

All Ireland International Conference Pushing Boundaries in Palliative and End of

GOVERNMENT POLICY 2001

“. We now have a unique opportunity to ensure that every person in Ireland who requires palliative care, will be able to access with ease a level of service and expertise that is appropriate to their individual needs.

Such services must be provided by a highly trained and co-ordinated inter-professional team, and delivered at a time and in a place that will be determined by the specific needs and personal preferences of each individual patient.”

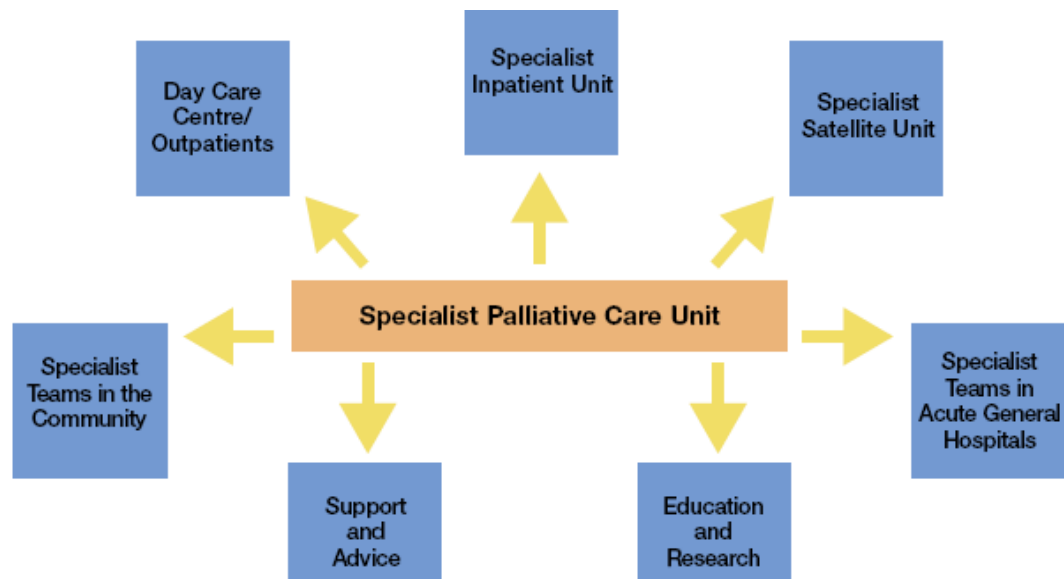
Dr Tony O’ Brien, M.B., F.R.C.P.I.

Chairman - National Advisory Committee on Palliative Care, 2001



Regional Structures for Specialist Palliative Care

The specialist palliative care unit should be the core essential element of the specialist palliative care service (NACPC 2001)



The Elements of Quality Hospice Care

Health Service Executive May 2006)

- The holistic approach to end-of-life care involving multi-disciplinary teams (doctor, nurse, care attendant, home help, social worker, psychologist, physiotherapist, pharmacist, occupational therapist, alternative therapist, bereavement counselor, chaplain) will need to be provided in every county.
- The Specialist Palliative Care Inpatient Units (1 bed per 10,000 pop.) will support a network of Specialist Multidisciplinary Homecare Teams providing services to the community in every county.(1 homecare nurse per 25,000 pop.). There will be strong links with the evolving Primary Care Teams.
- Consultant-led Multidisciplinary Specialist Teams will service all acute hospitals with over 150 beds.
- Specialist Day Care facilities attached to all inpatient units (including satellites) will provide access to day care programmes for medical, social, nursing or rehabilitation interventions. The range of day care activities provided includes nursing procedures, personal care, physiotherapy, occupational therapy, complementary therapies, relaxation, music and art therapy. These facilities will also be provided at strategic locations distant from the Specialist Palliative Care Inpatient Units and Satellite Units.

