



# Home-Based Palliative Care: Benefits, Challenges, Opportunities and Future Directions in a Super-Aged Society

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Home-based palliative care (HBPC) has emerged as a critical model to address the complex needs of individuals with life-limiting illnesses, particularly in super-aged societies. This review explored the key components of HBPC and elaborated on its benefits, challenges, opportunities, and future directions, drawing on international evidence and practical frameworks. HBPC is reported to enhance the quality of life, reduce unnecessary hospitalizations, and increase the likelihood of patients dying in their preferred settings. Successful care delivery requires integrated multidisciplinary teams, effective symptom management, holistic care, and timely support from caregivers. However, barriers such as resource constraints, caregiver burden, and a lack of psychosocial support remain significant. Future directions and opportunities include integrating hospital-at-home models into routine HBPC services, strengthening the education of healthcare professionals and the public, and fostering compassionate communities to promote social engagement in end-of-life care. Advancing HBPC within diverse sociocultural contexts can bridge the gap between patient preferences and actual care delivery, offering a sustainable pathway to improve continuous palliative care provision for older adults globally.

**Key Words:** Home care services, Palliative care, Patient care team, Community health services, Social support

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## INTRODUCTION

For millennia, the concept of “home” has occupied a central position in human development. Beyond its physical function as a place of shelter and gathering, the home carries profound emotional significance. It serves as a space for mutual support, attentive listening, and interdependent growth. Symbolically, the home embodies identity, security, and continuity and plays a crucial role in fostering psychological well-being, emotional

attachment, and a sense of belonging [1]. At the same time, the home provides a space for social interactions, family life, cultural transmission, and daily routines. It functions as both a point of connection and an anchor between individuals, communities, and interpersonal relationships [2]. However, over the past century, rapid advances in medicine have shifted the paradigm of care from a family based model to an institution-centered healthcare system. Modern Western medicine emphasizes patient monitoring and centralized medical authority

within hospitals, redefining the locus of care as away from home [3]. People who fall ill are often compelled to leave their homes for treatment.

Population aging is an ongoing global phenomenon with profound implications for how societies address serious illness and end-of-life care [4]. According to the World Health Organization (WHO), a society is considered “aging” when individuals aged 65 years and older comprise more than 7% of the total population, and “aged” when this proportion exceeds 14%. Historical data show that France took approximately 125 years to transition from 7% to 14% of older adults, the United States underwent this shift in 72 years, and Japan experienced this transition at an unprecedented pace, completing it in just 25 years. Such disparities highlight the diverse challenges countries face in adapting their healthcare systems and social structures to the needs of aging populations. As longevity increases, more people are living with chronic, life-limiting illnesses, making it imperative to reimagine care models, including home-based palliative care, that support individuals and families through aging, illness, and dying in settings that honor their preferences and dignity.

Studies have consistently shown that, although many older individuals with life-limiting illnesses express a strong preference for dying at home, this wish often remains unfulfilled. The actual place of death frequently diverges from the stated preferences of patients and their families. Although the home is commonly identified as the most desired place for death, these preferences are not static. They may evolve over time and are shaped by clinical trajectory, symptom severity, and availability of care and support systems. For instance, some patients may shift their preference toward hospital or hospice settings when symptom management becomes complex or home care is no longer practical [5,6]. The alignment between an individual’s preferred and actual place of death varies substantially across studies, ranging from approximately 30% to over 70%. This congruence tends to be higher when a patient’s preferences are explicitly discussed and documented, and when specialized palliative care services are available to support care delivery at home [7,8].

To bridge this gap between preference and reality, home-based palliative care has emerged as a key model of care, aiming to support patients in spending their final days in the place

they most often call “home” – where could be the patient’s own home, long-term care facility, nursing home, or hospice etc.

## WHAT IS HOME-BASED PALLIATIVE CARE? WHY DO WE NEED HOME-BASED PALLIATIVE CARE?

According to the projection model proposed by Sleeman et al. [9], there will be an increase of approximately 155% in the number of people suffering from serious illnesses globally between 2016 and 2060. Among these, the majority are adults aged 70 years or older living in low- and middle-income countries. Malignant cancer, cardiovascular disease, lung disease, dementia, and liver disease are the top five causes of death that drive this suffering. The burden on patients and their family caregivers and the related costs for healthcare systems and society caused by such diseases, corresponding treatments, and care are increasing tremendously, which has been proven to be alleviated by palliative care provision [10,11]. Evidence shows that the majority of people with palliative care needs live in the community or in their homes, making home-based palliative care (HBPC) provision inevitable and crucial within continuous care provision for patients and their families [12].

