) cujos resultados indicam que a integração dos cuidados paliativos na atenção primária melhora a qualidade de vida dos pacientes promove redução significativa nas taxas de internações, diminuição dos custos financeiros e maior eficiência dos profissionais de saúde. Verificou-se também que a heterogeneidade da população global representa um desafio complexo, o que impede a consolidação de um modelo efetivo, tanto em sua viabilidade financeira quanto em sua aplicabilidade na formação profissional. No Brasil, onde, embora a Atenção Primária à Saúde possua extensa cobertura e seja um componente estratégico para o cuidado integral, os Cuidados Paliativos ainda permanecem à margem do sistema. Esse cenário se deve a questões como a lacuna na formação profissional, limitada estrutura das equipes para essa abordagem e escassez de políticas públicas que garantam sua plena integração. **Conclusão**: a Atenção Primária à Saúde é um local potente no Brasil, dada a sua cobertura; no entanto, é preciso integrar os Cuidados Paliativos e fomentar mais estudos acerca do tema.
Palavras-chave: Cuidados paliativos; Atenção Primária à Saúde; Morte; Oncologia; Assistência terminal.

Resumen:
Objetivo: identificar publicaciones sobre cuidados paliativos en el ámbito de la atención primaria de salud. **Método**: revisión integradora en la que se seleccionaron artículos de las bases de datos PubMed, Elsevier y Biblioteca Virtual en Salud, analizados mediante la estrategia *Patient, Intervention, Comparison and Outcomes*, con la siguiente pregunta orientadora: “¿Qué estrategias pueden adoptarse para integrar los cuidados paliativos en la esencia de la atención primaria de salud?”. La búsqueda abarcó el período de 2009 a 2024 y se realizó entre julio y agosto de 2024. **Resultados**: de las 30.872 publicaciones iniciales, se seleccionaron 11 trabajos (de los cuales solo dos eran brasileños) cuyos resultados indican que la integración de los cuidados paliativos en la atención primaria mejora la calidad de vida de los pacientes, promueve una reducción significativa de las tasas de hospitalización, disminuye los costos financieros y aumenta la eficiencia de los profesionales de la salud. También se verificó que la heterogeneidad de la población global representa un desafío complejo, lo que impide la consolidación de un modelo eficaz, tanto en su viabilidad financiera como en su aplicabilidad en la formación profesional. En Brasil, donde, aunque la atención primaria de salud tiene una amplia cobertura y es un componente estratégico para la atención integral, los cuidados paliativos siguen estando al margen del sistema. Esta situación se debe a cuestiones como la laguna en la formación profesional, la limitada estructura de los equipos para este enfoque y la escasez de políticas públicas que garanticen su plena integración. **Conclusión**: la atención primaria de salud es un ámbito potente en Brasil, dada su cobertura; sin embargo, es necesario integrar los cuidados paliativos y fomentar más estudios sobre el tema.
Palabras clave: Cuidados paliativos; Atención Primaria de Salud; Muerte; Oncología Médica; Cuidado Terminal.

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INTRODUCTION

According to the World Health Organization (WHO), Palliative Care (PC) is defined as an approach that improves the quality of life of patients and families with life-threatening conditions associated with illnesses. It does so through prevention and relief of suffering, achieved by early detection and treatment of physical, social, and spiritual issues. PC aims to recognize the needs of patients during a phase of gradual worsening of the disease. The approach is to meet the patient's needs holistically: practical, physical, and emotional[1].

Primary Health Care (PHC) is the first level of health care, and it is characterized by a set of actions at the individual and collective levels aimed at promoting and protecting health, preventing harm, and developing comprehensive care. The PHC, in addition to being the organizing and communication center for the Health Care Networks (HCN), is the main gateway to the Unified Health System (*Sistema Único de Saúde* - SUS), whose principles are comprehensiveness, universality, and equity. Within this system, the PHC organizes the flow of services across all sectors, from Family Health Strategies (FHS) to tertiary care units[2].

The Brazilian Ministry of Health stipulates that PHC staff are responsible for monitoring patients undergoing PC, emphasizing longitudinal care. Furthermore, due to the bond established between staff and patient, there is greater interaction between them and greater ease in identifying the patient's needs. The PHC team can also select patients to receive Home Care (HC), which is offered according to individual needs with the support of multidisciplinary teams. The *Melhor em Casa* Program, part of the HC network, offers PC and home care initiatives[3].