– (Source: Specialist Palliative Care Services, HSE South, May 2006)



A Strategy for Cancer Control in
Ireland (National Forum, 2006)

*“The Health Service Executive should ensure that each Managed Cancer Control Network has **a comprehensive specialist palliative care service** to meet the needs of patients and families. This will enable a range of benefits including the incorporation of palliative care into patient care plans at an appropriate stage in the management of their disease; an enhancement of the palliative care capacity of primary care; integrated care pathways and multidisciplinary teams that incorporate palliative care services.”*



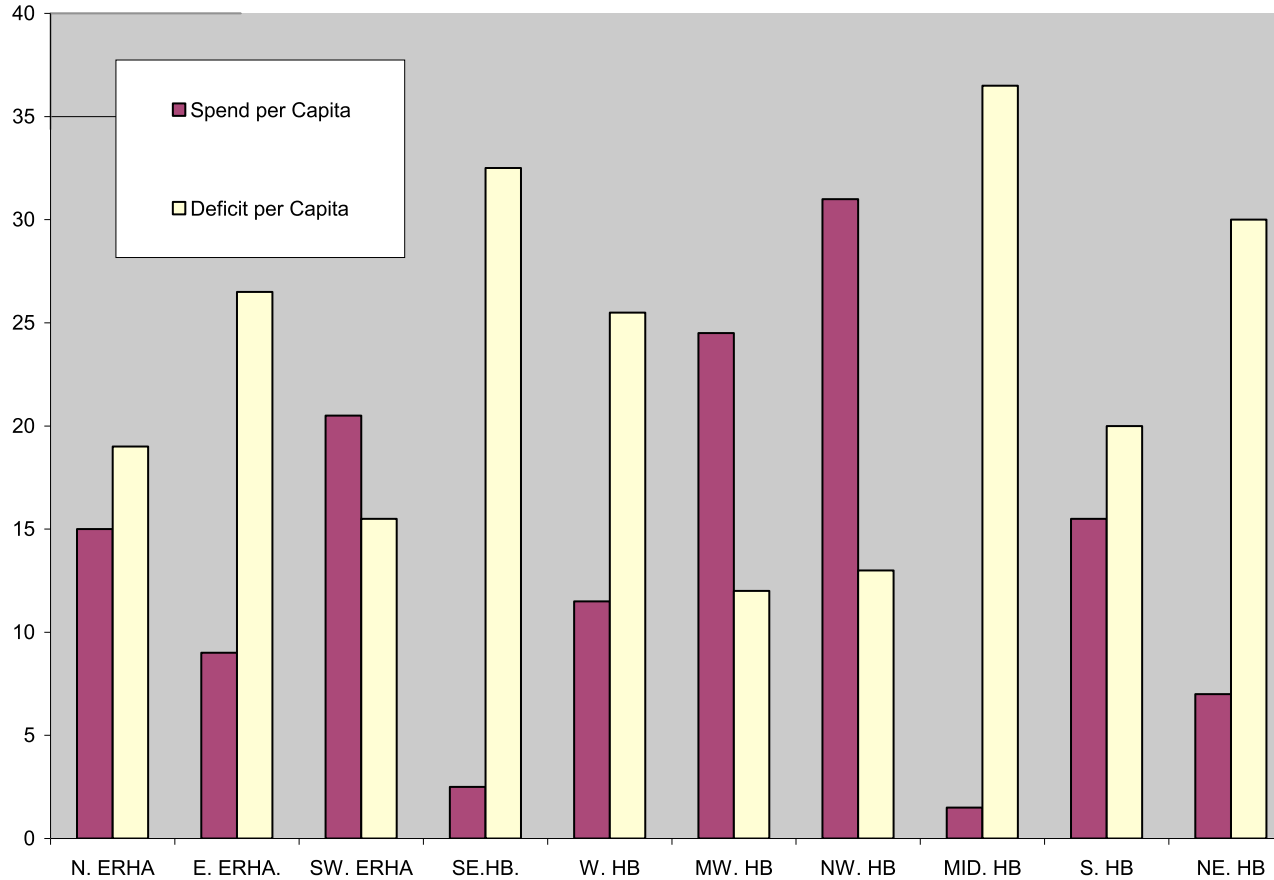
Baseline Study

- Major hospice bed and staff deficits in all care settings
- Major regional inequity
- Minister agrees that there is a need to double funding from €70m to €140m.

