

Better Investment Better Dying

Tom McBride National Audit Office

End of Life Care

NAO Report – November 2008

PAC Report – March 2009

Government Response – July 2009



End of Life Care

REPORT BY THE COMPTROLLER AND CHIEF EXECUTIVE OFFICER (C/CEO) NOVEMBER 2007-2008 (30 November 2008)

What we Said

- PCTs spent an estimated £245m on specialist palliative care services in 2006-07
- There are variations in the average spend on specialist palliative care (£154 to £1,684 per death)
- The Department estimates that the overall annual cost of end of life care to NHS and social care services is measured in billions of pounds.

What we Said

- We estimate that the annual cost of providing care to cancer patients in the year prior to death is £1.8 billion
- We estimate that for cancer £104 million could be redistributed to meet people's preferences for place of care by reducing emergency admissions by 10% and the average length of stay in hospital by 3 days
- The lack of robust data on the cost of care for other conditions limits our ability to extend this analysis

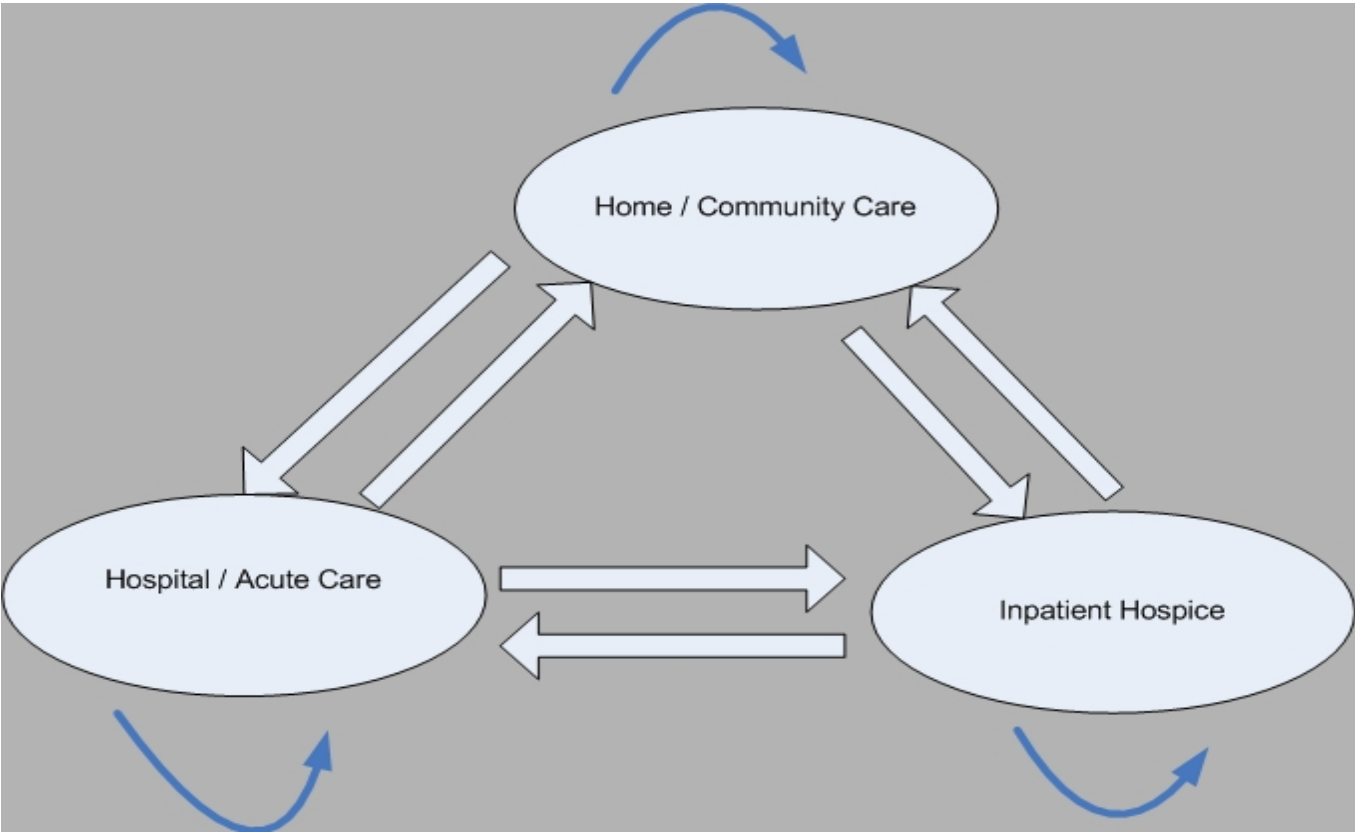
VfM Conclusion

- Given the potential to redistribute resources identified in our work, there is scope for PCTs to improve services in all settings by deploying resources more efficiently and effectively in supporting people in their preferred place of care. To achieve this there will be a continuing need for the Department to support PCTs as they reconfigure services and redeploy resources to better meet the needs of their local population.

