

Research Article

Oncological Palliative Care: The Guarantee of Rights to Vulnerable Populations in Brazil

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Abstract

This study leads both experts and all those interested in the field of palliative care to an immersion in caring from the point of view of technique and humanization. Consequently, the strategic role of social assistance in this context is required. The objectives of the study are to understand the relationship between social inequality and Palliative Care in Oncology with emphasis on end-of-life care and to identify the advances and perspectives of the field of Palliative Care in national territory. The research is based on bibliographical and documentary research using the integrative review method. An active search was carried out in the following databases: Latin American and Caribbean Literature in Health Sciences (Lilacs) and Medical Literature Analysis and Retrieval System online (Medline). The following descriptors and their associations in Portuguese, Spanish and English were used to search the articles: Care, Palliative Care, Vulnerability, and Social Assistance. The inclusion criteria defined for the selection of articles were: articles published in Portuguese, Spanish and English; and full texts that expressed the study regarding the integrative review. The analysis and synthesis of the data were described and classified aiming to gather knowledge available in the specialized literature. It is concluded that a dignified death distances itself from a picture of unfortunate death. Thus, it is a conception of care that provides access to appropriate treatment even for those who have never had a decent life avoiding abandonment. Hence, the importance of the association of social assistance with health policies is emphasized.

Keywords: Care; Palliative care; Social assistance; Vulnerability

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Introduction

The 1988 Federal Constitution of Brazil emphasizes the importance of research for the State in its article 218, when explaining that “basic scientific research and technology will receive priority treatment of the State, in view of the public good and progress of science, technology and innovation”.

In this perspective, universities and research institutions should be encouraged to incorporate the social dimension into their research agendas by promoting citizen education, seeking to integrate the social and human sciences into Science, Technology & Innovation (CT & I) policies.

Brazil is experiencing a moment of epidemiological transition, in which the increased life expectancy and the changing of eating and behavioral patterns are contributing to the increasing incidence of chronic Non-Communicable Diseases (NCDs), especially cardiovascular diseases, neoplasms, chronic respiratory diseases and neurodegenerative diseases [1].

Chronic non-communicable diseases account for more than 70% of all deaths in the world which is equivalent to 41 million deaths. This includes 15 million people who die prematurely, that is, between the ages of 30 and 69. More than 85% of these early deaths occur in low and middle-income countries [2].

According to the Pan American Health Organization (PAHO, 2019), CNCDs are the leading causes of mortality and premature disability in most countries of our continent including Brazil. In addition, the increase in the occurrence of these diseases has been driven by five risk factors: tobacco use, physical inactivity, harmful use of alcohol, unhealthy diets and air pollution. It should be noted that the treatment and care associated with CNCDs have a high impact on the Single Health System [SUS].

It is noted that there is a difficult road to be covered, for example, by people close to death, in terms of Palliative Care. In the latest edition of the Death Quality Index, where the British consultancy Economist Intelligent Unit evaluated 80 countries, Brazil ranked 42nd - ranking below nations like Uganda, Mongolia and Ecuador.

In this way, it is necessary to highlight an area of knowledge that the general public is still not aware. It is strategic to promote the vision of palliative care as a human right, aiming at solidifying important principles to life, such as the sense of caring.

Caring for a patient palliatively leads to interdisciplinary work that excels in the contemplation of knowledge and sharing of responsibilities, activities and care. It is evident that dealing with difficult situations in the processes of treatment of patients without possibilities of curative treatment - many with prognosis of near death - requires adequate support of all the involved subjects: family, interprofessional team and, especially, the Social Work professional [3].

Thus, the field in focus encompasses a range of actions that seek to offer comfort, hope, effective listening and attention to the different and complementary dimensions of pain known as total pain (deep

suffering caused by pain impacting the patient's social, spiritual, physical and psychological state), according to Saunders (1967) [4]. In addition, it offers resolution to pressing causes, considering that every human being is unique, with their needs, desires, possibilities and limits.

In developing countries, most patients present the disease at an advanced stage at the time of diagnosis (WHO, 2002), which is, therefore, a daily challenge for palliativists, especially regarding those patients who are in vulnerable intensified.

In this sense, it is necessary to highlight the importance of the concepts of prevention and relief of human suffering in Palliative Care based on the study promoted by the WHO in conjunction with the World Hospice Care Alliance (2017), which defines the objectives of palliative care: Physical, psychological, social and spiritual suffering in adults or in children with different degrees of impairment related to health (chronic, severe, complex and limiting).

