



Palliative Care Journal Watch

A partnership between Pallium Canada and several Divisions of Palliative Care/Medicine across Canada and Internationally: University of Calgary, University of Alberta, Queens University, Hadassah-Hebrew University Medical Center, Israel University of Navarra, Spain

Hosts and Panelists

Dr Leonie Herx, Dr Jose Pereira, Dr Sharon Watanabe

May 25, 2026



Welcome to the Palliative Care Journal Watch!

- Keeps you up to date on the latest peer-reviewed palliative care literature.
- Led by palliative care experts from several divisions of palliative care/medicine across Canada and internationally.
 - University of Calgary
 - University of Alberta
 - Queen's University
 - Hadassah-Hebrew University Medical Center, Israel
 - University of Navarra, Spain
- With the assistance of the Pallium Canada team
- We regularly monitor over 30 journals and highlight articles that challenge us to think differently about a topic or confirm our current practices.

Introductions

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Disclosures

Pallium Canada

- Pallium is a registered charity.
- Pallium generates funds to support operations and R&D from course registration and registration fees, sales of the Pallium Pocketbook sales, and philanthropy.

Mitigating Potential Biases

- The curriculum team and scientific planning committee had complete independent control over the development of course content.

Disclosures of Hosts/Guest Panelists

No conflicts of interest to disclose

Editorial Team

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- Dr. José Pereira
- Dr. Sharon Watanabe
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Featured Articles

Featured Articles

1. May P, Nikram E, Johansson T, et al. **Specialist palliative care improves patient experience, reduces bed days and saves money: An economic modelling study of home- and hospital-based care.** *Palliat Med.* Published online March 4, 2026:02692163261423755. doi:10.1177/02692163261423755
2. Rosa WE, Ursoleo JD, Connor S, et al. **Palliative care integration in primary health care across the life course: a global health imperative.** *The Lancet Primary Care.* 2026;2(4). doi:10.1016/j.lanprc.2026.100106
3. Tripodoro VA, Fidalgo JFL, Pons JJ, et al. **First-Ever Global Ranking of Palliative Care: 2025 World Map Under the New WHO Framework.** *J Pain Symptom Manage.* 2025;70(5):447-458. doi:10.1016/j.jpainsymman.2025.07.026

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Specialist palliative care improves patient experience, reduces bed days and saves money: An economic modelling study of home- and hospital-based care.

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Presented by:

Sharon Watanabe

Background

- <1% of people in high income countries die annually, but they account for 8-10% of healthcare spending, primarily driven by hospital admissions.
- Most people with serious illness in high income countries visit hospital in the last month of life and die in hospital.
- In England, less than half of people who die from a non-sudden cause receive specialist palliative care (SPC).

Objectives

- To estimate the cost-effectiveness of home- and hospital-based SPC for adults in England.

Methods

- Design: Health-economic decision-modelling using five-state Markov cohort models with a 24-h cycle and lifetime horizon.
- Evaluated home- and hospital-based care separately.
- Modelled counterfactuals using Cochrane review evidence of treatment effects on place of death and quality of life.
- Estimated place of death distributions, utilisation, quality adjusted life years, and unit and intervention costs from the literature.

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Key Results

- Home SPC patients: formal costs were £7908 lower than usual care patients (95% CI: –18,044 to 395); Quality Adjusted Life Years (QALYs) were higher by 0.035 (95% CI: 0.033 to 0.037); Incremental Cost Effectiveness Ratio (ICER) was –£227,781 per QALY (95% CI: –482,524 to 12,151).
- Hospital SPC patients: formal costs were £6480 lower than usual care patients (95% CI: –11,482 to –1671). QALYs were higher by 0.033 (95% CI: 0.031 to 0.035). ICER was –£196,696 per QALY (95% CI: –331,714 to –53,294).
- For both models, the estimated cost-savings come mostly from reductions in acute hospital bed days.
- Home-based SPC: 17,098 fewer deaths in hospital (95% CI: –30,681 to –2985); 1.0 million fewer bed days (95% CI: –1.9 to –244,164 million); £533.1 million lower costs for the NHS (95% CI: –1.2 billion to 31.2 million).
- Hospital-based SPC: 3906 fewer deaths in hospital (95% CI: 6269 to –1627); 491,601 fewer bed days (95% CI: –789,873 to –205,748); £283.9 million lower costs for the NHS (95% CI: –503.4 to –73.5 million).

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Key Discussion Points

- As per the authors, this is the first study to examine the economic implications of SPC, and represents the best available evidence of the cost-effectiveness of SPC for adults in England.
- The SPC workforce requires expansion to address unmet needs, but examination of how to work most effectively with primary PC providers is warranted.

Strengths and Limitations

- Strengths:
 - Combines high-quality data from multiple sources
- Limitations:
 - Used aggregate, population-level data in a cohort model, which cannot account for timing of SPC and is not necessarily generalizable.

Practice Implications

- Compelling evidence for cost-effectiveness of SPC, although uncertain if generalizable to other healthcare systems/populations.
- How could such evidence be used to influence decision-makers/funders?
- Need to consider local context in deciding how to allocate funds for maximum benefit.