Palliative Care Staff/Beds : Government Spend Per Capita by Region

Current position on recommendations* from Report of National Advisory Committee on Palliative Care (2001) (* based on current population / bed numbers)

€Euro



Palliative Care in Ireland : Totals

Implications of current position relative to the recommendations* of the Report of the National Advisory Committee on Palliative Care (2001)

(* based on current population / bed numbers)

	Total	Total Approved	Recommended	Deficit	Current Cost inc. overheads	Cost Deficit	Current + Deficit Total
Staff	582.1	45.5	1270.2	-732.2	€35,486,483	-€50,302,367	€85,788,849
Beds	131.0	0.0	390.0	-259.0	€19,650,000	-€38,850,000	€58,500,000
Totals					€55,136,483	-€89,152,367	€144,288,849

Towards 2016: Ten-Year Framework
Social Partnership Agreement
2006-2015

Provision has been made in the new Social Partnership Agreement to prioritise hospice care over the next three years by:

... further developing palliative care throughout Ireland, with particular reference to the Baseline Study on the Provision of Hospice/Specialist Palliative Care Services.

The National Development Plan 2007-2013 Transforming Ireland

Includes a commitment to developing palliative care services around the country.

The Plan specifically states:

“Support will be provided to develop specialist palliative care beds in-patient units, palliative care community support beds, day services and ancillary supports.

The HSE has worked with key stakeholders to prioritise capital projects for palliative care. These projects will be progressed in the context of overall funding for Services for Older People and Palliative Care.”



“ I want to speak about the Baseline Study - The Baseline Study has provided the evidence to underpin the investment and could be viewed as a “roadmap” of where we want to go and how we are going to get there. “

An Taoiseach

Bertie Ahern T.D. December 2006

- “We will do our utmost to ensure that everyone, regardless of where they live, can access appropriate services.
- The HSE will work with the newly established Development Committees to determine priorities and allocations.
- The increased profile of Palliative Care is reflected by the fact that it is explicitly mentioned in the new Social Partnership Agreement – *Towards 2016*.
 - The Government looks forward to working with all of the Social Partners to implement this new Agreement.”



Programme for Government “Transforming Ireland A Blueprint for Ireland's Future 2007 -2013”

- “The Government will ensure that the needs of all people who require palliative care are met, whether this is needed at home, in the community or in a specialised hospice.....We sre committed, within the next 5 years, to removing the regional disparities in the provision and funding of palliative care”

Health Service Executive

National Action Plan for Palliative Care Services

IN TOTAL, THE DELIVERY OF THE 41 NATIONAL PALLIATIVE CARE ACTIONS OUTLINED ABOVE WILL REQUIRE:

- 272.19 WTE AND
- 203 SPECIALIST IN-PATIENT BEDS (LEVEL 3).

How Hospice Care saves the

- There is overwhelming international evidence that investment in comprehensive hospice services saves money. The economic downturn strengthens the case for implementing the many commitments to eliminate the regional inequity in hospice services.

How Hospice/Palliative Care saves the taxpayer money

- At least €70,000 or between a 25% and 33% of a person's lifetime health services consumption of around €300,000 happens in the last year of life.
- About 40% (€28,000) of this "last-year" expenditure happens in the last month of life.
- Proximity to death – not age is the biggest factor influencing health services consumption.
- More than 20% of all medical expenditure for people over 65 is consumed by those in the last year of life.
- People in the last year of life comprise only 1% of the population, yet they account for almost 30% of all hospital expenditure.
- **When people enter hospice programmes they are cared for and die mostly at home, use much less acute hospital services, and they live longer in greater comfort and dignity. They also consume at least 25% fewer medical resources than those who access "usual care".**
- Spending on patients in the last year of life is estimated at between 10% and 15 % of the total healthcare budget. In Ireland this would amount to between €1.6 billion and €2.4 billion from of a total health budget of €16 billion.
- The total hospice/palliative care budget in all care settings is €75m. or less than 5% of "last year of life " spend
- We could implement the current plans for comprehensive hospice/palliative care services in all regions for an additional €75m – and save money.
- We can enhance the whole family experience in enabling those with incurable advanced illnesses to live life to the full to the end.

How Hospice Care saves the

- 2007 – US Medicare Study - savings of 25% when patients enter hospice care programmes.
- Barcelona region palliative care programme - use of hospital resources fell 61 %, Length of hospital stays reduced by 25%, use of emergency hospital rooms reduced by 42%.
- 2007 San Francisco study average daily care costs were lower by 33%.