The human being, when experiencing disease situations with no chance of cure from the clinical diagnosis, begins a trajectory in which people who are close to them must deal with social, emotional and financial difficulties, among others.

The above study advocates a user-centered, evidence-based view of care to maximize quality of life, from the perspective of respect for human dignity. Here, the process of adapting the way of life of the people to reality by aligning it with progressive illnesses becomes central. In addition, it is proven that providing early access to skilled palliative care can have many benefits, including prognosis.

Materials and Methods

Considering the above, it is clarified that the research emphasizes a dimension of Oncologic Palliative Care, which is: end-of-life care including the role of social assistance in this field, aiming to understand the relationship between social inequality and Palliative Care in Oncology with emphasis on end-of-life care and identify the advances and perspectives of the Palliative Care field in national territory.

This is a bibliographical and documentary study using the integrative review method. The aforementioned literature review is a method directed to the screening, critical analysis and synthesis of the available evidence on the subject of research, with the purpose of presenting the updating of pertinent knowledge, the development of interventions in the provision of health care and, not least, the identification of gaps that signal the necessary development of further research.

Results and Discussion

Social protection of social assistance and its association with palliative care

The number of people living in extreme poverty in Brazil in 1993 was around 20 million, falling to around 14 million after the implementation of the Real Plan. By 2013, it was around 13 million and fell to 5.2 million in 2014. But the number of people living in extreme poverty increased to 6.4 million in 2015, 10 million in 2016 and 11.8 million in 2017 [5].

Social inequality is a structural, historical and persistent theme in the country. There are populations that experience these multiple inequalities and exclusions, even with the existence of universal

policies. It is extremely important to have policy measures and actions that remove these barriers and incorporate black women, children and indigenous people into these systems [6].

It should be remembered that social protection is "a fundamental right for the exercise of other rights, such as health, education and consolidation of a state of social welfare. It is, therefore, a key role in reducing poverty and inequality" [6].

For Castellanos and Baptista [7]: Social inequalities in health are produced in diverse social contexts and relationships in which processes of vulnerability and resistance to the colonization of identities, sensitivities, action and life are outlined! [...] among the contexts of vulnerability, there are those produced by the health policies themselves directed at indigenous populations, at-risk populations and refugees/immigrants. These contexts of vulnerability, however, are sensitive to social mobilizations in search of recognition and overcoming the invisibilities and absences produced. This is often due to contradictory actions and positions, not reducible to simplifying stereotypes".

The elements mentioned above lead to the necessary deepening of the relationship between social assistance and health from the perspective of the vulnerable population. It is notorious that the control of cancer or chronic disease is closely conditioned to regional development and adequate socioeconomic conditions of populations.

The end-of-life cancer patient has a trajectory marked by difficult situations (for example: abandonment with total loss of social contact, social invisibility and even dying as indigents). And, when it comes to vulnerable populations, the suffering situations are even worse, as they depend on special protective measures [8].

Considering this discussion, we ask: whoever has never had a decent life can have a worthy death? In this sense, it is worth emphasizing the meaning of the term "mistanasia" that comes from the Greek words *mis* (unfortunate) and *thanatos* (death), which means "unfortunate death". It is used to refer to the death of people who, being socially excluded, end up dying with poor or no health care. In general, it refers to people who do not have financial means to afford the costs of their own health care, and depend on the provision of public assistance [9].

Collière [10] states that "we can live without treatment, but not without care". Thus, death should not be seen an enemy of man, but as something to be faced with the awareness that it is part of life. Even finitude being known as a real event, as a natural process of life is still stigmatized.

From the social point of view, death derives from an extensive historical process, pointed out by different social and economic models, as well as by practices that surround subjective, existential and spiritual areas. In this context, health professionals develop their competencies so that the end-of-life cancer patient can be assisted in its entirety, have quality in care support and, consequently, have the right to a good death.

In the humanizing vision of the National Social Assistance Policy (Brazil, 2010), assistance as a policy is aimed at guaranteeing rights and dignified living conditions, understanding protection as a means of ensuring the security of survival (performance and autonomy) and of social interaction or family experience.

It should be remembered that, in the study conducted by the Data-folha research team, published in *Folha de São Paulo* Newspaper on

01/29/2018, with a sample of 2,732 people from different Brazilian regions, it was verified that Brazilian people fear the loss of independence and the lack of control over human pain.