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DISCUSSION



Rosa WE, Ursoleo JD, Connor S, et al.

Palliative care integration in primary health care across the life course: a global health imperative.

The Lancet Primary Care. 2026;2(4).
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Palliative care integration in primary health care across the life course: a global health imperative.

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Presented by:

Leonie Herx

Background

- Globally >70M people have health-related suffering, >85% of these have unmet PC needs (L/MIC),
- Community settings all countries lack access to palliative care
- Primary health care (PHC) often initial point of contact for health needs
 - lack of PC training in PHC professionals, PC largely disconnected from routine PHC delivery
- 2014: WHA recognized PC as essential component of comprehensive care & should be integrated in all levels of care
- 2018: WHO Global Conference on PHC=> *Declaration of Astana: PHC should include universally accessible palliative care*, requires:
 - PHC workforce equipped to provide generalist PC, including: early identification/triggering of PC as part of chronic disease mx; collaborating with SPC services; ↑ professional capabilities in PPC

Goals of Article

- Provide evidence-based rationale for improved integration of PC into PHC, sharing best practice exemplars - training, mentorship, service development, international collaboration & system adaptation

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Leonie Herx

Key Discussion Points

- Integration of PC within PHC depends on level of primary care:

<p>High primary care adoption, high health human resources</p>	<ul style="list-style-type: none"> Primary care well resourced and central to medical service delivery, with a focus on community settings Primary care more likely to be delivered across the life course; in a regional model, palliative care is often delivered by generalists, supported by palliative care specialists who take on complex cases, including in hospital or institutional settings 	<ul style="list-style-type: none"> Primary care often funded by public system; struggles to meet demand because of multiple factors (eg, ageing population and health professionals choosing careers in specialties) Primary care clinicians struggle to contribute to generalist palliative care, given the challenges associated with workforce capacity Palliative care delivered haphazardly by some primary care practitioners (ie, those who make palliative care a priority) 	<p>High primary care adoption, low health human resources</p>
<p>Low primary care adoption, decent health human resources</p>	<ul style="list-style-type: none"> Heavy medical specialist involvement in health care; often uses a parallel private system, resulting in reduced care continuity Primary care clinicians often do not act as gatekeepers to specialist-based care Involvement from palliative care specialists more likely at end-stage disease 	<ul style="list-style-type: none"> Deficiency of primary care resources, including the delivery of palliative care (eg, some low-income countries) Palliative and end-of-life care often delivered by families, community members, and others in a less medicalised approach 	<p>Low primary care adoption, low health human resources</p>

Figure 1: Variations in primary care adoption and health human resources

Palliative care integration in primary health care across the life course: a global health imperative.

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Leonie Herx

Key Discussion Points

- Urgent global need to integrate PC across PHC settings
- Evolving global normative framework legitimating PC provision and an obligation to integrate PC into PHC
- Exemplars of PC integration that show benefits of routine community-based practice & use of policy/system infrastructure for coordination & scale
 - Kenya Hi-Five initiative
 - WONCA- standardized toolkits & international frameworks
- Key elements to advance PC access in PHC:
 - Advocacy
 - Community-partnerships development
 - Context-specific implementation
 - Sustainable resourcing
 - Coordination between generalists and specialists in PC

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Strengths and Limitations

- Strengths:
 - Numerous evidence-based examples that can be adapted for context, scale and spread
 - Recommendations from international, interprofessional group of palliative care experts from diverse practice settings, country-income levels, pediatric and adult specialties, and cultures
- Limitations:
 - Lack of systematic literature search - expert group identified relevant literature, exemplars and guidelines
 - Expert opinion

Practice Implications

- Need to better understand jurisdictional contexts across key elements needed to advance PC in PHC; different approaches req'd
- Canadian considerations:
 - Provincial vs Federal roles/responsibilities for healthcare
 - Palliative Care is not an essential service
 - Regional variation in level of PHC access & resources

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DISCUSSION



Tripodoro VA, Fidalgo JFL, Pons JJ, et al.

**First-Ever Global Ranking of Palliative Care:
2025 World Map Under the New WHO
Framework.**

J Pain Symptom Manage. 2025;70(5):447-458.

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Background

- The 2014 World Health Assembly resolution urged the integration of palliative care (PC) into national health strategies; recognition of PC increasing
- Previous global atlases (2006, 2011, 2017/20)
- A new WHO framework (2021) provides an updated methodology for assessing national palliative care systems.
- The ATLANTES Global Observatory, a WHO Collaborating Centre, piloted this model in Benin, Morocco, and Uruguay:
- The Observatory has also developed many continental atlases over the years:
- Europe, Latin America, Africa, Asia, etc

Objectives

- To assess the current state of palliative care development worldwide using the WHO framework and produce a global ranking of countries based on their performance across 14 indicators..



Conceptual framework for palliative care development (WHO, 2021).