In 2018, the WHO released a guide for integrating palliative care into primary care. Its recommendations list continuing education initiatives for nurses and physicians, consisting of 30-40 hours at an intermediate level and offered by universities. Caregivers and volunteers would receive 3-6 hour courses on the foundations and fundamentals of palliative care, and managers would receive a 5-6 week course like the "Palliative Care Initiators Course" offered in Uganda. The guide emphasizes the importance of public health practices, the integration of palliative care with other health services, primary care tasks, community participation, and task assignments[1].

In Brazil, the underutilization of public health services is evident in the daily lives of the population. The greatest challenges highlighted between 2001 and 2023 are due to the scarcity of financial resources and their misuse by incompetent managers, misappropriation of funds, corruption, fragmentation of health services, low pay for professionals, and poor workplace conditions[4].

In Brazil, multiple challenges remain for its full consolidation within the healthcare system. The main obstacles include insufficient academic training for professionals, poor communication between healthcare teams, patients, and families, limited access to essential medications, and weak public policies in this field. Historically, health sciences education in the country has offered little structured approach to palliative care, leaving students with the responsibility of seeking additional knowledge through extracurricular means[5].

This lack of professional preparation and consistent public policies directly compromises the quality of palliative care. Ordinance No. 3,681 of May 7, 2024, created the National Palliative Care Policy (*Política Nacional de Cuidados Paliativos* - PNCP) within the SUS. The new policy establishes guidelines for the progressive implementation of palliative care in all spheres of care, strengthening palliative practices and expanding the population's access to qualified services. This initiative demonstrates a recent government effort to structure and consolidate palliative care as an essential component of healthcare in Brazil[6].

The palliative care approach allows for a reduced service burden and aligns with the crucial element of PHC: resolution. Therefore, this study aimed to identify publications on palliative care within the scope of Primary Health Care.

METHODS

This integrative review was conducted according to the method proposed by Mendes, Silveira, and Galvão[7], which includes six steps: developing the research question, defining inclusion and exclusion criteria, selecting the sample, extracting data, critically analyzing the included studies, and presenting the results. The guiding question was: "*What strategies can be adopted to integrate palliative care into the core of PHC?*"

The Patient, Intervention, Comparison, and Outcomes (PICO)[8] strategy was used to assist in formulating the question that led to the research theme, in which the elements were defined as: PHC professionals who do not know how to deal with patients in PC in a practical, financial, or sociocultural manner (P); implementation of PC in PHC more effectively through the adoption of pre-established models of education or related to the financial scope (I); PC only in health services with high specialization or PC in PHC in an inefficient way (C); a better quality of life for the patient and/or a lower demand for specialized services in order to alleviate the burden (O).

Searches were conducted between July and August 2024 in the following databases: PubMed, ScienceDirect (Elsevier), Virtual Health Library (VHL), and the Google Scholar online search platform. Controlled DeCS/MeSH descriptors were used, combined with the Boolean operators: "palliative care" AND "primary health care" AND "model health care."

Original articles published in the last 15 years, in Portuguese, English, and Spanish, that answered the guiding question were included. Reviews, book chapters, editorials, articles in other languages, or those not directly addressing the proposed topic were excluded. The selection was carried out by all authors independently, and disagreements were resolved in meetings with the group and the supervising researcher.

Data extraction was performed using a Microsoft Excel spreadsheet developed specifically for this review. The spreadsheet contained the following fields: author, year, country of publication, type of study, population studied, objective, proposed interventions, main results, and recommendations. This instrument enabled the systematization of information and facilitated the critical analysis and synthesis of findings.

Data analysis was conducted using a qualitative approach, using narrative synthesis. Results were grouped by thematic similarity, allowing us to identify the main strategies and models for integrating palliative care into PHC. Study selection followed PRISMA guidelines[10].

RESULTS

Initially, 30,872 publications were identified, of which 2,487 articles were related to the study topic. Of these, 33 were selected for full review and application of the inclusion criteria, with 11 articles being considered. The selection process flowchart is shown in Figure 1.

Chart 1 presents the study types: two randomized clinical trials, two cross-sectional studies, one exploratory study, one cohort study, one multicenter study, one four-phase study, one case report, one retrospective observational study, and one opinion article, published between 2013 and 2024. The nationality of the articles identified was as follows: two Brazilian, two Canadian, one American, one Iranian, one Spanish, one Indian, one Arabic, one Portuguese, and one Norwegian. The main aspects evaluated were: the effectiveness of the model's implementation, user satisfaction (professional, caregiver or patient under PC), the reduction in the hospitalization rate and the reduction in expenses (Chart 1).

Figure 1. Flowchart for inclusion of reviewed articles, according to the PRISMA methodology. Passos, MG, Brazil, 2025.

