Can palliative care teams relieve some of the pressure on acute services?

All the evidence points that way; commissioners take note

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Specialist palliative care teams are those with palliative care as their core daily work. They are multidisciplinary teams, have specialist skills and experience, and deliver palliative care both directly and indirectly; directly by providing care to patients and families, and indirectly by supporting other professionals to deliver such care.¹

Providers, commissioners, and funders of health services need to know whether specialist palliative care teams make a difference and, if so, how. They need to know this, not only to determine whether these teams make a positive difference for patients and families, but also because of the urgent need for health services across the world to do things differently; to shift the emphasis from acute care to better coordinated care at home and across the interface between acute and community care. In this issue of The BMJ (doi:10.1136/bmj.g3496) Seow and colleagues report a retrospective cohort study from Canada which suggests that community based specialist palliative care teams are effective in reducing use of acute care services (hospitalisation and emergency department attendance) in the last weeks of life.² This adds to growing evidence that specialist palliative care teams not only improve patients’ symptom control, quality of life, and satisfaction with care, but can change patterns of acute care use, supporting health services in their urgent need to do things differently and more cost effectively.

Illness in the last year of life places a major burden on patients and families, and considerable resource burden on health services. Between 69% and 82% of those who die need palliative care,¹ and up to a quarter of healthcare expenditure is spent in the last year of life,⁴ mainly on inpatient care.⁵ In the face of ageing populations, growing numbers of people with multiple long term conditions, and major funding deficits for health systems internationally, the way frontline healthcare is delivered has to change. Reducing use of acute services such as hospitals is at the heart of this change, and reducing ineffective or futile use of acute interventions near end of life is also a factor.⁶

There is good evidence from controlled trials that specialist palliative care teams (whether in the community, hospital, or inpatient hospices) consistently deliver better symptom control, more satisfaction with care, improved quality of life, and better outcomes for families.⁷ In a recent Cochrane review, Gomes et al also found clear and reliable evidence that home based palliative care increases the likelihood of dying at home, in accordance with the preferences of many for death at home.¹⁰ But do specialist palliative care teams also make a difference to the patterns (and therefore costs) of acute care use? This is important, since if they reduce hospitalisations towards end of life, and deaths in hospital, there may be an opportunity to relieve some of the current pressures on acute services, while at the same time delivering better care and meeting many patients’ preferences for place of death.

There is some early evidence that provision of palliative care can lead to cost savings,¹¹ largely through reduction in hospital admissions, and reduction in acute interventions near end of life. To further consider use of acute services, Seow and colleagues use propensity score matching to reduce confounding and better test the effects of 11 community based specialist palliative care teams against usual care.² Their carefully considered use of both administrative databases and propensity score matching enabled them to make robust conclusions; that delivery of community based, specialist palliative care (regardless of size of team or geography) is associated with significant reductions in patients’ use of acute services in the last two weeks of life. If the associations reported by Seow and colleagues are causal, access to a palliative care team cuts hospitalisations by a third, use of emergency departments by a quarter, and risk of hospital death by a half, compared with usual care. The size or exact configuration of the community palliative care team didn’t seem to matter, but the teams were specialist; delivering palliative care as their core work, being multidisciplinary (with at least nursing and medical input), with specific palliative care skills and experience, and being closely integrated with primary care teams (so delivering indirect as well as direct care).

One of the limitations in this study is the focus on use of health services alone; the design and data sources did not allow for reporting of important outcomes such as symptoms, satisfaction with care, quality of life, and family or caregiver outcomes. It would be a major advance to know whether community based...
specialist palliative care teams can deliver—within the same cohort or study population—better symptom control, more satisfaction with care, improved quality of life, and better family outcomes while simultaneously reducing acute care use (hospitalisation and emergency department attendance). This would require linked administrative and research datasets with detailed clinical outcomes, but would be an important next step in advancing the evidence. There is particular concern that, in delivering end of life care at home, the physical, emotional, and financial burden may fall on family caregivers. It is critically important, therefore, to include measures of family impact and outcomes in future studies.

There is, however, a clear and welcome message here for providers, commissioners, and funders of health services. In the intense pressure for health services to do things differently and more cost effectively, specialist palliative care teams may have a central role in delivering better care and outcomes while reducing acute care use in last weeks of life, and should be resourced and commissioned to do so. Emerging evidence on the value of expert palliative care services based in the community offers a glimpse of light in the midst of pressures arising from the major funding deficits in many health services, and suggest at least one way to shift emphasis away from acute care to better coordinated, home based care, where—with the right support—most prefer to be for the last weeks of life.

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