Scuola universitaria professionale della Svizzera italiana
Dipartimento economia aziendale, sanità e sociale

SSPH+ SWISS SCHOOL OF PUBLIC HEALTH

SUPSI

Economia e cure palliative in controluce

Prof. Dr. Luca Crivelli

palliative ti

Lugano, 3 maggio 2022

Il valore etico della valutazione economica

Il principio economico del *costo opportunità*:

Quando risorse collettive, finanziate in modo solidale tra sani e ammalati, vengono sprecate:

1. si mette a repentaglio il patto sociale;
2. si manca l'obiettivo di assicurare ai cittadini il massimo livello di salute e di benessere.

Per questo l'approccio economico ha sempre una **valenza** anche **etica**.

RSI NEWS

SVIZZERA

Casse malati, possibile forte aumento

I premi per il 2023 potrebbero subire un rincaro tra il 7 e il 9%

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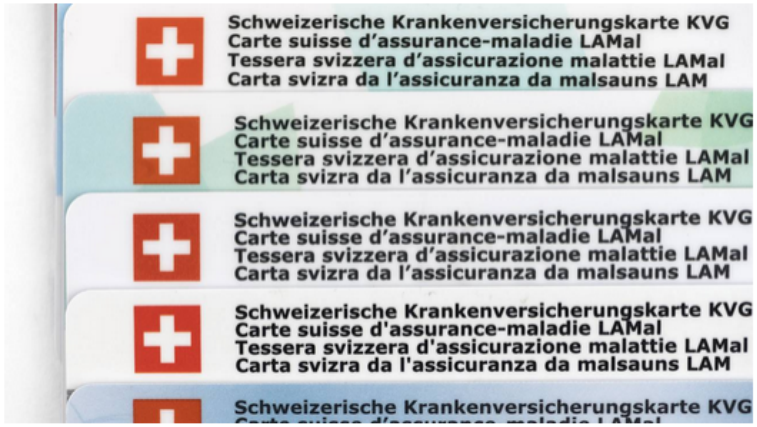
Ascolta



Indice della presentazione

Indice della presentazione

1. I costi del fine vita a livello globale

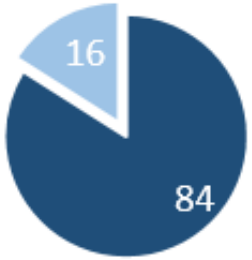
Constatazione nr. 1:

la maggior parte dei costi della salute sono investiti durante gli ultimi mesi di vita del paziente

- Negli Stati Uniti, il 25% dei costi Medicare sono determinati da pazienti che si trovano nel loro ultimo anno di vita (Smith, Brick, O'Hara, & Normand, 2014).
- In Corea, le fatture mediche per l'ultimo mese di vita di un paziente rappresentano in media il 44.6% delle spese sostenute negli ultimi 6 mesi (Jung, Kim, Heo, & Baek, 2012).

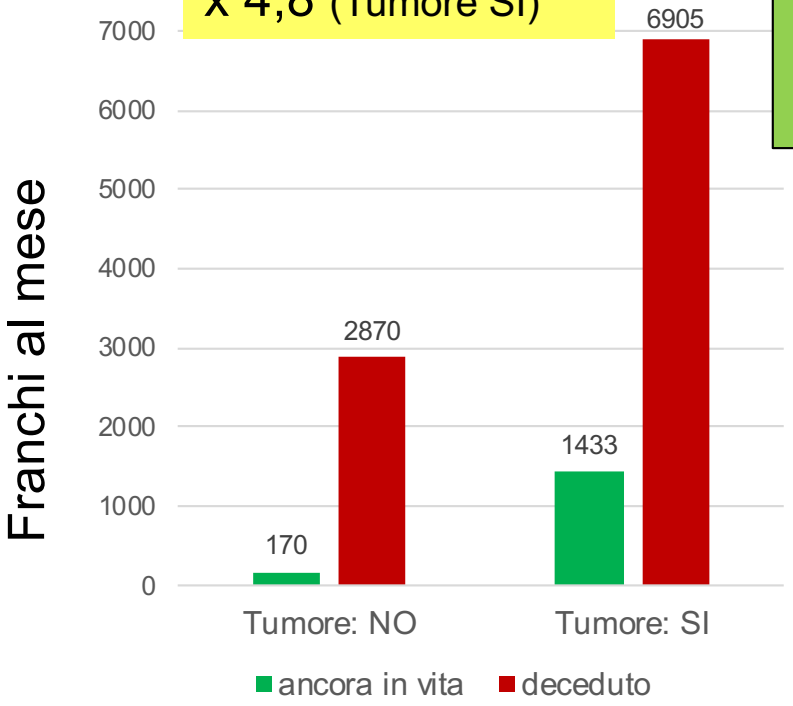
I costi del fine vita in Svizzera

End of Life
National Research Programme NRP 67

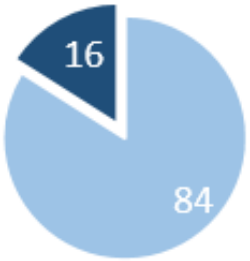


Assicurati ≤ 65 anni
(56,6% dei costi LAMal)

x 16,9 (Tumore NO)
x 4,8 (Tumore SI)

