

# The Economic Value of Palliative Care and End-of-Life Care



## WHAT IS PALLIATIVE CARE AND END-OF-LIFE CARE?

The WHO defines Palliative Care as “an approach that improves the quality of life of consumers and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.<sup>1</sup> Palliative care is for people of any age who have a serious illness that cannot be cured. Dying is a normal process with palliative care offering a support system to help people to live their life as fully and as comfortably as possible until death and to help families cope during this illness and in their bereavement. People are approaching the ‘end of life’ when they are likely to die within the next 12-months.<sup>2</sup>

## DYING IN AUSTRALIA AND USE OF PALLIATIVE CARE SERVICES

In Australia, palliative care services are provided in a range of healthcare settings including acute hospitals, neonatal units, paediatric services, general practice, residential aged care as well as in community settings such as people’s homes. There were 159,052 deaths in Australia in 2015.<sup>3</sup> Two-thirds of deaths occurred in people aged 75 years or older, with the most common underlying causes of death being coronary heart disease (12.4%), dementia (7.9%), cerebrovascular disease (6.8%), lung cancer and cancer of the trachea (5.3%), and chronic lower respiratory diseases (5%).<sup>3</sup> Although 70% of Australians say they would prefer to die at home, only 15% do.<sup>4</sup> Around half of all deaths occur in hospital and just over a third in residential aged care.<sup>5</sup> Compared with other OECD countries such as New Zealand, South Korea, Ireland, France and the US, the rate of deaths at home in Australia is low.<sup>4</sup>

Many Australians reaching the end of life do not receive palliative care, even though when asked, they have clear preferences for the type of care they would like. In 2014-15, of the 76,856 people who died as a patient admitted to hospital, only 46% had received palliative care during their final hospitalisation; only 4% of residents in aged care had a formal appraisal indicating that they required palliative care; only 1 in 1,000 patient encounters with GPs was palliative care-related. Of all the services provided in 2015-16 by palliative medicine specialists and which were subsidised under Medicare, only 5.8% involved consultations in a patient’s home; and the majority of patients who received palliative care had advanced cancer.<sup>6</sup> People with other chronic life-limiting conditions such as chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD) or dementia have symptoms as severe and distressing as those of cancer patients, but they do not have the same access to palliative care services as those with cancer.

## ECONOMIC BENEFITS OF PALLIATIVE CARE

Research consistently shows that people who receive palliative care compared with those receiving usual care, have less hospitalisations, shorter lengths of hospital stay, reduced use of Intensive Care Units (ICUs) and fewer visits to Emergency Departments (EDs). Cost-savings from palliative care interventions occur across a number of settings including delivery at home, in hospital, in residential aged care, for cancer and non-cancer life-limiting illnesses and early versus late delivery of care.

**Palliative care at home:** Most people prefer to die at home or in a home-like environment surrounded by family and friends.<sup>7</sup> The evidence shows that home-based palliative care saves costly resources while improving consumer quality of life and that person-centred palliative home care is cost-effective.<sup>8-10</sup> When palliative care is provided at home, palliative care patients are 87.5% more likely to remain in the community until death.<sup>11</sup> While there are increases in the costs of GPs and other health professionals providing palliative care relative to usual care, home palliative care programs are cost-effective with the reduced need for and decreased costs of hospital-based care more than offsetting the costs of the program.<sup>3,12,13</sup>

**Palliative care in hospital:** Inpatient specialist palliative care consultation teams are found consistently to be less costly than usual care practices.<sup>14</sup> Cost-savings from palliative care are greatest among persons who die in hospital and increase the earlier palliative care is introduced.<sup>15,16</sup> Both inpatient palliative care consultation services and specialised palliative care units in hospitals are associated with economic benefits. Cost-savings accrue through earlier hospital discharge, reduced intensity of care (use of resources including clinical services, ICUs, therapeutic procedures, diagnostic and imaging, pharmacy), or a combination of both.<sup>14,17,18</sup> Inpatient palliative care has also been shown to reduce 30-day hospital re-admissions, an indicator of quality of healthcare. The provision of palliative care decreases costs of hospitalisation by better matching treatments to patients’ and families’ preferences and goals of care. This not only improves the quality of end-of-life care also the quality of dying.

**Palliative care in residential aged care:** Identifying the need for end-of-life care in aged care residents is difficult as residents often have multiple morbidities, symptoms are under-estimated, underlying illness trajectories vary and time to death may be unpredictable.<sup>19-22</sup> Staffing levels also tend to be low, there are competing demands on nursing time, and medical care to residents is largely provided by GPs and is very time limited.<sup>19,20</sup> These aspects of residential aged care lead to residents

receiving sub-optimal care.<sup>19,20</sup> The economic evidence shows that an investment in palliative care in residential aged care significantly reduces costs in the hospital sector through reduced visits to EDs, decreased overnight hospital admissions and reduced days stayed while providing more symptom control, pain relief and comfort for both residents and their families. The percentage of residents dying in hospital also decreases.

**Non-cancer Life Limiting Conditions:** Traditionally palliative and end-of-life care is associated with advanced cancer. Palliative care improves symptom management, pain relief and quality of life but in many chronic life-limiting conditions, like CHF or COPD, palliative care is still significantly underutilised and referral delayed.<sup>23-27</sup> There has been a small but appreciable increase over the past 10 years in access to palliative care services in Australia by patients dying from non-cancer conditions, but the majority of people with other life-limiting illnesses still die before they receive palliative care.<sup>28</sup> The continuing high use of costly resources in the final months of life suggests models of care still focus on prolonging life and a tendency toward aggressive care.<sup>19,21</sup> Palliative care saves resources and is cost-effective in delivering compassionate person-centred care to this group of Australians.

**Early Access to Palliative Care:** The strong association between early palliative care and decreased costs suggests that palliative care teams are effective in modifying the care and health trajectories of patients and improving quality outcomes.<sup>29,30</sup> With respect to the hospital sector, cost-savings associated with early inpatient palliative care are more pronounced the earlier palliative care is integrated into patient care.<sup>31</sup> The main reasons underlying the economic benefits of early palliative care are the reduction in clinically futile treatments and more patient-focussed and less aggressive care due to improved clinician-patient-family communication about treatment goals, preferences and transition planning.<sup>29,32</sup> Early palliative care mediates the escalation of direct costs of care towards the end of life. Despite its cost-effectiveness and recommendations that early palliative care is offered to consumers, specialist palliative care services are still underutilised in Australia.

## CONCLUSION

If the place of death and care preferences of people approaching end of life are to be realised then a much greater investment is needed in the provision of specialist palliative care services in Australia. There is clear evidence of the cost savings that accrue from palliative care and its cost-effectiveness. It is imperative to expand the scope of economic evaluations to more fully understand and recognise the role palliative care plays in enhancing value in healthcare and improving the quality of life of people with progressive life-limiting illness.<sup>14</sup>

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