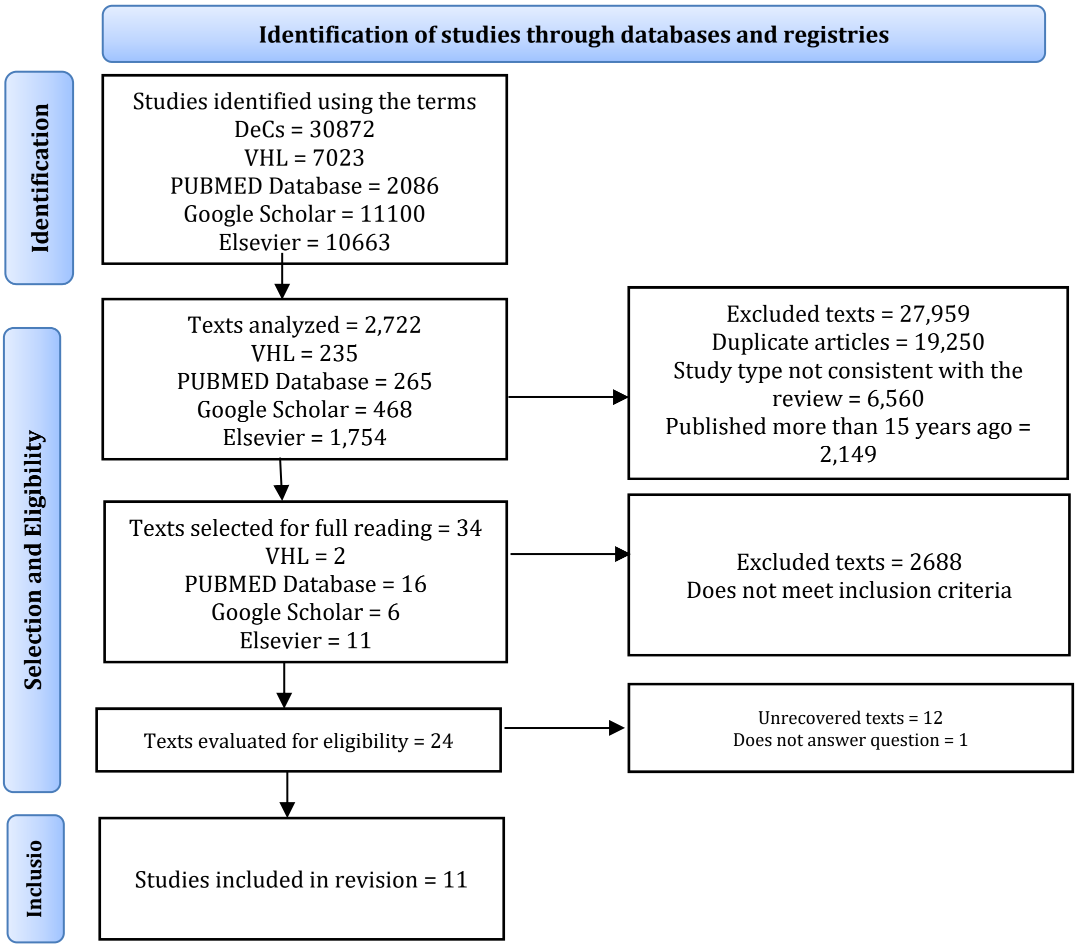

Chart 1. Primary studies included by author and year, journal, database, objectives, country of origin, and methodology. Passos, MG, Brazil, 2025.

Author year	Journal	Database	Objectives	Origin	Methods
Rao *et al*, 2024 [11]	J Pain Symptom Manage	PubMed	To determine whether an integrated, multicenter, primary care-led palliative care model improves clinical, utilization, and economic outcomes.	United States	Retrospective observational study
Alizadeh *et al*, 2024[12]	Asia-Pacific Journal of Oncology Nursing	Elsevier	To analyze whether early integration of PC into home health care services is essential for cancer patients to improve their quality of life and reduce their healthcare costs. Therefore, the study aimed to develop a home PC model for cancer patients in Iran.	Iran	Four-phase study: integrative review (1); qualitative study of semi-structured interviews (2); integration of results (3); Delphi study (4)
Pelayo-Alvarez *et al*, 2013[13]	J Palliat Med	PubMed	To test the effectiveness of an online teaching tool on PC for primary care physicians through the impacts on symptom control, quality of life, and knowledge gained over 18 months.	Spain	Randomized clinical trial