In 2022, Professors Christine Ritchie and Bruce Leff introduced the concept of a “home-based medicine ecosystem” [13,14]. This framework recognizes that, within the home setting, diverse models of care have evolved to meet patients’ varying needs across time, space, and disease trajectories. These include home-based primary care, transitional care, home-based rehabilitation, and home-based palliative care. Home-based palliative care refers to specialized medical and supportive services delivered to individuals with serious life-limiting illnesses in the familiar environment of their own homes. The primary goal is to enhance the quality of life of patients and their families by addressing physical discomfort, managing pain and other distressing symptoms, and providing psychological, social, and spiritual support. This model of care also plays a critical role in assisting patients and their families to navigate complex end-of-life decisions. Care is typically provided by a multidisciplinary team, often comprising physi-

cians, nurses, social workers, and other professionals, who work collaboratively to coordinate regular visits and deliver individualized, compassionate care that aligns with each patient's needs, values, and preferences [15,16].

## WHAT ARE THE BENEFITS OF IMPLEMENTING HOME-BASED PALLIATIVE CARE?

Home-based palliative care has gained global recognition for its potential to enhance the quality of life, reduce healthcare expenditures, and align care with the preferences of patients and their families, particularly at the end of life. Evidence suggests that home-based palliative care not only improves patients' quality of life but also reduces unnecessary hospitalizations and increases the likelihood of dying in one's preferred setting, most commonly at home [17]. Families often value home care because of a sense of privacy, normalcy, and active involvement in the care process. Notably, it significantly enhances patients' quality of life by delivering care in familiar surroundings that promote comfort, autonomy, and emotional security [16]. In both adult and pediatric populations, home-based palliative care has been linked to improved symptom control, enhanced emotional well-being, and reduced caregiver burden [18].

In geriatric oncology, HBPC has proven both feasible and acceptable, showing effectiveness in pain control and preserving functional status in elderly patients with cancer [19]. Furthermore, HBPC enhances the experiences of both patients and caregivers; patients often report feeling more dignified and emotionally supported at home, while caregivers express a greater sense of security and support in the caregiving role [20,21].

However, although physical care needs are generally well-identified and addressed, gaps remain in meeting communication and psychosocial needs, indicating areas for ongoing improvement in HBPC models [22]. These frequently require additional support and respite services to manage not only the physical but also the emotional and logistical demands of caregiving [23].

## CHALLENGES AND BARRIERS TO PROVIDING HOME-BASED PALLIATIVE CARE

There are several challenges and barriers identified via evidence.

### 1. System-Level and Resource Challenges

HBPC implementation is significantly constrained by system- and resource-related limitations. One of the most prominent challenges is the limited availability of trained healthcare professionals capable of delivering high-quality palliative care in home settings, especially in rural or underserved regions, where the recruitment and retention of qualified staff remain difficult [22]. This uneven distribution of resources leads to disparities in the access to care and undermines the goal of equitable service delivery. Moreover, insufficient coordination and integration across different healthcare sectors, particularly between hospitals, homes, and community-based providers, compromises the continuity of care. Fragmentation of care delivery often results in duplicate services, information gaps, and patient safety risks [22]. Funding and reimbursement mechanisms present another barrier, as many healthcare systems lack the financial infrastructure to support critical HBPC components such as 24/7 professional availability, multidisciplinary team coordination, and comprehensive psychosocial support. These limitations restrict the scalability and sustainability of HBPC programs, even when clinical needs and patient preferences strongly support home-based care [19].

### 2. Informal Caregiver Burden

A central yet often-overlooked challenge in HBPC is the substantial burden placed on informal caregivers, typically family members, who serve as the cornerstones of home-based support. Caregivers are frequently required to manage complex care tasks such as medication administration, symptom monitoring, and emotional support without formal training or adequate guidance. This heavy reliance on informal caregiving can lead to significant physical fatigue, emotional distress, and psychological strain [22]. Furthermore, caregivers often sacrifice their own health, employment, and social relationships to meet the demands of care, yet receive limited recognition

or structured support from the healthcare system [24]. Many informal caregivers report feeling isolated and overwhelmed, which not only affects their well-being but also compromises the quality and continuity of care provided to the patient [25].