In the above study, it is evident that the Brazilian has less a feeling of fear of death or old age, and more fear of becoming physically, mentally or financially dependent. 74% of respondents do not fear death. Among elderly women, the fear of becoming physically or mentally dependent reaches 83%.

In the perspective of Humanization, the care model promotes service to the needs of users with no possibilities of cure, seeking to offer individualized care, both for those who need to be hospitalized and for those enrolled in Palliative Care programs in primary care units or in home care, with special attention to their desires and choices [10].

In this way, it becomes pertinent to establish a strategy for the integration of services beyond those inserted in health policies, in order to prevent situations of violation of rights, especially in vulnerable populations. Therefore, it is about integrating actions in the field of Palliative Care with those of social assistance.

Thus, social security is understood as the protection to citizens in vulnerability, especially to the victims. Article 203 of the Brazilian Federal Constitution states that "[...] social assistance will be provided to anyone who needs it, regardless of social security contribution". There are different treatments between social assistance and social security. The first is not conditional on contributions by the beneficiaries, and the second is conditional on their contributions (insurance).

In this perspective, it is worth mentioning that social protection can be understood through four articulated aspects: non-contributory-care; contributory- retirement and pensions; labor market regulation regarding labor rights; and care systems [11].

Finally, it is understood that it is a public function of social assistance to contribute to the demands and guidelines of the Social Assistance Policy. It is responsible for identifying situations of vulnerability and social risks present in the territories, from an interconnected view between demands and responses of social protection and rights defense [12].

Vulnerability concept

In 1980, of the use of the word "vulnerability" was published, in the health field, referring to patients diagnosed with Acquired Immunodeficiency Syndrome (AIDS). The characteristics of the evolutionary development of the epidemic and the change in people's public and social relations provided new associations to the context of infection, which demanded a redefinition of individualized ideas regarding vulnerable groups. In this way, "vulnerability" is used instead of "vulnerable groups", indicating an extension of possibilities and the forms of infection to the population [13].

Vulnerability is defined as a dynamic process established by the combination of elements that make it up, such as: age, race, ethnicity, poverty, schooling, social support and the presence of health grievances. It is admitted that each person has a threshold of vulnerability that, when exceeded, results in illness. Depending on the changes in the daily lives of cancer patients in the context of Palliative Care due to the evolution of the disease, many experience situations of vulnerability [13].

Thus, vulnerability includes individual and social spheres and can be aggravated by the fragility of care and assistance, related to the lack of efficient and satisfactory public policies. This reaffirms the importance of raising the awareness of health professionals and society about the prevention of grievances and promotion of well-being in a context of state of vulnerability.

The authors Meyer et al. [14] clarify that the individual component of vulnerability presupposes the quantity and quality of information, ability to elaborate, as well as the ability and interest to transform those considerations into protectionist attitudes and actions that are unequivocally related to the cultural and social conditions in which individuals are inserted.

The social component is associated with access to material resources, social institutions such as schools and health services and the possibilities of autonomy that enable such opportunities. The program component unites the first two, involves the degree of commitment and the quality of programs of prevention, care and identification of needs.

It is believed that the understanding of the condition of vulnerability must go beyond a simple relation between autonomy and indefensibility, since it is the consequence of understanding the existence of plurality and contingent diversity in all human beings.

In relation to autonomy, Barroso [15] understands it as one of the ethical pillars of human dignity. It is the foundation of the free will of individuals, which allows the search for the ideal of living well and having a life with acceptable standards of quality. For him, autonomy rhymes with freedom something that cannot be suppressed by social or state interferences, as it covers decisions of personal nature, like religion, profession, political conceptions, among others.

In this author's view, it is relevant to highlight the concept of existential minimum that is innate to the idea of human dignity, that is, the concept that relates to the needs of human beings for a decent living, such as basic education and housing, for example. Therefore, to be free and equal with the capacity to practice responsible citizenship, citizens need to guarantee these minimum levels of well-being, so that their autonomy does not become unreal and, consequently, distances itself from what is considered human dignity.

In the daily routine, patients in Palliative Care may present an intensified vulnerability condition. Therefore, they require protective measures to have their rights ensured. The principle of respect for human vulnerability and personal integrity, article 8 of the Universal Declaration of Bioethics and Human Rights, published in 2005 by UNESCO [16], states that: In the application and advancement of scientific knowledge, medical practice and associated technologies, human vulnerability must be considered. Particularly vulnerable individuals and groups must be protected and the personal integrity of the affected individuals must be respected.

