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Policy forum

Should cost be a consideration in palliative care?

by Maria J. Silveira, MD, MA, MPH

“We’ve got people knocking on our door all the time,” he said. “If you want us to pay attention, you’re gonna have to show us that what you have to offer can either save or make us some money.”

It was surprising to hear this coming from the mouth of a hospital administrator, especially after a tear-jerking presentation and heartfelt pleas for the funds to start a palliative care service at our institution. We had put so much time and energy into collecting the anecdotes of patients, families and staff to demonstrate the burden of needless suffering at the end of life and how good people could make a difference…and it all came down to *money?* Why should we care about money? This is palliative care we’re talking about.

Granted, the case can easily be made for why money is an important consideration in the provision of most medical care. After all, American medicine *is* a business. But should the same metric apply when talking about palliative care? Is there something special about palliative care that makes it a core service; that is, an essential service to which all individuals should have equal access, regardless of its cost to our health care system? I posit that, yes, palliative care is indeed special and that cost should be a secondary consideration.

While the miracles of science may allow us to diagnose and treat diseases, let us be mindful that, at their inception, the health sciences were meant to help people feel better, regardless of the pathology that lay beneath. This notion is embodied in the principles of nonmaleficence and beneficence upon which medicine was founded. Palliative care is the branch of medicine that attends to the physical and emotional suffering of patients with advancing conditions and the families of those patients. Palliative care is critical to accomplishing what medicine and nursing fundamentally seek to do: help people feel better. Palliative care, in short, is the most basic way hospitals meet one of their foremost responsibilities to patients and their moral obligations to society. For this reason, palliative care should be a core service that all hospitals provide. In short, wherever patients are dying, there should be palliative care.

The notion of core services is not new to medicine. All hospitals have services that are essential to their mission—internal or family medicine and general surgery, for example, that allow an acute care institution to call itself a “hospital.” Regardless of what the bottom line shows, patient needs for primary care and general surgery must be met in some degree. A hospital that did not meet these needs would, simply stated, not be a hospital. These standards are reflected in the Joint Commission on Accreditation of Healthcare Organization’s standards of accreditation, which most hospitals voluntarily adhere to [1].

I believe that palliative care belongs among these core services that all hospitals should offer. Now, should it be offered regardless of the cost? After all, the bottom line is what allows hospitals to remain open. Without financial solvency, these institutions could not exist. To deny this fact of American medicine is tantamount to being the “bioethicist in a bubble.”

I acknowledge that money is an important consideration in determining whether a hospital can afford to offer palliative care, but I would argue that it should not be the primary consideration, as it often is for nonessential services. Palliative care should be held to somewhat less stringent standards of cost and profitability. This does not mean that hospitals should go bankrupt providing palliative care but that they should be willing to offset costs in palliative care by shifting profits in other areas—an option that arises when hospitals offer a diverse set of services.

Still, there are many other reasons why stringent accounting to determine the worth of a palliative program is not appropriate. Mostly these reasons boil down to the inability to capture intangible costs and value.

1. Palliative care recognizes that illness does not occur in a social vacuum. Unlike other branches of medicine that focus only on the patient, palliative care programs incorporate the patient, his family, his community and the people taking care of him into the plan of care. Palliative care specialists are able to address the substantial amount of suffering at the end of life that emanates from strained human relations, patchy family support and financial hardship due to illness and debility. This expanded sphere makes it difficult, if not impossible, to quantify the value and impact of palliative care. How do you identify all the people touched by one encounter? The stakeholders vary from day to day and case to case. So, where patient-level accounting might be an accurate reflection of value in other branches of medicine, it is not an accurate reflection of the value of palliative care.
2. Measuring the value of palliative care—or what you get for your money—is an impossible task. Standard outcomes, like “life years,” are irrelevant when most patients receiving palliative care are expected to die. Other outcomes may be difficult to measure. How do you ask the deceased if their death was good, for example?
3. Lastly, some services of palliative care are provided largely for cultural purposes. Much of what happens around the death of a patient, for example, the hand holding, caressing, suctioning, wiping and medicating, is done not only for the sake of the dying patient but also for the benefit of his family

> who must live with the memory of his death. Practices such as these should not be subject to accounting.

In conclusion, palliative care is a practice that should be thought of as a core service and made available to all patients. Cost should be a lesser consideration than in other areas of health care because palliative care is a core service whose purpose is special, making its true costs and outcomes impossible to measure.

Reference

1. Joint Commission Accreditation Healthcare Organizations. *2006 Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. Oakbrook, Ill: Joint Commission Resources; 2006.

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