**PALLIATIVE CARE VERSUS HOSPICE**

**By Terry Meyer, M.D**

The **hospice model** was originally created by Dame Cecily Saunders in London, England in the early 1960’s. It made its way across the big pond and became a mainstream health care delivery system in the United States when it was first introduced as a Medicare benefit to the older population in 1982. It was designed to improve the quality of remaining life for terminally ill patients. This was done by providing specially trained health care personnel to provide holistic interdisciplinary care for the whole person including the psychological, social, spiritual, as well as physical dimensions. The immediate family of the patient was also acknowledged as being affected by the patient’s terminal illness, and therefore psychological and spiritual support was included for the family. Bereavement for survivors is offered for up to a year after the patient dies. The majority of care takes place in the home, assisted living facility or nursing home. In-patient arrangements are available for refractory symptom control, during the active dying process, respite care, as well as a few other reasons. The results regarding quality of care, patient and family satisfaction have been very positive. The typical insurer, Medicare, has also enjoyed cost savings. It’s been a win-win situation. These observations have been qualitatively and quantitatively documented by researchers. So, why then is the program seriously underutilized by those who could benefit? It is noted that only about one quarter to one third of hospice patients actually avail themselves of the program. Also, when they use the program, the median length of stay is only 24 days, far less than how the program was designed which was approximately a six- month length of stay before death, with recertification of eligibility available for those patients whose life expectancy extends beyond six months. Common conditions referred to hospice include end-stage cancer, chronic heart failure, chronic obstructive pulmonary disease, dementia and other end-stage degenerative neurological diseases.

The problem is that there is a serious gap in our health care system between when a person is diagnosed with one or more chronic serious progressive illnesses and when they actually avail themselves of hospice care. The most significant barrier to hospice is the Medicare requirement that, in order to receive hospice benefits, the patient must relinquish regular Medicare benefits which includes potential life prolonging and disease directed treatments. The treatments may be futile for a given patient, but the assurance that they are still available is commonly reason enough for a patient to decline the hospice benefit. A second barrier includes the formal acknowledgement by the patient that he/she has a terminal illness with only a six months prognosis. Sometimes this is just too much for the patient to hear. Denial can be a powerful force when coping with a life- threatening illness.

**Palliative care** has evolved as a separate and distinct entity from hospice care over approximately the past ten years. It has been a response to above mentioned barriers. The service populations are the same as hospice but the limited life expectancy issue has been extended to those patients who are typically expected to live another one or two years. Similar to hospice care, an interdisciplinary team of specialists holistically addresses the patient’s illness from a psychological, social, spiritual and physical perspective. Additionally, there is no requirement that the patient stop any perceived life prolonging or disease directed treatments. One classic example of this is the cancer patient who wants to continue on chemotherapy or irradiation treatments despite only remote evidence that the treatments may be beneficial. However, palliative care places a strong emphasis on highly skilled communication by the provider to ensure the patient truly understands the complete risk/benefit profile of any and all recommended diagnostics or treatments. The desired outcomes are is to improved quality of care and increased patient and family satisfaction. Another expected outcome is a decrease in the substantial amount of unnecessary medical treatment or over- medicalization, unfortunately still common in the United States.

Studies have indicated that Palliative Care saves hospitals substantial costs for hospitalized patients. This savings is realized by a decreased number of rehospitalizations within 30 days, decreased number of emergency room visits, decreased number of days in the intensive care unit and length of hospitalization. The majority of hospitals with 150 beds or more now offer an in-patient Palliative Care Consult service. The regular Medicare benefits typically cover for in-patient care provided by a physician or nurse practitioner.

However significant problems with the provision of this type of care to out-patients remain. Only a few states cover this service as part of their Medicaid program, and only a very few private insurance programs include palliative care for out-patients. The Center for Medicare and Medicaid Services is currently researching the cost effectiveness of the program but is several years away from determining whether or not it will be included as a Medicare benefit.

Diane Meier, M.D. (no relation to author) has been a central figure promoting Palliative Care in the United States. She is the Director of the Center to Advance Palliative Care, New York, New York. Please check the website for additional information.

Please let me know if you have any interest in advocating with me for community based palliative care. There’s got to be a way to make this type of care available to the estimated 45 million Americans living with one or more chronic conditions that limit personal function and are likely to worsen rather than get better.