It is clarified that certain population groups such as children, persons with disabilities, the elderly and women are, in the light of human rights, vulnerable groups. Likewise, people living with HIV or tuberculosis, those who abuse drugs, and those who need palliative care and who, therefore, are more dependent on public policies, are also part of this group.

The integral and humanized care of vulnerable populations in the context of palliative oncological care is a challenge for palliators and, specifically, for the Social Service professional, since it identifies individuals and populations in intensified fragility and its determining factors in the individual and social sphere.

The patient, when diagnosed with cancer, usually starts a treatment that indicates that the disease is life threatening and, in these conditions, this patient presents a set of vulnerabilities, often being transferred to Palliative Care. The treatment of the disease conditions and includes several hospital admissions that cause the patient to move away from his home and his context of social and family support.

In order to analyze and discuss the factors concerning vulnerable populations in the context of the oncological palliative care, it is pertinent to emphasize the importance of adequate family support, since it is considered as a primordial nucleus of the practices that shape the sphere of social reproduction.

For Frossard [8], it is necessary to identify the factors that make a person or a population vulnerable, that is, in a situation of intensified vulnerability, thus lacking special protective measures, as is the case of many patients and their families inserted in Palliative Care programs (abandonment with total loss of social ties, insecurity regarding the future, inaccessibility to services, death as a destitute, social invisibility and lack of dignified life and death).

The above explanation leads to the following statement about the concept of vulnerability: it is related to cultural, individual and socioeconomic factors, requiring a differentiated and precise view of its complexity. It is known that the human being, at birth, already becomes vulnerable. However, some conditions place us in the face of the concreteness of that state in relation to its intensity.

In this way, conditions related to the different situations presented by patients in the daily life are emphasized: when they lose control over their bodies (example: Loss of pain control), when their daily social activities become limiting; when their financial situation becomes chaotic, etc. Undoubtedly, difficult situations are intensified when they are addressed to the people subject to the various conditions of the health-disease relationship (access to information, identification of the susceptibility by the individual and access to the mechanisms of prevention), called cognitive conditions.

The paliativists know that there are recurrent situations of psychic suffering, for example, that may limit the understanding of information related to treatment. Situations like these require care with the transfer of adequate information between the health team and patients, aiming at the guarantee of established and divided behaviors.

In addition, a patient with chronic disease, especially in the final phase of life, regardless of their age group or social class, must be understood by the health professional as a person who may be in distress. Communication is effective when non-verbal messages are also recognized and interpreted appropriately.

In this line of reasoning, the approach and strengthening of the relationship between institutions inserted in the daily life of vulnerable in condition the intensified vulnerability is considered essential, as it makes possible to become aware of their weaknesses by promoting actions such as the intersectorality from an interdisciplinary perspective.

Temporary vulnerability and palliative care

In Brazil, cancer is the leading cause of death in 516 of the 5,570 Brazilian municipalities. Of the 516 municipalities where tumors most kill, 80% are in the South (275) and Southeast (140), while the Northeast concentrates 9% of these localities (48); the Midwest, 7% (34); and the North, 4% (19). In 2015, according to DATASUS, 209,780 deaths were recorded [17].

These data highlight the understanding of the fundamentals of Palliative Care, its specificities and applicability for the development of humanized practices that enable protagonism, co-responsibility and the autonomy of users and family members, as established in the National Humanization Policy (NHP). Thus, an adequate articulation between social assistance policies is pertinent.

Vulnerability-defining attributes are included in the context of the disease, having disruption, estrangement, alteration in family life and conflicts. Thus, the family structure and the frailties of the family have direct implications on the vulnerability of all the ones who make up the family nucleus.

In the definition of Carvalho [18], it is necessary to: recognize the reality of the patient's life and that of his family: the family organization, the quality of the relationships, the limits of comprehension of the situation, the role of the patient in the family, the impact on the work activities of potential caregivers, housing conditions, family income. In short, to understand the complexity of having a seriously ill person to take care of, especially when the conditions of life and work are precarious.

In the recognition of the reality of the patient's life, there is a confrontation of the socioeconomic vulnerability that provokes the combination of efforts inherent not only to health, but from the articulation between the various sectors of society, such as education and social assistance. It is possible to alleviate the suffering of end-of-life patients by granting possible benefits to vulnerable populations, for example.

