

How palliative care can reduce healthcare costs & improve quality of care

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ABSTRACT

The sustainability of the healthcare system has been in question for several years. With rising healthcare costs, limited resources and an aging population, society needs to come up with innovative ideas to reduce healthcare spending. This paper attempts to illustrate how addressing goals of care can have a significant impact on healthcare costs.

Keywords: Palliative Care; Healthcare Cost; Advance Care Planning

1. INTRODUCTION

The sustainability of the healthcare system has been in question for several years. With rising healthcare costs, limited resources, an aging population and with healthcare professionals becoming more proficient at extending life, society needs to come up with innovative ideas to reduce healthcare spending and at the same time maintain or improve quality of care. It is clear that hospital expenditures represent a significant cost to the healthcare system. In 2005, it was estimated that 36.8% of the public health expenditures was through hospital spending [1]. Some of the daily costs are higher than one might expect. For example, a visit to a Vancouver hospital emergency room can cost anywhere from \$510 - \$860. An admission to a ward bed can cost anywhere from \$3000 - \$4000 per day. Intensive care admissions can cost over \$7000 per day [2]. It is evident that a strategy of reducing emergency visits, hospital and ICU admissions could significantly impact healthcare costs. Increasing palliative involvement in patients with terminal illnesses can be a simple strategy that can help attain these goals.

2. EARLY PALLIATIVE CARE

Palliative care is a unique specialty that focuses on

pain and symptom management. They also serve as experts in communication and end-of-life issues. Studies have shown that with increase palliative care involvement, patients and their families have improved quality of life and may indeed have an impact on healthcare savings [3]. The issue with palliative care has been they have traditionally gotten involved in patient care near the end of their illness. With this strategy patients are being assisted with their symptoms at the end stages of life but there is an opportunity lost by not getting involved earlier. If palliative care is involved from the beginning, their symptoms are addressed earlier and often advance care planning is initiated. Patients may have a better opportunity to do things such as dying at home, which can be difficult to facilitate without advance planning. A recent study looked at stage 4 non-small cell lung cancer patients that were randomized to either early palliative care involvement or standardize care. Those patients that received early palliative care had improved quality of life measures, decreased hospital admissions, had less aggressive care at the end of life, improved mood and even increased survival [4]. Cost analysis was not done on this study but one can imagine with decreased hospital admissions and less aggressive care, there is potential for significant healthcare cost savings.

3. IMPACT OF PALLIATIVE CARE

As mentioned previously, ICU admissions are very costly to the healthcare system. In the United States it was estimated that 1% of their GDP was directed towards ICU costs [5]. Some of these costs are incurred on patients that are poor ICU candidates (they are unlikely to survive or live independently) or goals of care are not being addressed and the patients would not want heroic measures done. It has been proposed that proactive or even early palliative care involvement can help reduce ICU admissions and ICU length of stay. Back in 2003, Margaret Campbell published a study looking at proactive palliative care involvement with patients with mul-

tiorgan failure or significant brain injury after CPR. This resulted in decreased hospital and ICU length of stay. DNR status was also addressed sooner. Overall there was earlier identification of patients with poor prognosis, earlier transition for changing goals to comfort measures only, and earlier implementation of palliative care interventions [6]. A similar study was published in 2007 by Sally Norton. These ICU patients were randomized to standard care versus proactive palliative care consults for patients that met certain criteria that represented poor outcomes (hospital stay greater than 10 days, age greater than 80 with two or more life-threatening co morbidities, active metastatic cancer, post-cardiac arrest or intracranial bleed requiring life support). The palliative care arm had significant decrease length of stay in ICU (8 versus 16 days) and at the same time there was no difference in mortality [7]. It is clear that proactive palliative care involvement can impact ICU and hospital length of stay and potentially healthcare costs.

4. HOW TO INTEGRATE PALLIATIVE CARE

It is clear that there are benefits to addressing goals of care and increasing palliative care involvement in patient care. The true question is how best to implement these concepts. First, education needs to improve from an undergraduate level to a health authority level. There needs to be more value on effective communication and the importance of addressing goals of care. At the undergraduate level it may be more valuable to teach these skills in their third and fourth year when they are actually having patient contact. Studies have shown communication is a teachable skill. In 2006, Lorin *et al.* published a study looking at an educational intervention focused on the initial meeting with the family member of an ICU patient and included formal teaching on communication. The students were randomized to formal teaching versus no formal teaching in communication. The group that received formal teaching had improved scores in gathering information and setting goals [8]. If we have an approach similar to this, the benefits could be paramount.

Second, at a hospital level palliative care could get more involved in interdisciplinary teams. Departments such as radiation oncology, hematology and medical oncology could benefit from having a member of the palliative care team provide input on a weekly basis.

Lastly, issues on improving communication skills and addressing goals of care can be addressed at a health authority or ministry level. For example, a task force implemented on how best to approach the issue. This could provide further innovative ways on how to address the issue at a larger scale. For example, ad campaigns could be initiated. Videos can be produced for nursing homes to emphasize the importance of addressing goals of care. Incentives could be given to specialists for early pallia-

tive care referrals. All these ideas would have cost to incur but overall could save healthcare dollars.

One of the main obstacles is that palliative care has traditionally been thought of as a specialty only associated with death. The attitude has been “once palliative care is called, you know you will die within a couple weeks.” These beliefs of course are unfounded. Regardless, some of these attitudes will serve as roadblocks for advancement.

5. CONCLUDING REMARKS

In conclusion, increasing palliative care involvement is a logical and potentially an evidence-based strategy to reduce healthcare spending and improve quality of care. There is certainly an argument for further studies looking at the cost-effectiveness of such a strategy.

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