Atreya *et al*, 2019[14]	J Family Med Prim Care	Google Scholar	Seek to bridge the gap between the hospital specialist and the Family and Community Doctor through the implementation of the Patient-Centered Model in PHC, thus reaching patients who lived far from specialized care.	India	Original exploratory study
Howard *et al*, 2019[15]	J Palliat Med	Google Scholar	To examine whether the use of different PHC care models is associated with end-of-life and its outcomes.	Canada	Retrospective cohort study
Alshammary *et al*, 2020[16]	Cureus	PubMed	To evaluate the results of integrating PC services into primary health care and assess patient satisfaction with the services provided by PHC.	Saudi Arabia	Cross-sectional study
Matthew *et al*, 2023[17]	BMC Palliative Care	PubMed	To qualitatively explore the experiences of primary health care teams in Ontario, Canada, who participated in the CAPACITI pilot, seeking to understand the factors that helped or hindered the participating teams in applying the components in practice.	Canada	Randomized clinical trial
Corrêa *et al*, 2017[18]	Revista Brasileira de Medicina de Família e Comunidade	Google Scholar	To present the process of identifying PC patients in a FHS team in Brazil.	Brazil	Cross-sectional study
Junges *et a*l, 2022[19]	Revista de Políticas Públicas	Google Scholar	To discuss the case of a patient with severe chronicity and incapacitating conditions treated at a health unit in the metropolitan region of Porto Alegre, Rio Grande do Sul, as a candidate to receive PC in the PHC.	Brazil	Case report
Gouveia *et al*, 2023[20]	Revista Portuguesa de Medicina Geral e Familiar	Google Scholar	Analyze the ACERTAR method, an acronym that brings together the seven objectives (and resulting interventions) of home care provision: Assess; Communicate; Empower; Review/Reduce; Treat; Anticipate and Refer.	Portugal	Opinion article and debate
Kittang *et al*, 2024[21]	BMC Health Services Research	PubMed	To describe the impact of the coronavirus pandemic on a nursing home and its impact on older individuals who required primary care.	Norway	Retrospective observational study

Chart 2 presents the professionals analyzed, the intervention performed, and the main results found. PC in PHC by multidisciplinary teams was shown to be essential: various medical specialties, as well as nurses, social workers, and politicians. Regarding the patients considered eligible for PC in PHC, the studies highlighted cancer patients, elderly patients, and those with chronic diseases.

The main results generally observed in the selected studies were: a higher likelihood of death at home, fewer hospitalizations, lower costs, greater patient satisfaction, greater professional knowledge, and greater integration of care.

Chart 2. Primary studies included, by author and year, professionals analyzed, patients analyzed, intervention, and main results. Passos, MG, Brazil, 2025.

Author and year	Professionals analyzed	Patients analyzed	Intervention	Main results
Rao *et al*, 2024[11]	PHC professionals from Western New York (n=47), Central Ohio (n=258), Northeast Ohio (n=89), Western Pennsylvania (n=46), Southeast Ohio (n=30), and Northwest Ohio (n=67). Physicians, nurses, and social workers were included.	Medicare beneficiaries who died between January 1, 2021, and January 31, 2023 (n=889).	Eight groups were established in six communities with 20 or more patients receiving palliative care. All groups underwent training. The groups had the flexibility to choose between partnering with a local palliative care agency or forming a group with specialized palliative care professionals. The study model prioritized lower patient outlays (Value-Based Care Chassis).	PC centered in PHC demonstrated an improvement in patients' quality of life. The following were listed in a combination between the groups: 5.4 more days at home (P<0.001), 40% fewer hospitalizations (p<0.001), 17% fewer in-hospital deaths (p<0.001), and $10,393 lower overall costs per patient (p<0.001).
Alizadeh *et al*, 2024[12]	Phase 1: Does not apply. Phase 2: 2 oncologists, 1 palliative care physician, 1 general practitioner, 7 nurses, 1 psychologist, 1 physical therapist, 1 social worker, 1 religious affairs specialist, 3 administrators, and 3 nursing faculty members. Phase 3: 2 faculty members specializing in oncology and community health nursing, 2 health policy managers at MOHME (Ministry of Health and Medical Education) specializing in cancer PC, and 1 doctoral nursing student specializing in medical-surgical nursing. Phase 4: Of the 23 PC specialists, only 12 remained in the study (1 palliative care physician, 1 oncologist, 1 administrator, 1 director of a home care center, 4 administrators, and 4 nurses).	Phase 1: Does not apply. Phase 2: 10 cancer patients and 7 caregivers (family or otherwise). Phase 3: Does not apply. Phase 4: Does not apply.	Phase 1: Integrative review of 12 articles focused on identifying barriers to home-based PC. Phase 2: Semi-structured interviews conducted for 20-60 minutes. Data analysis was based on the Hsieh and Shannon method using the WHO guidelines and MAXQDA-10 software. Phase 3: Data integration with reassessment by experts. Phase 4: Delphi study to determine the importance of indicators, create the initial draft of the model, and validate it.	Phase 1: 52 indicators were found, divided into 7 pillars (policy development = 11, healthcare financing = 5, service delivery = 12, workforce development = 11, access to medicines = 5, information and research = 6, and ethical and legal issues = 2). Phase 2: 546 codes, 22 subcategories, and 8 pillars were extracted. The difference from Phase 1 was the addition of the "family empowerment" pillar. Phase 3: 118 indicators were obtained across 8 study pillars to prepare the questionnaire for the next phase. Phase 4: The model was approved after 4 adjustments, with the inclusion of "focus on the principle of comprehensiveness" and the addition of "development of a monitoring program for outpatient PC professionals." The final eight pillars were ethical and legal issues, policy development, financial resources, service delivery, workforce development, information and research, access to medicines, and family empowerment. All of these pillars must be considered for an effective PC model without gaps in the level of care provided.