Regarding the eventual benefits, Silvano [19] ponders: It is important to emphasize that even if it is of an eventual character, the Occasional Benefits may be necessary in a recurrent way, considering that they are situations of the condition of the life of the individuals, especially of the poorest individuals, that face a greater social contingency and that they need greater social protection by the State. Recurrences to Occasional Benefits reflect the conditions arising from social inequality, consequence of the structural conditions of the capitalist system and its advances in recent decades.

Thus, the main national regulatory frameworks on eventual benefits are the Organic Law of Social Assistance (LOAS) - Law 8,742 / 1993 amended by Law 12,435 / 2011, Federal Decree 6,307 / 2007, Resolution of the Federal Council of Social Assistance (CNAS) 212/2006 and Resolution 39/2012. LOAS and NOB / SUAS (2012), establish the technical assistance and co-financing to the municipalities, aiming at the improvement of the Social Assistance policy [20].

Occasional benefits are understood as provisions of the Supplementary and Provisional Social Assistance Policy, provided in accordance with Article 22 of the Organic Law of Social Assistance, to citizens and families due to birth, death, situations of temporary vulnerability and of public calamity.

These benefits are compulsory supply provisions to the municipalities and the Federal District within the framework of the Unified Social Assistance System (SUAS). They are, therefore, local Social Assistance management. In 2018, the Brazilian government launched the document “Notebook of Technical Guidance on Incidental Benefits”, that has as its main topic the right of the citizen and the duty of the State to provide access to benefits in all situations: birth, death, temporary vulnerability and public calamity [21].

It is observed, in the course of monitoring the treatment, the need for medication and support of Palliative Care to patients, who are already with the body weakened, sometimes causing dependence on others for the development of basic functions of daily life, such as mobility, feeding and hygiene care.

When the patient recognizes his reality, he faces socio-economic vulnerability that gives rise to the unity of efforts that come not only from health, but from the articulation among the different sectors of society, like education and social work.

We must reinforce that thinking about the attention to the needs of this part of the population is a challenge for the paliativists, as they aim to offer not only technical care, but assistance that promotes transformations.

Considering the above, it is pertinent to address the so-called eventual benefits and associated issues, such as basic documentation and funeral, considering the state of indigence and poverty of many patients. The absence of basic civil documentation launches the patient in a situation of insecurity, compromising the full exercise of their citizenship, freedom and human dignity, having the Social Assistance policy as a vector of access. The following documents are considered basic documentation: identity card or general Registry (RG); registration of natural person (CPF) and work and social security card (CTPS) [21].

The eventual death benefit modality is a form of offer made through the provision of services envisaged by CNAS Resolution 212/2016 and must be articulated with other public policies according to the need and desire of the family [21]. Burial is the act of burying the dead and the funeral is a set of acts and procedures that involve burial, namely: offering a funeral urn, a wake, the removal of the body, etc. The analysis of the technical guidelines cited above and its importance in the current Brazilian context of ultra-right ideological bias will be the subject of a later study.

Network connections and services in Brazil

In 2016, the WHO suggested that Palliative Care services should have four key characteristics: desirable (high quality, safe and effective), sustainable (resilient in an ongoing way), equitable (fair and accessible to all) and accessible (making the best use of public funds).

The proposal is to know what is being debated and developed in the national territory about the use of technologies and innovation considering the regional differences. Thus, the National Academy of Palliative Care (ANCP, 2017), based on Palliative Care Alliance World Projections (WHPCA) has announced that in only 20 countries, Palliative Care is well integrated into the health system, with 40 million people needing palliative care annually, including 20 million at the end of life. It is observed that only 14% of the need for palliative care is met at the end of life, less than 10% in total. 78% of those in need of Palliative Care live in low and middle-income countries, and finally, it records that less than 1% of children who need palliative care are receiving them [22].

It is known that Brazil was classified in group 3A by the WHO in 2014, which means that the provision of palliative care is offered in an isolated way [23].

Thus, the country, as a member of this group, is in a condition of irregular development, presenting a small number of services compared to the size of the population (220 million Brazilians), with funding sources dependent on private donations, with limited availability of medicines such as morphine, lack of strictosensu post-graduation programs which makes it difficult to train highly qualified teachers and, consequently, affects the entire education chain in this field. Therefore, it is evident that much needs to be done for the integration of services and equipment.

Considering the above, it is worth highlighting the positioning of the National Palliative Care Academy for the improvement of the offer and the quality of the services provided in the country [10].

