



Trinity College Dublin

Coláiste na Tríonóide, Baile Átha Cliath

The University of Dublin

Achieving Value for Money in Palliative and End of Life Care

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Cicely Saunders
International
Better care at the end of life

WHO Collaborating Centre
for Palliative Care, Policy and
Rehabilitation



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Outline of Presentation

- The reality of health care choices and the need for evidence
- Economic evaluation and its application to complex services
- The nature of palliative care and measurement challenges
- Some evidence on cost-effectiveness in palliative care.



The reality of health care choices and the need for evidence

- Healthcare choices will always be made, and services with better evidence tend to win out
- In palliative care the lack of evidence on value for money has often been mistaken for evidence of poor value
- Good evidence is easier to assemble when objectives are simple and measurement is simple
- In palliative care objectives are complex and measurement is difficult



Economic evaluation and its application to complex services

- Economic evaluation works best when the intervention is simple and the outcome is simple
- Generally the aim is to determine effects on survival and quality of life

In complex interventions

- it is more difficult to define the intervention
- the effects depend on other factors
- the goals can be quite personal and include caregivers
- outcomes can be hard to measure.



The nature of palliative care

- An approach as well as a service
- Goals of care may change and evolve
- Work in teams (including with informal care)
- Availability can be as important as use
- Outcomes depend on multiple, often inter-dependent interventions
- Important effects often occur over short time periods



Measurement challenges in palliative care 1

Defining the intervention

- Interventions may be part of a package of services
- Intervention may be through others (advice, support etc)
- Availability rather than use may be important (the insurance value of services)
- Interventions are bespoke and differ between seemingly similar cases
- Interventions occur over time and are not independent of each other
- To what extent are these features unique to palliative care?



Measurement challenges in palliative care 2

Assessing costs

- How wide to go?
- Some activities displace others and are cost neutral
- How to cost available services that are not used
- Do we cost actions, linked actions, programmes?
- Costing consequences of palliative care for other care



Measurement challenges in palliative care 3

Assessing benefits 1

- Widely used tools (e.g. SF36, EQ5D) have limited domains and may have very limited sensitivity
- Most studies show that people value palliative care services but may not show up in the outcome measures
- Generally the scope and sensitivity of tools is inadequate



Measurement challenges in palliative care 4

Assessing benefits 2

- Some new approaches aim to increase the scope of measurement, such as ICECAP and POS e
- This potentially allows better measurement of benefits and includes benefits to families and caregivers
- Early results suggest these tools do much better at capturing the benefits in complex outcomes
- Problem remains of how to compare outcomes measured with these tools and those using simpler tools.



Measurement challenges in palliative care 5

Assessing benefits 3

- Timescales in palliative care are often short, limiting the scope for benefits of longer life
- Unless QoL can be better than perfect this also limits scope for benefits as measured by QALYs
- Some countries give bonus points for end of life benefits to compensate for this – does this make any sense?
- Units of time are probably not additive in this context.



Measurement challenges in palliative care 6

Assessing benefits 4

- An alternative approach is to measure what matters to users of palliative care services
- Choice experiments allow researchers to understand what is considered to be more important and a higher priority for patients and families
- The choice of services and styles of services can provide some information on the preferences of services users
- Some examples from choice experiments are in the following slides



Some evidence on cost-effectiveness in Palliative Care 1

Choice experiments show that

- Process as well as content, but sometimes mainly process (how services are delivered) can be key
- Availability (even if not used) - very easy access with no hassle to patient or family is valued
- Minimising burden on family is valued – care time commitment is largely fixed, and should be used for what they alone can do.



Some evidence on cost-effectiveness in Palliative Care 2

Services users want

- Prepayment – no worrying about paying at time of service use – timing of payment more important than level of payment
- Participation in making choices
- Expert help in making choices (even in US)

‘It’s bad enough to be dying without all this nonsense!’



Findings from Pal.M.ED 1

- Pal.M.ED was a study of enhanced palliative care activity in an Emergency Department
- Patients with previous PC consultations were flagged in ED system
- PC staff visited ED daily and liaised with ED staff
- The aim was to identify the known repeat attenders and plan better care.

Findings from Pal.M.ED 2

PAL.M.ED intervention was associated with

- An increase in palliative care referral OR 10.5, $p < 0.05$
- Shorter LOS -13.4 days $p < 0.05$
- Fewer microbiology tests
- Fewer haematology tests
- Fewer CT scans $p < 0.05$
- Higher satisfaction
- Probably fewer readmissions

Dying in Limerick – the EEPCI study

EEPCI study compared PC in 3 regions

- Mid West has a well developed hospice and community PC service, South East has good community PC.
- Overall over 30% of decedents died in hospital
- Only 10% died in hospital around Limerick
- Better community PC services (as in South East) did not reduce hospital deaths.

Findings in US Hospital studies

(May et al, JAMA Internal Medicine (in press))

Studies were of Palliative Care Consultation Teams or Units

- *Timely* consults resulted in shorter stays, fewer tests and interventions, higher satisfaction
- Effect was particularly strong in cancer patients
- Effect was particularly strong in cases of serious multimorbidity
- Costs savings were from both shorter stays and reduced treatment intensity.

Implications of findings 1

- One aspect of specialist Palliative Care is to support better choices near the end of life
- The context is generally of admission under a single specialty
- Other evidence from our studies demonstrates that people value process highly, especially when choices are difficult

Implications of findings 2

- The evidence shows that various versions of supporting better decisions reduce time in hospitals and costs of care – there is a problem of poor decision making and avoidable costs
- Since this version of supporting better choices is free (the evidence shows lower costs of hospital care) there is no case for not focussing on how we can do this better.

Some Concluding Remarks

- Ignoring the economic issues is not an option
- Accepting orthodox approaches to economic evaluation in palliative care is not an option
- We need to continue to evolve ways of valuing the benefits of good palliative and end of life care that cover all domains
- We have some good evidence that palliative care is valued and can also be cost saving
- We need to go beyond arguing that it must be good because the context is so important.





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Thank you for your attention



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