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Methods

- Survey: applied the WHO's 14-indicator framework for PC development
- Data collected through national cross-sectional studies, employing a mixed-methods approach that
- Combined quantitative scores with narrative justifications and documentary evidence.
- National experts reviewed Country profiles and, when possible, responses endorsed them by national PC associations..
- 5 steps:
 - 1) identify national experts: at least 2 per country
 - 2) Survey instrument (with online training for respondents)
 - Respondents rated their country's development on a four-point scale
 - 1 = Emerging, 2 =Progressing, 3= Established , 4 = Advanced;
 - 3) validation of reports:
 - Responses were reconciled and triangulated with literature and official documents,. National experts reviewed their respective country profiles. Profiles formally endorsed by national PC associations.
 - 4) Statistical analysis and classification based on scores: See Supplement
 - 5) mapping global PC development.
 - Emerging, Progressing, Established, Advanced

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Dimension	#	Indicators for Monitoring Pall Care Development
Empowerment of people and communities	1	Existence of groups dedicated to promote the rights of patients in need of palliative care, their families, their caregivers and disease survivors (1 item)
	2	Existence of national policy or guideline addressing advance care planning of medical decisions for the use of life-sustaining treatment or end-of-life care (1 item)
Health policies	3	Existence of a current national palliative care plan, programme, policy or strategy with a defined implementation framework (10 items)
	4	Inclusion of palliative care in the list of health services provided at the primary care level in the national health system (2 items)
	5	Existence of a national coordinating authority for palliative care (labelled as unit, branch, department) in the Ministry of Health (or equivalent) responsible for palliative care (5 items)
Research	6	Existence of congresses or scientific meetings at the national level specifically related to palliative care (1 item)
	7	Palliative care research in the country estimated by peer-reviewed articles (1 item)

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Dimension	#	Indicators for Monitoring Palliative Care Development
Essential medicines	8	Reported annual opioid consumption, excluding methadone, in Defined Daily Dose for statistical purposes (S-DDD) (1 item)
	9	Availability of essential medicines for pain and palliative care at all levels of care (2 subitems)
	10	General availability of immediate-release oral morphine (liquid or tablet) at the primary level
Education and training	11	Proportion of medical and nursing schools with palliative care formal education in undergraduate curricula (6 subitems)
	12	Specialisation in palliative medicine for physicians (1 item)
Integrated palliative care services	13	Number of specialised palliative care programmes in the country per population (2+ 8 subitems)
	14	Number of specialised palliative care programmes for the paediatric population in the country (1 item)

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Key Results

- 201 countries studied
- 29 (14%) “Advanced”
 - Germany, Netherlands, United Kingdom, Spain, Australia, Ireland, Thailand, Uruguay, Portugal, United States.
- 34 countries (17%) “Established”
 - Canada, South Africa, Argentina, etc
- 57 countries (28%) “Progressing”
- 81 countries (40%) “Emerging”
- Higher PC development scores correspond with more developed countries...

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Key Discussion Points

- Highlight persistent disparities and offer a tool for targeted improvement.
- The Global Development Score enables countries to benchmark progress, identify gaps, and develop strategic responses.
- Results reveal stark inequities: > half global population in countries with Emerging or Progressing
- Downgrades in countries such as Israel, Canada, Liechtenstein, Romania, and Mongolia may reflect data gaps, methodological shifts, or actual declines. These variations underscore the need for robust data validation and ongoing refinement to facilitate consistent, longitudinal analysis.

Strengths and Limitations

- Strengths:
 - Author stress rigorous process and use of indicators
- Limitations:
 - Described by authors: focus on specialized PC
 - Not first global ranking (The Economist Lien Foundation 2010 & 2015)
 - Impact of individuals (doves versus hawks)
 - Does not capture country nuances
 - Excessive weighting placed on laws, policies and plans

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DISCUSSION



Honourable Mentions

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- Downing J, Knaul FM, Kwete XJ, et al. **The global need for paediatric palliative care: the evolution of serious health-related suffering in children aged 0-19 years from 1990 to 2023.** Lancet Child Adolesc Health. 2026;10(3):167-178. doi:10.1016/S2352-4642(25)00338-4
- Knaul FM, Arreola-Ornelas H, Kwete XJ, et al. **The evolution of serious health-related suffering from 1990 to 2021: an update to The Lancet Commission on global access to palliative care and pain relief.** The Lancet Global Health. 2025;13(3):e422-e436. doi:10.1016/S2214-109X(24)00476-5
- Arioiz U, Allsop MJ, Goodman WD, et al. **Artificial intelligence-based approaches for advance care planning: a scoping review.** BMC Palliat Care. 2025;24(1):268. doi:10.1186/s12904-025-01827-x
- Nascimento A, Brandão-Silva J, Cunha D, et al. **Caregiver perceptions of the impact and effect of family conferences for patients with complex and high-level palliative care needs: a cross-sectional survey study.** BMC Palliat Care. Published online January 9, 2026. doi:10.1186/s12904-025-01978-x

Wrap-up

- Please provide your feedback, complete the survey at the link shared in the chat!
- A recording of this webinar and a copy of the slides will be e-mailed to registrants within the next week.
- Recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/
- The **Palliative Care Journal Watch** episodes are also available as podcasts.



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Thank you | Merci

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