In the document “Panorama of Palliative Care in Brazil - 2018”, the ANCP noted that the effective development of Palliative Care must be based on three fundamental pillars: national policy of palliative care incorporated into the health system; availability policy and access to essential medicines; and education and training programs for health professionals.

According to the entity, it is possible to project in the short term the existence of an even greater demand for Palliative Care services by specialized professionals with the professional regularization, promulgation of laws, as well as the existence of teams of palliatives in the oncological field in different health care levels. See table 1 below.

The ANCP [10] understands that a:

Analysis of the services registered in the map of the ANCP until 8/16th/18	Quantity	Percentage %
Total number of CP services registered	17 7	100%
Midwest	8	5%
North	5	3%
Northeast	36	20%
Southeast	10 3	58%
South	25	14%
Start of service activities		
2016-2018	40	23%
2011-2015	49	28%
2006-2010	23	13%
2000-2005	12	7%
1999 or before	7	4%
Unacquainted	46	26%
Action		
They work in hospital	13 1	74%
They work in hospice	8	5%
Attends patients from the Brazil Unified Health System (SUS)	11 7	66%
Attends pediatrics	38	21%

Table 1: ANCP (2018).

National Policy that guides and directs CP in Brazil is urgently needed. Considering the current crisis of the Brazilian health system, we considered that the minimum to be included in such a policy would be to specify the levels of palliative care to be offered, following the recommendations of the best societies in the world. And from this regulation, create a National Registry in the Ministry of Health, where the specialized services of Palliative Care can register and, for this, they can issue specific codes of procedure. We understand that, to improve, we need to measure, and this measurement would need to be contemplated within DATASUS. Currently, the 177 teams working in the country are invisible to the DATASUS database, and thus, their impact on the sustainability and quality of the system cannot be nationally assessed.

The Brazilian reality explains the need for the improvement and creation of palliative care services oncology, as well as the dissemination of knowledge in Palliative Care among health professionals and the population in general.

In the country, activities related to Palliative Care in Oncology need to be adjusted and regularized in the form of law. In general, in the health scenario, health professionals, hospital managers and the judiciary are not aware of the palliative care fundamentals which compromise their expansion and consolidation as a medical area.

It should be noted that the majority of oncological palliative care services depend on the implementation of standardized care models that guarantee efficacy and quality at all levels of care in the health area, respecting the hierarchy concept of care within Brazil's publicly funded health care system (SUS), which translates into basic health care in the medium and high complexity, guaranteeing to the citizen the integral, equitable and universal right to health.

Oncologic Palliative Care reduces the costs of health services and brings enormous benefits to patients and their families [10]. It is important that the Brazilian population is aware of the importance of this type of assistance in the health system, since it is mainly a humanitarian need, so that there are modifications in the approach to patients with diseases that threaten the continuity of life.

There is a significant demand of oncology patients for access to Palliative Care services, especially of those in the context of social vulnerability in all Brazilian states, whose access is far from being facilitated. [24-30].

Corroborating the affirmative woven, it is recorded that, on October 31st, 2018, the Resolution on Palliative Care for the SUS was officially approved at the 8th Ordinary Meeting of the Tripartite Intergovernmental Committee (CIT), a fundamental step for the supply of good, evidence-based Palliative Care in the country. In 2019, the effectiveness of an Ordinance on Palliative Care and the establishment of a guideline for health professionals acting closer to the patient are expected, specifying technical aspects related to care [10].

Conclusion

The investigation has signaled that a dignified death distances itself from a picture of "mistanásia". It advocates a conception of care aimed at providing access to appropriate treatment, even for those who have never had a dignified life, avoiding abandonment. Consequently, the association of social assistance and health policies is relevant.

It was understood that vulnerability is related to individual and social spheres, which can be aggravated by the fragility of care and assistance, related to the lack of efficient and satisfactory public policies. This retakes the importance of sensitizing health professionals and society on the intensified vulnerability process with a view to preventing harm and promoting well-being.

In this way, the participation of the family, of the public agencies (specialized technicians), of health institutions and of the society in general is important in minimizing the exposure of patients to the factors that generate vulnerability.

It has been reinforced that Oncologic Palliative Care reduces the costs of health services and brings significant benefits to patients and their families [10]. In this sense, a strategy was presented to reduce the suffering of end-of-life patients by granting eventual benefits, even as an instrument to reduce the number of health-related lawsuits in Brazil.

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