Intelligence MEMOS

From: Kieran Quinn, Sarina Isenberg and James Downar

To: Canadians Concerned about Healthcare Costs

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Re: **End of Life: How to Improve Care and Save (Much) Money**

Canadians spend more on end-of-life care than other high-income countries, including the United States, yet we achieve poor results compared to most.

There are structural factors and inefficiencies within our healthcare system that facilitate unhelpful and unwanted medical interventions at the end of life.

In our new C.D. Howe Institute **Commentary**, we review these factors and suggest several structural changes to address the high costs for healthcare and low satisfaction for patients.

A major avenue to cost saving is greater use of palliative care, rather than more costly acute care, in end-of life treatment. Palliative care primarily focuses on improving comfort and quality of life, often avoiding hospital-based, invasive, costly and potentially inappropriate care.

Palliative care is preferably (but not always) delivered outside acute care settings, including in patients' homes.

People approaching the end of life often require an intensification of healthcare services and at least three in four would potentially benefit from palliative care prior to death. Yet, only one in five Ontarians, for example, receives a physician home visit or palliative homecare in their last year of life, and only half receive palliative care in any setting. (Our **Graphic Intelligence**, outlines the landscape.)

Instead, most Canadians get acute care as they approach death, with no palliative focus. As a result, the cost of healthcare delivery increases significantly in the final months of life and does so in particular for hospital admissions and emergency room visits.

Several structural problems exacerbate the situation. They include:

i. Inadequate end-of-life beds and options. In-patient palliative-care units and residential hospice beds may be appropriate for people with significant symptom control and supportive needs, but there are so few such beds available that admission is usually restricted to people in the final weeks of life.

ii. Budget siloing. Canadian healthcare budgets are siloed by sector. Acute-care beds are substantially more expensive than hospice or in-patient palliative-care beds, long-term care beds or homecare. If budgets were global, efficiencies could be found by increasing capacity in lower-cost settings to reduce backlogs in higher-cost settings. But since each sector or organization manages its own budget, any decision to increase costs faces resistance no matter how large the benefits that would bring to the system as a whole.

iii. Lack of timely prompts. Acute care, usually beginning in the emergency room, is all too often the starting point for patients at end of life. Mechanisms to introduce palliative care earlier are broadly missing and would avoid acute-care hospitalization and intensive care.

iv. Barriers to home and community-care resources. There are some notable barriers to increasing the use of homecare for patients nearing the end of life. These barriers cannot be overcome by simply increasing the number of available caregiver hours.

If implemented, the structural changes we recommend could result in substantial improvement in end-of-life care and potentially save hundreds of millions of dollars annually for the Canadian healthcare system.

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