Pelayo-Alvarez *et al*, 2013[13]	169 doctors from 17 health regions in Spain.	117 patients with advanced cancer undergoing PC.	Physicians were divided into an intervention group (n=85) and a control group (n=84). The intervention group received a 96-hour online course on PC, with 86.6% (n=71) completing the full course. The control group optionally received a 20-hour in-person course, which 13.4% (n=11) chose to take. Patients were divided between physicians who received the online course and those who received the in-person course or no course at all. The intervention group consisted of 63 patients and the control group consisted of 54. Symptom control was assessed using the Brief Pain Inventory (BPI) and the Palliative Care Outcome Scale (POS), both completed by the patients. The physician questionnaire included Eastern Cooperative Oncology Group (ECOG) performance status. Quality of life was assessed using the Rotterdam Symptom Checklist (RSCL). Caregiver satisfaction was measured using SERVQUAL, which analyzed tangibles, reliability of treatment/care, safety, responsiveness, and empathy. Physicians' knowledge was assessed using a questionnaire at the end of the 18 months.	Of the 169 physicians in the analysis, only 67 physicians collectively treated 117 patients. The other 78 stated that they had no patient demand for PC. The intervention group had reduced pain, symptom, and family anxiety scores compared to the control group (p=0.039). Quality of life showed no significant change between the groups. Caregiver satisfaction showed no significant differences. Physicians' knowledge was measured by a questionnaire with a maximum score of 33, showing a significant difference between the intervention and control groups that received in-person training (p=0.0001) and those that did not (p=0.0018).
Atreya *et al*, 2019[14]	165 family doctors or doctors working in the PHC of Kolkata.	Does not apply	Exploratory study with the intention of understanding the facilitators and challenges regarding PC integrated into PHC through the Integrated Primary PC Model.	One hundred of the 165 physicians completed the survey. Regarding barriers, it was found that 62% had cared for a palliative patient in the last year and 34% felt confident in providing the necessary PC. Lack of confidence was associated with lack of knowledge (32%), lack of self-confidence (34%), lack of resources (67%), lack of hours (89%), and poor communication from the hospital where the patient comes from (87%). Regarding facilitators, 46% of physicians would be willing to offer support to patients in PC, 21% would discuss the care plan with the patient and family, 32% attempted to prepare for PC care online, and 75% would be willing to receive training on primary PC.