### 3. Communication and Information Gaps

Effective communication among patients, caregivers, and healthcare professionals is essential in palliative care; however, it remains a persistent challenge in HBPC. Poor communication is the most common unmet need among patients and families receiving care at home [22]. Families often report inadequate information regarding disease progression, care expectations, and available resources. In addition, difficulties in contacting healthcare providers, especially during emergencies or after-hours, can exacerbate stress and anxiety. The absence of real-time communication channels or care coordination platforms results in delays in decision-making and contributes to feelings of uncertainty and abandonment among caregivers.

### 4. Psychosocial and Emotional Issues

The transition from hospital to home care, particularly when it is abrupt or poorly coordinated, can evoke strong emotional reactions in patients and families [20]. Many families reported feeling emotionally unprepared for discharge, especially when they perceived a hospital environment as safer or more supportive [22]. At home, patients may experience feelings of isolation, fear, and anxiety, which may be intensified by a lack of visible clinical support. These emotional and psychosocial challenges within the HBPC framework have often not been systematically addressed. Furthermore, the sudden shift in care responsibilities to family members or paid caregivers (in some cultures, they are migrant live-in caregivers) [26] coupled with the emotional weight of impending death can create an overwhelming and distressing home environment. Without structured emotional and psychosocial interventions and training, patients and caregivers are left to independently cope with the mental toll of serious illness and end-of-life transitions.

### 5. Gaps in Holistic Support

While HBPC often succeeds in managing physical symptoms, such as pain and fatigue, it frequently falls short in addressing the broader dimensions of holistic care. Psychosocial,

spiritual, and practical needs, such as emotional counseling, spiritual rituals, transportation assistance, and respite services, are inconsistently integrated into standard HBPC models [22]. For many patients and families, the absence of such support services leads to a care experience that feels fragmented and incomplete [20]. Cultural and religious preferences are not always adequately considered, particularly in ethnically diverse or multi-faith populations. This gap in culturally competent care can result in unmet needs, decreased satisfaction with care, and emotional distress during a critical time [27].

### 6. Geriatric-Specific Barriers

Older adults, particularly those with cancer or multiple comorbidities, face unique challenges in accessing and benefiting from HBPC. Frailty, mobility limitations, cognitive impairments, and sensory deficits can hinder a patient's ability to participate fully in home care, making the management of symptoms and adherence to treatment plans more complex [19]. Furthermore, the current evidence base for HBPC often underrepresents older patients, which limits the applicability of interventions and service models to this population [28]. The lack of age-appropriate care protocols combined with limited caregiver training specific to geriatric needs exacerbates these barriers.

## KEY FACTORS FOR EFFECTIVE HOME-BASED PALLIATIVE CARE

The delivery of high-quality home-based palliative care (HBPC) requires a comprehensive and coordinated approach grounded in evidence-based practice. According to Seow and Bainbridge [15], six essential components consistently underlie successful delivery. First, integrated teamwork is vital, as it involves effective multidisciplinary collaboration among physicians, nurses, social workers, and spiritual care providers. Such integration ensures that patient needs are addressed from multiple perspectives, thereby enhancing the continuity and comprehensiveness of care. Second, effective symptom management, particularly pain and other distressing physical symptoms, requires proactive clinical intervention and skilled assessment. Timely control of symptoms is central to patient comfort and quality of life at home. Third, holistic care that

encompasses not only physical well-being, but also emotional, social, spiritual, and practical dimensions is essential to meet the full spectrum of patient and caregiver needs. This approach recognizes the interconnected nature of suffering and promotes person-centered care. Fourth, the presence of skilled, compassionate care providers (i.e., home palliative care team and informal caregivers) is critical. These caregivers must not only be proficient in palliative care, but also capable of demonstrating empathy, building trust, and offering reassurance during challenging circumstances. Fifth, timely and responsive services, including 24/7 availability and rapid response systems, are necessary to address symptom exacerbation and prevent avoidable hospitalization and emergency visits [29,30]. In addition, mobile health provides a promising future for improving care coordination, facilitating timely communication between healthcare teams and caregivers, and enhancing patient symptom management [31]. Finally, preparedness of patients and families through education, anticipatory guidance, and advanced care planning is fundamental. Empowering families to manage care confidently at home can significantly reduce anxiety, enhance autonomy, and ensure that care aligns with patient preferences [15].