How Hospice Care saves the

- Healthcare costs are highest at the end of a person's life. International studies have shown that more than **25% of a person's lifetime health expenditure** will be consumed, on average, in the last year of life (McGrail et al, 2000; Spillman & Lubitz, 2000; Yang et al, 2003; Miller, 2001) [1,2,3,4,]

How Hospice Care saves the

- Hoover et al (2004) [5] found that in the United States from 1992 to 1996, about **22 percent of all medical expenditure** (\$282 billion) for **people over the age of 65** was consumed by a cohort of people who were in the last year of life.
- "All of these studies provide evidence that it is proximity to death rather than age which results in very high consumption of health service resources. For example a Netherlands study of all those making health insurance claims found that healthcare costs in the last year of life accounts for **10% of the total health budget**. The average cost of healthcare per health insurance claimant, in the year preceding death is 13.5 times greater than the costs for claimants who live. (Polder, Barendregt and van Oers, 2006) [6].

How Hospice Care saves the

- A UK study followed 91,000 patients over the age of 65 from 1970 until death. They found that **while people in the last year of life comprise only 1% of the population they account for 29% of hospital expenditure.** The also observed that while on average each year those who died comprised only around 5% of the group, they accounted for 55% of hospital spending on the group. (Seshamani and Gray, 2004) [7].
- Spending on patients in the last year of life is estimated at between 10 and 15 percent of the total healthcare budget in a diverse range of countries with different health systems. In Ireland's case this would amount to **between €1.6 billion and €2.4 billion** from of a total health budget of €16 billion. Keeping this figure as low as possible will deliver real savings in health the health budget.

How Hospice Care saves the

- There is compelling evidence that comprehensive specialist palliative care services which are integrated across all care settings yield significant savings.
 - **Reduced lengths of stay in hospital and utilization of intensive and expensive high technology medical interventions and enables patients to spend a higher proportion of time in a home setting.**
- Several recent international studies have pointed towards major savings in health resource consumption by patients who access hospice programmes.
 - These studies also show improved length of life, symptom control and patient and carer satisfaction. A US study by Taylor et al (2007) [8] found that **hospice care saved Medicare an average 25% per person, versus the non-hospice option.** This study is consistent with an earlier (1996) US study by E. J. Emanuel, “Cost savings at the end of life : What do the data show ?” [9]. This study found that hospice and advance directives can save between 25% and 40% of health care costs during the last month of life.

How Hospice Care saves the

- At any one point in time the vast majority of hospice care patients are being supported in the home. **Most palliative care is provided by family members at home supported by their general practitioner, community nurse, home helps and a specialist palliative care nurse.**
- A 2007 study of the cost of home hospice care for terminal patients in Israel examined and compared the cost of care provided to terminal metastatic cancer patients by home hospices and by conventional health services. The study population included 146 patients with metastatic cancer. Half received home hospice services, and the other half received conventional services. **The average overall per-patient cost of care was, respectively, \$4761 and \$12 434.** Shnoor et al (2007) [10]

How Hospice Care saves the

- Two different “before and after” studies, in Spain and Canada detailed the impact on the cost of care following the establishment of regional palliative care programmes.
- In the Catalan region around Barcelona there was a reduction in resource consumption of 61% following the implementation of a palliative care programme. **Deaths in the home increased from 31% to 42%. Length of hospital stays were reduced by 25% and use of emergency hospital rooms was reduced by 42%.** All this was achieved without compromising patient care. (Gomez et al 2006) [11] The Canadian study followed the establishment of a regional palliative care programme in Edmondton. **There was a 71% reduction in the palliative care costs in acute facilities (from \$11.9m to \$3.4m.), arising from a 73% reduction in acute bed days.** While there were increases in community care costs the annual savings in the region were Can\$1.6m. (Bruera et al., 2000)

[12]

How Hospice Care saves the

- A study in the 1990's in a 1000 bed veterans hospital in Evanston, Illinois demonstrated that a palliative care programme delivered **savings of 18%** and greatly improved patient and carer satisfaction. 171 terminally ill patients were split into two groups with approximately half entering a palliative care programme. Those in the palliative care programme consumed 47% fewer hospital resources. Hughes et al (1992) [13]
- A recent 2 year study in an academic medical centre in San Francisco compared daily patient costs, length of stay and patient outcomes between a group of patients in palliative care and a group in "usual care". **The palliative care group had an average 50% lower length of stay and daily care costs were lower by 33%.**, resulting in annual savings of \$2.2 million. Ciemins et al. (2007) [14]