Howard *et al*, 2019[15]	Three groups of physicians in Ontario, Canada, were analyzed. The first consisted of family physicians and general practitioners, the second of palliative care physicians, and the third of other specialist physicians.	194,112 deceased patients who received PC divided into 3 groups: capitation (n=98,578), improved FFS (fee-for-service) (n=64,913) and traditional FFS (n=30,621).	Medical records covering the final six months of patients undergoing PC between April 2010 and March 2013 in Ontario were analyzed. The data obtained were analyzed according to the institution's remuneration model to achieve lower costs and hospitalization rates. To this end, we analyzed the patient's total expenditure, services provided, professional involvement, home visits, and place of death. SAS 9.3 software was used for all analyses.	62.7% of the deceased had more contact with a specialist than with their family and community physician at the end of their lives. 22.5% of patients received a visit from their family physician before death, and 1.1% received a visit from a specialist. Among the remuneration models, those with the enhanced FFS model (23.3%) performed the most home visits, followed by the capitation model (22.9%) and the traditional FFS (19.5%). The involvement of a palliative care physician was higher in the enhanced FFS model (41.5%). The total cost per patient in the enhanced FFS model was CAD $38,905, in the capitation model $36,229, and in the traditional model $36,752. Patients in the enhanced FFS model were more likely to die in institutions than those in the capitation model (p=0.02).
Alshammary *et al*, 2020[16]	Family physicians working in PHC in Riyadh district, Saudi Arabia, who received training for 3 months.	110 participants between patients and caregivers (7:3) who had a demand for PC at the PHC level.	The questionnaires were completed only by patients and caregivers, and questions were answered on a Likert scale. The data were analyzed using SAS software.	Overall, the overall satisfaction rating was 88%. Waiting times were extremely satisfied (83%), satisfied (9%), and dissatisfied (1%). Regarding the appropriate information delivery, 89% felt extremely satisfied or satisfied, 4% neutral, and no one had any complaints about the information they received. Regarding patient dignity, 96% felt extremely satisfied with the way they were treated. In the general PC evaluation, 84% rated themselves as extremely satisfied, 3% as satisfied, and only 1 patient as dissatisfied.
Matthew *et al*, 2023[17]	CAPACITI participants (159): physician (n=39); registered nurse (n=29); practicing nurses (n=28); administrator (n=27); social worker (n=15); pharmacist (n=7); registered practical nurse (n=7); dietitian (n=4); others (n=3).	Does not apply.	Healthcare teams in Ontario, Canada, were invited to participate in CAPACITI, which is offered free of charge. In this initial implementation, virtual sessions via the Zoom Video Communications app were held in 10 facilitative modules. Each session focused on a central topic, such as improving communication skills, early identification and assessment, team building, and engagement with specialist caregivers. All sessions included educational support, evidence-based tools, and training and facilitation to support professionals.	The multicenter educational program in question (CAPACITI) was designed to develop PC capacity within primary care teams. With a facilitated approach to knowledge translation, it helped primary care teams develop the principles for applying a palliative approach to care.

Corrêa *et al*, 2017[18]	Professionals from a PHC team in the city of Rio Grande (RS).	38 patients.	The "*Estar ao Seu Lado*" Project aims to provide primary care with a focus on developing community caregivers alongside primary care teams. To identify patients requiring PC, the identification process was carried out 1) using the work system of a Family Health Strategy Team and the principles of primary care, and 2) applying SPICT, a tool to help identify patients who could benefit from PC.	At the end of the 12-month period, 38 people were identified with palliative needs from a total population of 3,000 (1.2% of the practice population). Of these, 58% (n=22) were women, 63% (n=24) were over 65 years of age, and 74.7% (n=28) self-reported white ethnicity. The most frequent primary diagnoses were cancer (39.5%), psychiatric illness (18.4%), cardiovascular disease (15.8%), frailty (10.5%), dementia (10.5%), and respiratory disease (7.9%). Multimorbidity was higher in patients over 65 years of age (t-test, p=0.009), with a median of four diseases. The most prevalent pathologies among those with multimorbidity were cardiovascular disease (73.7%), psychiatric illness (65.8%), cancer (50%), frailty (39.5%), diabetes mellitus (31.6%), and respiratory diseases. The application of the tool proved to be practical and feasible in the context in question.
Junges *et al*, 2022[19]	PHC health professionals responsible for the PC of the patient in question in the reported case.	Diabetic patient with chronic renal failure.	In the case of a patient with mental health issues, the healthcare team recognized the need for more in-depth intervention only through care erroneously considered essential for her health, such as medication for diabetes and hemodialysis for her kidney condition. The patient required care with light medical technologies because the focus of her needs had shifted from a cure to relief and quality of life through the provision of appropriate information and dialogue about the patient's wishes at this point in her life.	PC in PHC can provide a better quality of life for patients with severe sequelae of chronic conditions and enable discussion about the dying process, if the patient so desires. The various facets of care require a combination of professional training in recognizing the timing of PC introduction, psychological and spiritual support, and clinical follow-up. Analyzing the use of soft technologies over soft-hard technologies is essential for the best PC approach in PHC.
Gouveia *et al*, 2023[20]	Family doctor and family nurse from Portugal.	Does not apply.	The difficulty in providing PC services is evident due to the lack of standards and models to guide PHC professionals. To address this issue, the ACERTAR method was proposed, an acronym that guides professionals to practically structure the methodology for applying PC during home visits. The acronym lists the seven objectives of PC provision: A - assess the needs of the patient and those close to them; C - communicate effectively with participants; E - empower those involved; R - reverse and/or reduce symptoms with appropriate therapeutic interventions; T - treat current	Patient monitoring by a primary care physician or family nurse is extremely important, especially in the palliative setting. The intervention method guides the professional in providing PC, disseminating and disseminating knowledge to care for patients without avoidable suffering.