Methods

- We developed a model using a combination of national datasets and cost data
- The model was run to replicate the amount of time an 'average' patient spends in hospital, hospice and the community over the last year of life
- Then, we simulated various scenarios of decreased use of acute care over this period to examine the economic and patient outcomes

Patient level Markov model



Data Sources

- Cost of care in each setting
 - D. Coyle et al (1999). *Costs of palliative care in the community, in hospitals and in hospices in the UK*. Critical Reviews in Oncology/Haematology 32(2)

Data Sources

- Cost of hospice and community care adjusted to represent cost to the tax payer
 - 31% of hospice costs met by the state (Help the Hospices)
 - Unit Costs of Health & Social Care 2007, Curtis & Netten and The State of Social Care in England 2006-07, CSCI

Data Sources

- **Hospital**

- Number of emergency admission and length of stay per admission by condition taken from Hospital Episode Statistics

- **Hospice**

- Number of emergency admission and length of stay per admission by condition taken from NCPC's Minimum Dataset

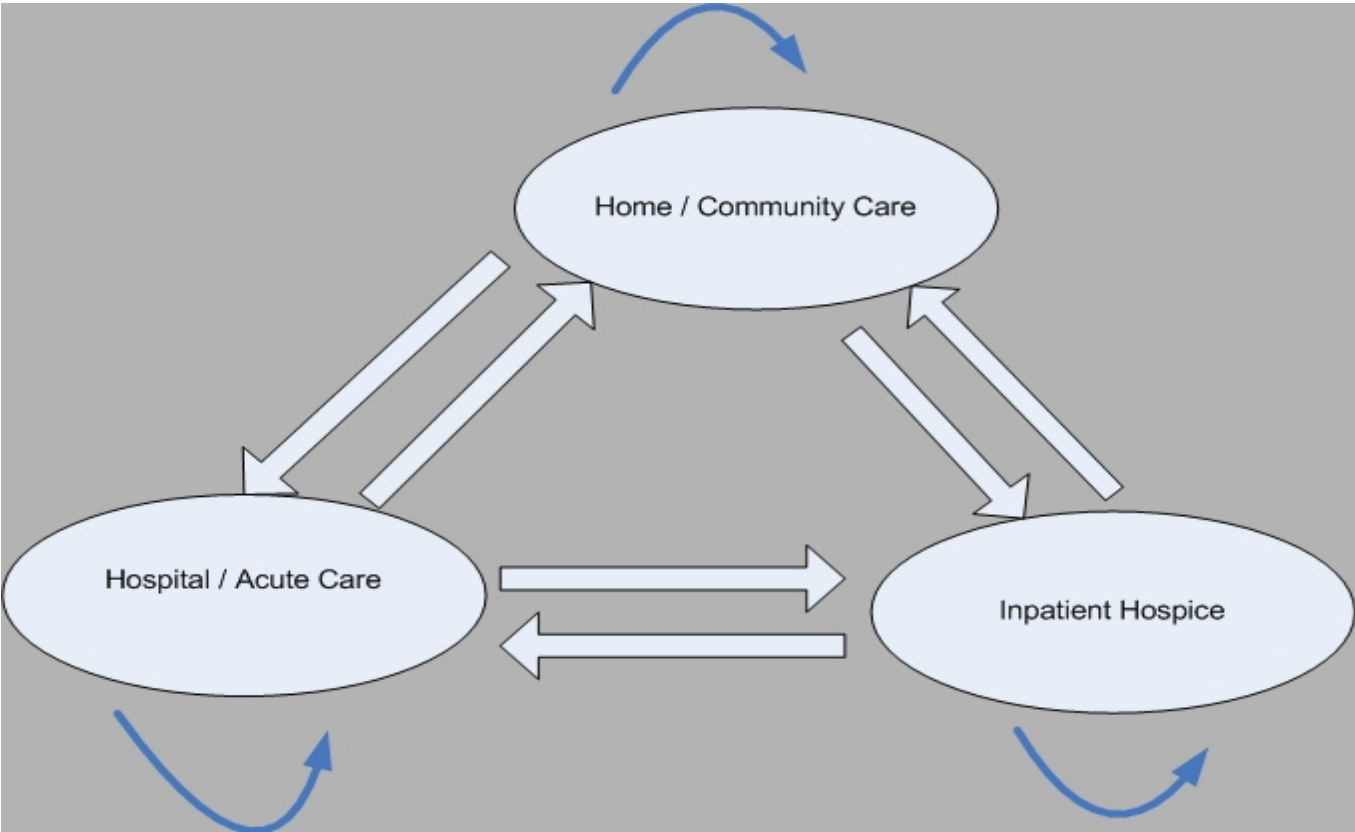
- **Community**

- All time not spent in hospital or hospice assumed to be spent in the community

METHODS

- Model run to establish a baseline
- Acute utilisation is decreased in the model by either:
 - reducing emergency admissions;
 - reducing the mean length of stay in hospital, following an admission; or
 - both

Patient level Markov model



RESULTS

Cancer

- In 2006 the average cancer patient had:
- 1.2 emergency admissions,
 - 17 days in hospital;
 - 3.5 days in hospice; and
 - the remainder in the community
- The cost of care in the last year of life for the 127,000 who died from cancer was approx £1.8 billion, or £14,236 per patient.

Potential Savings

	0 days	1 days	3 days	5 days
0%	£0m	£26m	£78m	£132m
5%	£16m	£42m	£91m	£141m
10%	£33	£56m	£104m	£151m
15%	£49m	£71m	£117m	£161m
20%	£66m	£87m	£129m	£171m

Potential days of acute care avoided in last year of life

	0 days	1 days	3 days	5 days
0%	0	1.1	1.6	2.1
5%	0.6	2.7	3.3	3.2
10%	1.2	3.6	4.1	4.5
15%	1.8	5	5.4	5.7
20%	2.4	6	6.4	6.7

Results

Organ Failure

- In 2006 the average organ failure (heart and respiratory diseases) patient had 3 emergency admissions