Hospital Palliative Care Services save hospitals money

- Cost savings also extend to the hospitals that offer palliative care
 - Studies reported lower use of acute care beds, aggressive therapies and intensive care units by patients in the care of specialist palliative care teams.
- A study in the states of California and Massachusetts found that **those receiving hospice care were significantly less likely to die in the hospital (11% vs 43% in Massachusetts and 5% vs 43% in California)**. Emanuel et al (2002) [15]
- In 2005 The Cleveland Clinic's Inpatient Palliative Medicine acute care unit's costs were compared with 12 other hospitals. Davis et al (2005) [16] They observed that between 13% and 18% of hospital admissions involve patients with advanced, incurable illnesses. They found that **the total mean charges per admission to the Cleveland palliative care unit were 27% lower** than at other peer institutions despite an equivalent severity of illness.
- Another hospital based study sampled five hundred seventeen patients with life-limiting illnesses from hospitals in Denver, Portland, and San Francisco. The patients were enrolled from June 2002 to December 2003. Gade et al (200) [17]”
- They found that the IPCS;
 - Had higher scores for the Care Experience scale
 - Had fewer intensive care admissions on hospital readmission (12 versus 21)
 - and lower 6-month net cost savings of \$4,855 per patient



Hospital Palliative Care Services

- A 2003 study in a hospital in Richmond, Virginia concluded that patients who were admitted to the 11 rooms in the hospitals palliative care unit had **57% lower care costs** compared to terminally ill patients who did not access the service. Smith et al (2003) [18]
- A study of 8 regionally dispersed US hospitals was published in September 2008 which, clearly demonstrates the cost benefits of hospice care. It found that: *“palliative care consultation was associated with a reduction in direct hospital costs of almost \$1700 per admission (\$174 per day) for live discharges and of almost \$5000 per admission (\$374 per day) for patients who died. For an average 400-bed hospital containing an interdisciplinary palliative care team seeing 500 patients a year (300 live discharges and 200 hospital deaths), these figures translate into a net savings of \$1.3 million per year. This study demonstrates that in addition to improved clinical care and patient, family and physician satisfaction, these programmes are associated with considerable reductions in hospital costs.”* Morrison et al. (2008) [19]
- A 2006 study in New York of terminal patients in two urban hospitals found significant **savings in end-of-life care costs for palliative care recipients, more than 20% per patient per day, and a 42% lower likelihood of intensive care admission.** Those palliative care patients who were admitted to intensive care had much shorter

The benefits and potential cost savings of greater use of home and hospice-based end of life care in England National Audit Office

- In 2006 the average cancer patient had:
 - 1.2 emergency admissions,
 - Spent: 7 days in hospital;
 - The cost of care in the last year of life to the nearly 127,000 who died from cancer was approximately £1.8 billion, or £14,236 per patient.
- In 2006 the average organ failure (heart and respiratory diseases) patient had 3 emergency admissions,
 - Spent: 40 days in hospital;
 - The cost of care in the last year of life to the 30,000 who died from organ failure was approximately £553 million, or £18,771 per patient.

The benefits and potential cost savings of greater use of home and hospice-based end of life care in England National Audit Office

- A lack of prompt access to services in the community leads to people being unnecessarily admitted to hospital
- 40% of people who died in hospital did not have medical needs that required them to be treated in hospital and nearly a quarter of these had been in hospital for over a month.
- Since hospital care is more costly than community based alternatives; and most people wish to die at home; we estimated the financial consequences, and patient benefits during the last year of life.
 - Decrease Acute utilisation
 - Reducing emergency admissions
 - Reducing the mean length of stay in hospital, via more rapid discharge following an admission

The benefits and potential cost savings of greater use of home and hospice-based end of life care in England National Audit Office

- A **lack of support** means many people die in hospital when there is no clinical reason for them to be there.
- Reducing admissions requires **services to respond quickly to needs 24/7** ? (are a number of service models but few 24/7)
- Reducing average LOS requires **effective and timely discharge arrangements** involving multiple agencies with appropriate packages of care.
- There is scope to **improve training** of NHS and social care staff, and **extend specialist palliative care services to all need them**, whatever their condition.
- **More effective partnerships** between the NHS, social services and the voluntary sector is required
- The **skills developed in the hospice movement**, primarily in working with cancer patients, **could be extended** to patients with other terminal conditions.
- The Department should support PCTs to **reconfigure services** and to better meet the needs of their population
- People should have the right to die in the place of their choice - need for SHA and PCTs to agree:
 - plans for increase in community services
 - 24 hr district nursing and pain relief services
 - **equal access for people in care homes;**
- People nearing end of life should be allocated a **single health or social care professional contact to improve co-ordination of care and PCTs should develop care plans** for all who want one.