			symptoms and anticipate likely ones; A - anticipate through an effective care plan; R - refer patients to relevant cases and situations.	
Kittang *et al*, 2024[21]	Nursing wards in 23 public and 11 private nursing homes in Bergen Municipality, Norway	257 COVID-19 patients were treated in the nursing ward, all diagnosed by RT-PCR for SARS-CoV-2. They were assessed according to their frailty, ranging from 1 - very fit, to 9 - terminally ill. Eighty-five patients (33.1%) were transferred from the hospital, while the remaining 172 came from nursing homes (n=149), home services (n=10), or their own homes (n=13). Ten patients (3.9%) were hospitalized with severe respiratory failure due to COVID-19 or sepsis due to respiratory coinfection.	Doctors and nurses used the "Livets Siste Dager/The Last Days of Life" method, the Norwegian guidelines for hospitals and primary care units, developed by the Liverpool Care Pathway. Advance PC planning was implemented in 95.3% of patients, and 29 died with symptom relief and treatment, with a frailty score of less than 7 (moderately frail).	With advance planning of PC for elderly individuals affected by COVID-19 (n=90%), mortality rates were reduced even in the early stages of the pandemic. Care with systematic assessment of the appropriate intensity of individual treatment for each patient and PC for those in need.

DISCUSSION

The effectiveness of PC integration was highlighted in all included studies, whether due to socioeconomic factors, improved quality of life for terminally ill patients, or medical knowledge gained through the intervention. This highlighted the benefits of this integration, particularly by describing that PC should not be exclusive to secondary and tertiary healthcare services[11-21].

From a financial perspective, the US study demonstrated a model that allowed for greater flexibility based on Value-Based Healthcare (VBHC), in which healthcare professionals are compensated based on the quality of service, not the quantity[9]. Furthermore, the possibility of greater flexibility and autonomy for PHC members in selecting more individualized therapy led to lower costs ($p<0.001$) and a lower rate of deaths during hospitalizations ($p<0.001$), favoring the death of patients surrounded by loved ones within the family environment[11].

In the US study, there was a considerable reduction in care costs (a difference of -$10,393 between the treatment group and the control group); a reduction in overall hospitalizations (confidence interval [CI] = -0.49, -0.25); a decrease in ICU days (-0.6%); a decrease in the percentage of in-hospital deaths (-17% with CI = -0.20, -0.13); and an increase in days spent at home (+5.42 with CI = 3.67, 7.18)[11].

However, unlike the Brazilian model, where PHC is mostly public and universally accessible through the SUS, the primary care system in the United States is predominantly private, with access often conditional on health insurance coverage[22].

Furthermore, another study indicates that 16 of the 21 studies analyzed found that the cost of home-based PC significantly reduced service costs and hospitalization rates[23]. In association, another study addresses the topic of PC legislative issues that lack public policies for their proper and effective implementation in the PHC setting[24].

From another economic perspective, this time from a Canadian perspective, three different remuneration methods for professionals offering home PC were analyzed: (1) capitation; (2) fee-for-service; (3) enhanced fee-for-service. However, the study demonstrates a preference among patients for receiving home care from specialists when compared to a Family and Community Physician (FCP). A total of 62.7% had more contact with specialists than with FCPs. This may be explained by a generalist's lack of knowledge of PC practices, as such care is not required in most curricula[15].

Regarding the financial models, the greatest savings were observed in the capitation model, with a total of 36,229 Canadian dollars per patient. The enhanced fee-for-service model had a higher rate of deaths in institutions compared to the capitation model ($p=0.02$). The fundraising model proved to be the most economical, with a fixed remuneration based on the number of patients treated[15]. Furthermore, the fundraising model and the fee-for-service model do not show significant differences in the quality of care when applied outside of a palliative approach[25].

Regarding the analysis of improved quality of life, considerable benefits were observed with the proper application of PC to patients at the end of their lives. The studies provided significant samples in the following areas, respectively: symptom relief, family assistance and support in coping with grief, and holistic observation of the individuals involved, whether the direct patient or third parties, such as family members[16,19,21]. Similarly, a review focused on the dynamics of home-based PC shows that care provided in the patient's home is more economical and allows for a patient-centered approach. These data clarify the relevance of PC in improving the quality of life at the end of life for patients in need and their family members[26].