 - 40 days in hospital;
 - 0.1 day in hospice; and
 - and the remainder in the community
- The cost of care in the last year of life to the 30,000 who died from organ failure was approx £553 million, or £18,771 per patient

Potential Savings

	0 days	1 days	3 days	5 days
0%	£0m	£16m	£48m	£80m
5%	£13m	£28m	£57m	£88m
10%	£25m	£39m	£67m	£96m
15%	£37m	£50m	£77m	£104m
20%	£49m	£61m	£87m	£112m

Potential days of acute care avoided in last year of life

	0 days	1 days	3 days	5 days
5%	0	2.7	8.3	13.9
10%	1.9	4.5	9.7	15.1
15%	3.8	6.3	11.3	16.3
20%	5.8	8.1	12.8	17.6
25%	7.7	9.9	14.3	18.8

Caveats

- Reductions in length of stay and admissions are achievable - this is in line with the limited data
- Costs and savings are from the taxpayer perspective and indirect costs such as informal carers are not considered.
- Caution is needed in interpreting organ failure results

CONCLUSIONS

- The study contributes to the scant literature on the economics of palliative care. Results suggest the potential resources that could be released by decreasing reliance on acute care in England
- More work is required to understand the costs, including to carers, of delivering more community care and what reductions are achievable
- Better data on the cost of care for end of life care patients with conditions other than cancer is required

Research

- Since 1999 around 40 peer reviewed articles in the UK which include a reference to Palliative/EOLC AND Cost/Economic/Finance in abstract
- Most are cost effective comparisons of cancer treatments
 - e.g. metal stents vs. plastic endoprothesis in palliation of oesophageal cancer

Research

- Little on the UK
- Little on different care pathways or settings
- Little on non-cancer or non-acute treatments
- Activity and outcome data rather than unit costs
- King's Fund review of Delivering Choice Programme provides outcome and cost analysis but recognises the lack of control group and inability to adjust the comparator group

Future Direction

- Need for palliative care research to gather unit cost data for different models of care
- Ways of controlling for difficulty in carrying out RCTs in this area
- Commissioners need to understand current spend, supply, demand and cost effectiveness of service redesign

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