Palliative Care and Cancer

- More than 8,000 people die from cancer in Ireland every year
- 6,000 currently access hospice services – 95% cancer patients
- Needs analysis and international evidence suggest a demand from at least 12,000 patients - all diagnosis
- Major investment currently underway in Cancer Control Programme
- 55% of cancer patients die within 5 years
- Palliative care is part of the cancer journey for the majority of cancer patients
- Many cancer patients are inappropriately located within cancer wards in overstretched acute hospitals.
- This will become a greater problem as cancer services are increasingly centralised.

Location of Death - Cancer

County - with Comp. service	% at home or /hospice
Cork	48%
Donegal	47%
Dublin	44%
Sligo*	50%
Limerick*	69%

County – only homecare	% at home / hospice
Carlow	31%
Kilkenny	26%
Kerry	29%
Louth	27%
Mayo	30%
Roscommon	21%
Waterford	26%
Wexford	29%
Wicklow	28%

Reconfiguration is no just about Beds but they are an essential component

- SNAPSHOT – NORTH DUBLIN SPC
- 200 Patients
- 140 – 70% at home
- 20 – 10% hospice inpatients
 - Multidisciplinary Symptom Control
 - Daycare/Outpatients Clinics/Respite
 - Terminal Care
- 40 – 20% in acute hospitals
 - including recent referrals

Reconfiguring Services is Easy!!

Just decide the medium term destination.

- CASE STUDY- COUNTY WICKLOW
- 320 state funded beds
 - 130 acute
 - 190 long stay
 - Does not include contracted beds
- Policy for a 12 Bedded Inpatient Unit = 4%
 - Voluntary Sector provide capital and expertise
 - Manpower plan, training.

Reconfiguring Services is Easy!!

Just decide the medium term destination.

- CASE STUDY- Pop. 340,000
- North East Meath/Louth/Cavan/Monaghan
- Hospital Reconfiguration Programme
 - Cancer Services/Surgery/ ICU/A&E
- 1720 state funded beds
 - 920 acute
 - 850 long stay
 - 1720 Total
 - Does not include contracted beds
- Policy for a 34 Inpatient beds = 2%
 - Voluntary Sector provide capital and expertise
 - Manpower plan, training.

Reconfiguring Services is Easy!!

Just decide the medium term destination.

- CASE STUDY- Pop 420,000
- South East - Carlow/Kilkenny/Waterford/Wexford/S.Tipp
- Hospital Reconfiguration Programme
 - Cancer Services/Surgery/ ICU/A&E
- 2800 state funded beds
 - 1500 acute
 - 1300 long stay
 - Does not include contracted beds
- Policy for a 42 Inpatient beds = 1.6%
 - Voluntary Sector provide capital and expertise
 - Manpower plan, training.

Reconfiguring Services is Easy!!

Just decide the medium term destination.

- CASE STUDY-
- Midlands - Longford/Westmeath/Laois/ Offaly
- Hospital Reconfiguration Programme
 - Cancer Services/Surgery/ ICU/A&E
- 2200 state funded beds
 - 900 acute
 - 1300 long stay
 - Does not include contracted beds
- Policy for a 22 Inpatient beds = 1%
 - Voluntary Sector provide capital and expertise
 - Manpower plan, training.

CONCLUSION

- Healthcare costs are highest at the end of a patient's life.
 - 10 percent of the total healthcare budget.
- Two prominent end-of-life expenditures = oncology and acute inpatient hospital
 - These expenses are overwhelmingly incurred near the patient's death.
- Particular concentration of costs in the last three months and the last ten days of life.
- Expenses associated with patients near death represents a large cost burden on health service providers.
- Hospice care avoids many aggressive therapies in favour of active, total care of patients
- End-of-life care policy must consider the costs and benefits of

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