Among some of the extracted and selected articles, an expansion of medical knowledge and increased confidence in practicing PC with PHC patients is evident. This knowledge gain occurred primarily through the implementation of courses, questionnaires, workshops, and efficient training, respectively, for the subsequent practical implementation of this practice in the daily lives of well-qualified professionals providing services to end-of-life patients. Some studies highlight effective methods for disseminating PC among professionals who face the terminal phase of their patients throughout their professional journey[13,14,17,18,20].

This would be achieved through the implementation of strategies, as described by Gouveia *et al*, who summarized the main actions to be taken by the PHC team to systematize home visits with the main points to be discussed with the patient and their family members, empowering the patient and their caregivers to actively participate in the decisions made[20].

This approach is based on the ACERTAR method, an acronym that highlights the goals to be achieved by the PHC team during the visit to the patient undergoing PC. These include: holistic assessment of palliative needs; clear communication of the diagnosis and its complications, adjusting to family expectations and the patient's wishes; empowering the patient by allowing them to exercise their autonomy and clarifying their doubts; treating and medicating current symptoms; anticipating the main likely events with disease progression, discussing the patient's preferences regarding death; and finally, referral in difficult home and PHC management scenarios[20].

In Portugal, using the ACERTAR method, the healthcare system is based on the National Health Service (*Serviço Nacional de Saúde* - CNS), which, like the SUS in Brazil, provides universal and free care at all stages of healthcare[27].

A study conducted in Saudi Arabia seeks to portray the importance of professionals' interest in acquiring new knowledge to facilitate the practice of health sciences. The slightly significant participation rate among oncology care professionals was 75.4%, with a response rate and participation rate in a workshop on PC, which focused on assisting in the development of a care model for patients with life-shortening diseases in that country[16].

In Brazil, the weaknesses are similar, with emphasis on weak and ineffective public policies that guarantee the process of dying with dignity. Brazil, a country with a vast territorial dimension and only 198 PC service centers (0.94 per million inhabitants), is one of the worst countries to die in the world, ranking 79th. On the other hand, in 2022, there were 48,161 Basic Health Units (BHU) in Brazil, which can serve an average of 564,234 people per day[28].

The Iranian model proposes organizing PC in primary care around eight pillars - ethical and legal issues, policy development, financial resources, service delivery, workforce development, information and research, access to medicines, and family empowerment - which bear a notable resemblance to the principles and attributes established by the SUS in Brazil and are present in the country's PHC system[12,24,29].

Ethical and legal issues reinforce the values of universality and equity, ensuring fair and equal access to health care. Policy development guides care coordination, fostering integration and continuity of services. The provision of financial resources supports regular access to health services, while service delivery ensures comprehensive and consistent care. Workforce development contributes to cultural competence and community orientation, enabling interventions sensitive to local needs. Information and research, in turn, enable strategic planning and continuous evaluation of health practices[12,24,29].

PHC in Brazil plays a fundamental role in caring for people throughout their lives. Organized as the gateway to the SUS, it is present in the territories, close to communities and local realities. Through the FHS, PHC has strengthened as a form of care that values connection, listening, and continuous monitoring, playing a key role in promoting health and addressing inequalities[30].

Despite the country's regional and social inequalities, the SUS remains a public and universal system, with a structure capable of integrating palliative care into PHC. The continuous presence of teams in the territories favors the early recognition of palliative needs and the provision of close, humane care[31]. Therefore, incorporating palliative care into PHC ensures dignity, relief from suffering, and comprehensive monitoring. By being with people at all stages of life - including the end of life - HC becomes an essential space for providing care that respects each individual's history, values, and uniqueness[32].

Furthermore, access to medication reinforces comprehensive and equitable care, while family empowerment fosters family and community guidance, strengthening the bond between patients, families, and professionals. Thus, the pillars proposed by the Iranian study align with the essential and derived attributes of PHC, highlighting the importance of integrating palliative care and primary care for more comprehensive, equitable, and humane care[12,24,28].

CONCLUSION

PC presents many barriers to its implementation, whether in its context, teaching, or application: the idea of a "cure," the unavailability of professionals interested in the field, and patients who are poorly informed about their conditions and unaware of their prognoses.

Furthermore, the lack of a curriculum that addresses the topic in the teaching plan of health programs hinders the implementation of palliative care management for patients. Furthermore, the competent agencies need to work on developing and managing public policies that effectively address the problem.

In summary, PC in PHC aims to reduce hospitalization days, reduce potentially preventable suffering, and bring a more individualized humanization to the life-and-death period for patients and their families. However, there are few Brazilian studies on this topic and challenges such as the lack of public policies, a lack of interested professionals, and lack of training for them.

Therefore, further studies are essential to address the topic across a broader spectrum and better assess its effectiveness in Brazil.

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