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The Economic Benefits of Early Access to Palliative Care and End-of-Life Care

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KEY FINDINGS

- 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.[7,13]
- With respect to the hospital sector, cost-savings associated with early inpatient palliative care are more pronounced the earlier specialist palliative care is integrated into patient care.[5]
- The main reasons put forward for the economic benefits of early palliative care are the reduction in futile treatments, and more patient-focussed and less aggressive care due to improved clinician-patient-family communication about treatment goals, preferences and transition planning.[5,8,14]
- Early palliative care mediates the escalation of direct costs of care towards the end of life. However, despite its cost-effectiveness and recommendation that early palliative care is offered to consumers, palliative care services are still underutilised in Australia and often at a later stage.

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*".[1] 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.[2]

TIMELY REFERRAL TO PALLIATIVE CARE

Palliative care can help people realistically and openly consider their treatment options, goals and prospects, which may include declining treatment or care. There were 159,052 deaths in Australia in 2015[3] with most Australians dying in hospital (50%) or in residential aged care (35%). In 2014–15, some 76,856 patients died in hospital, and 55,605 deaths occurred in permanent residential aged care.[4] Early introduction of palliative has been shown to be beneficial in all care settings not only in managing people's pain levels, relieving symptoms, improving patient comfort and providing psychosocial and spiritual support but also in assisting the family and carers to help set care goals and participate in transition planning. While the concept of early palliative care has received widespread recognition and enthusiasm, especially for people with cancer, prevailing attitudes and scepticism of some medical practitioners have led to an ongoing underutilisation of early palliative care services.[5] A number of studies have reported cost-savings from palliative care programs operating in hospitals, residential aged care and within the home. The idea of "timely referral" to palliative care is not new in paediatrics for children with life-threatening illness.[6] However, the evidence base is limited on the timing of palliative care and how this affects both the quality and costs of care for both children and adults. This is an area that should be a focus of future research.

ECONOMIC BENEFITS OF EARLY PALLIATIVE CARE

Most of the available studies involve adult patients with advanced cancer. For example, in the US outcomes from early palliative care (defined in the study as being provided more than 90 days prior to death) were compared with late palliative care (less than 90 days prior to death) in patients with cancer who died having received specialty palliative care services.[7] Early palliative care was predominantly delivered in an outpatient setting while late palliative care was typically provided in hospital. The results showed that compared with patients receiving late palliative care, early palliative care patients had lower rates of hospital inpatient admission (33% vs 66%), lower rates of Intensive Care Unit (ICU) use (5% vs 20%), and fewer Emergency Department (ED) visits (34% vs 54%) in the last month of life. They also had lower rates of death in hospital (15% vs 34%), fewer deaths within 3 days of hospital discharge (16% vs 39%) and a lower 30 day mortality rate post-discharge (33% vs 66%). Direct costs of inpatient care in the last 6 months of life for the early palliative care group were 26% lower than those for the patients receiving late palliative care while outpatient costs were similar.[7]

A multi-site study was undertaken in the US of adults admitted to three hospitals with advanced cancer[8] comparing the outcomes of patients receiving palliative care intervention early in their admission, palliative care later or usual care. The findings confirmed that early palliative care confers greater economic benefits compared with either late palliative care or usual care. Patients receiving usual care had on average 17.8% higher overall costs and 16.4% longer length of stay than the group of advanced cancer patients receiving early palliative care. The reduction in costs was due largely to reduced length of hospital stay and the associated decrease in accommodation costs but also to a reduced intensity of treatment in the three days immediately following admission. This included a reduction in unnecessary testing and imaging but the overall costs

of pharmacy did not differ.[8] The shorter length of stay contributed to 63% of the savings. Patients who received palliative care relatively late had longer lengths of hospital stay compared with the two other groups and thus the total costs of their hospital stays were significantly higher. However, the daily cost ratios were only marginally higher.[8]

Another US study showed that early palliative care consultation during hospital admission of patients with advanced cancer, defined as the first inpatient palliative care consult occurring within two days of admission, was associated with a 24% reduction in hospital costs and late palliative care, contact within 6 days, with a 14% cost-savings compared with usual care.[9]

In Western Australia, early admission (defined as 91–365 days) to community-based palliative care was found to reduce visits to EDs in the last 90 days of life of patients with cancer and who did not live in residential aged care. Those who had no palliative care or who only accessed palliative care in the 90 days before death were far more likely to visit an ED in the last 3 months of life (52.0% of patients) than individuals who had early admission to palliative care(31.3%).[10]

Aggressive care at the end of life is regarded as indicative of suboptimal quality of end-of-life care but is modifiable by palliative care consultation. The medical records of 100 consecutive women who died from a primary gynaecological malignancy were retrospectively reviewed.[11] Timely palliative medicine consultation was defined as exposure to inpatient consultation 30 or more days before death. While 49% of patients had a palliative medicine consultation, only 18% had timely palliative care. The median direct hospital inpatient costs for the last 30 days of life were lower for the women who had a timely palliative care consultation.[11]

There is also a growing body of literature in support of early integration of paediatric palliative care for children with life limiting conditions, especially high-risk cancer.[6] A study undertaken in the US and Canada showed that more than 80% of children with cancer who were enrolled early in palliative care were still alive one month after entry to the study and about half were still alive nearly one year later.[12] However, there is little consensus on what constitutes the timely integration of paediatric palliative care and therefore it is inconsistently accessed.

JOHN'S STORY

John was 17 years old when he died of melanoma. After almost a year of intensive treatment with severe side effects his prognosis was six months, with the possibility of an additional few weeks with continued treatment. John opted to decline treatment with the full support of his family and specialist palliative care team as he did not want to spend the time he had left in hospital or very unwell.

Early referral facilitated John and his family to have open conversations with the PC care team and feel supported in their decision making. John lived for five months after stopping treatment, and in this time he achieved everything on his 'bucket list'.

When young people do not die well the flow on impacts are severe, with families suffering complex grief with lasting mental health impacts and considerable time away from employment. John's family were supported by the palliative care team, including funeral planning and assistance with organising time away from work. After John died comfortably in his home, surrounded by the ones he loved, the palliative care team continued to provide support for the family for a number of months.

Having access to the specialist palliative care team early not only meant a better death for John and less trauma for his family, it also led to avoiding hospital admissions and clinically futile treatment, which reduces the costs and demands on hospitals and the health system.

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