In addition to these six components, Cruz et al. [20] highlighted three critical domains that facilitate a smooth and effective transition from inpatient care to HBPC. First, emotional readiness of patients and their families plays a pivotal role in adapting to the home care environment, particularly after hospital discharge. Second, the availability of social support, including family caregivers and community resources, is essential for ensuring that day-to-day care needs are met. Finally, accessible healthcare resources and coordination mechanisms, such as reliable communication with healthcare providers, advance care planning, and logistical support, are indispensable for HBPC sustainability. Together, these principles underscore the multifaceted nature of HBPC and provide a roadmap for structuring services that are compassionate, comprehensive, and responsive to the evolving needs of patients and their families. Meanwhile, it is also important to consider the local context and jurisdiction, and cultural understanding of home palliative care to provide services to avoid disputes and maximize the impact for better quality of care [32].

## FUTURE DIRECTIONS AND OPPORTUNITIES

We believe that there are three major future directions and opportunities for the HBPC model.

### 1. Integration between home-based palliative care and Hospital at Home care model

Within the broader spectrum of home care medicine, the Hospital at Home (HaH) model is a critical component that bridges acute medical care and palliative services. It provides hospital-level interventions in a home setting, supporting patients with complex needs while maintaining comfort and familiarity at home. Previous studies have shown that even among terminally ill patients, the use of antibiotics for infections remains common before death [33]. However, systematic reviews have discussed both the potential benefits and drawbacks of antibiotic use in this population and recommended that care teams adopt shared decision-making (SDM) or time-limited trial (TLT) approaches early in the care process to prevent potentially nonbeneficial treatments [34]. Identifying the appropriate time to initiate discussions on discontinuing antibiotics is challenging. Acute care at home has been identified as a valuable opportunity to strengthen patient and family engagement in treatment discussions. Evidence suggests that the HaH model provides a critical window for initiating SDM or TLT, allowing earlier and more meaningful conversations regarding care [35].

### 2. To promote education for healthcare professionals and the public in home-based palliative care

To promote broader acceptance and implementation of home-based palliative care, it is essential not only to establish sound policy frameworks, comprehensive reimbursement systems, and clear clinical care guidelines but also to advance education for both healthcare professionals and the public. Several future directions for professional education have been envisioned. These include the development of clinical manuals for home-based palliative care, the integration of specialized curricula into both undergraduate and postgraduate medical and nursing education, and the organization of interprofessional workshops focusing on key competencies such as symp-

tom management, home-based point-of-care ultrasound, point-of-care testing, collaboration with palliative home care teams, and coordination with post-acute care services [36]. Simulation-based training that incorporates realistic scenarios and technologies such as augmented reality and virtual reality can further strengthen clinical competencies [37]. Moreover, competency-based education frameworks and the development of accessible online learning modules may serve as critical strategies to enhance the workforce's capacity to deliver high-quality home-based palliative care [38].

Equally important is the need to advance public education to foster understanding, acceptance, and engagement in home-based palliative care. Public initiatives could include community workshops, media campaigns, and educational programs that demystify palliative care, address cultural taboos surrounding death and dying, and highlight the benefits of receiving care at home. Encouraging early conversations about advance care planning and end-of-life preferences within families and communities can empower individuals to make informed decisions [39]. Such efforts are critical in building societal support that can complement professional care teams in providing holistic and dignified care.

### 3. Home-based palliative care as a public health approach, link with compassionate community

In a super-aged society, aging, disability, illness, and death are not only a series of medical events but also profound social events [40]. How society perceives the process of illness, navigates treatment, and fosters mutual support and collaboration during these transitions is critical for community coexistence. Home-based palliative care and compassionate community models are increasingly being recognized as essential frameworks for supporting individuals with serious illnesses and their families. In these approaches, family members are often empowered and trained to play an active role in caregiving, whereas community volunteers contribute significantly by providing social support and assisting in care navigation. In particular, compassionate community models emphasize the importance of care delivered in familiar environments, fostering community engagement, and promoting holistic support systems. Together, these approaches aim to enhance quality of life and address critical gaps within conventional healthcare

systems [35,41].

## CONCLUSIONS

Home-based palliative care is a critical model for addressing the complex needs of aging populations and individuals with life-limiting illnesses. By delivering holistic, patient-centered care within the home environment, it enhances the quality of life, reduces healthcare utilization, and aligns care with patients' and families' preferences. Successful implementation requires integrated multidisciplinary teams, robust support for caregivers and community engagement to ensure equitable access and sustainability. As societies face unprecedented demographic and healthcare challenges, advancing home-based palliative care coupled with compassionate community initiatives offers a promising pathway to improve end-of-life care outcomes globally.

## CONFLICT OF INTEREST

Authors declare that there are no conflict of interest.

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Conception of the work: CPL and WMC, Drafting of the article: CPL and WMC, Critical revision of the article: CPL and WMC, Final approval of the version to be published: WMC.

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