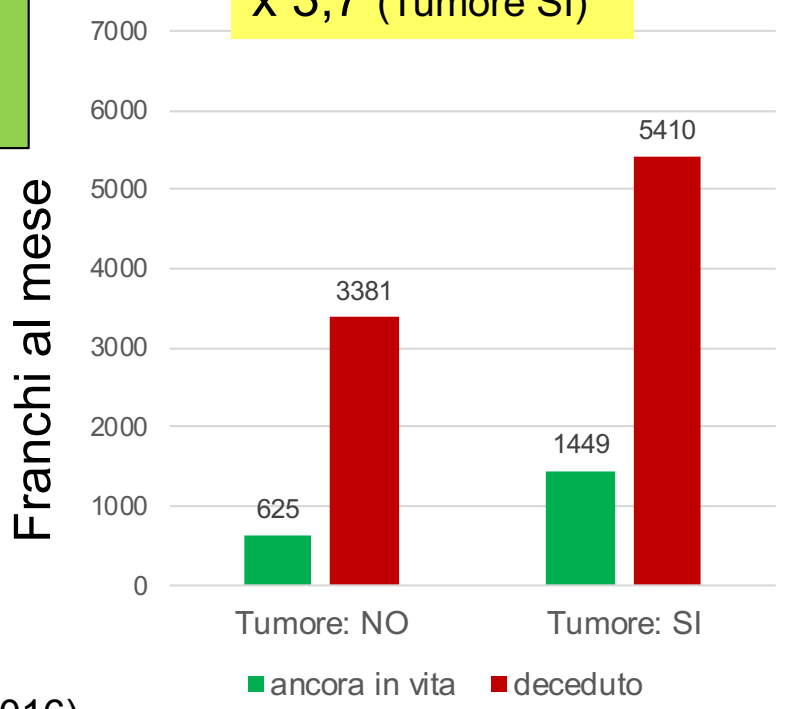


1,3 Mio di assicurati della CSS nel 2010, di cui 10'500 (0.8%) sono deceduti in quell'anno, determinando il 4.6% dei costi LAMal



Assicurati > 65 anni
(43,4% dei costi LAMal)

x 5,4 (Tumore NO)
x 3,7 (Tumore SI)



Fonte: Beck et al (2016)

Costi del fine vita (LAMal)
1,6% delle spese / mortalità 0,2%

Costi del fine vita (LAMal)
8.5% delle spese / mortalità 4,1%

Indice della presentazione

2. Variabilità regionale nei costi del fine vita

(ultimi 12 mesi)

- 113'277 individui deceduti tra il 2008 ed il 2010 e assicurati presso 6 casse malati (**61%** dei decessi totali), attribuiti a 564 regioni e 71 aree ospedaliere.
- Costo medio LAMal dell'ultimo anno di vita: **32'500 franchi**.
- La varianza regionale può essere ridotta in modo consistente controllando per differenze **individuali** (cause di morte/ICD-10) e **regionali** (urbanizzazione, lingua e offerta sanitaria), ma non eliminata.

ORIGINAL ARTICLE

OPEN

Regional Variation of Cost of Care in the Last 12 Months of Life in Switzerland

Small-area Analysis Using Insurance Claims Data

Radoslaw Panczak, PhD, Xhyljeta Luta, MPH,* Maud Maessen, PhD,* Andreas E. Stuck, MD,† Claudia Berlin, PhD,* Kurt Schmidlin, DMD, MPH,* Oliver Reich, PhD,‡ Viktor von Wyl, PhD,§ David C. Goodman, MD, MS,*‖ Matthias Egger, MD MSc, FFPH, DTM&H,* Marcel Zwahlen, PhD,* and Kerri M. Clough-Gorr, DSc, MPH*¶*

Background: Health care spending increases sharply at the end of life. Little is known about variation of cost of end of life care between regions and the drivers of such variation. We studied small-area patterns of cost of care in the last year of life in Switzerland.

Methods: We used mandatory health insurance claims data of individuals who died between 2008 and 2010 to derive cost of care. We used multilevel regression models to estimate differences in costs across 564 regions of place of residence, nested within 71 hospital service areas. We examined to what extent variation was explained by characteristics of individuals and regions, including measures of health care supply.

Results: The study population consisted of 113,277 individuals. The mean cost of care during last year of life was 32.5k (thousand) Swiss Francs per person (SD=33.2k). Cost differed substantially between regions after adjustment for patient age, sex, and cause of death. Variance was reduced by 52%-95% when we added individual and regional characteristics, with a strong effect of language region. Measures of supply of care did not show associations with costs. Remaining between and within hospital service area variations were most pronounced for older females and least for younger individuals.

Conclusions: In Switzerland, small-area analysis revealed variation of cost of care during the last year of life according to linguistic regions and unexplained regional differences for older women. Cultural factors contribute to the delivery and utilization of health care during the last months of life and should be considered by policy makers.

Key Words: end of life, health care cost, health insurance, regional variation, palliative care, Switzerland

(*Med Care* 2017;55: 155–163)

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Supported by funds from Swiss National Science Foundation (grant number 406740_1393333) and by the joint grant of Swiss Medical Association (FMH), Konferenz der Kantonalen Ärztegesellschaften (KKA) and NewIndex AG.

Preliminary version of findings shown in this manuscript were presented at the 2014 Wennberg International Collaborative meeting in London, UK; GEOMED 2015 Conference in Florence, Italy; and Swiss Public Health Conference 2015, Geneva, Switzerland.

The authors declare no conflict of interest.

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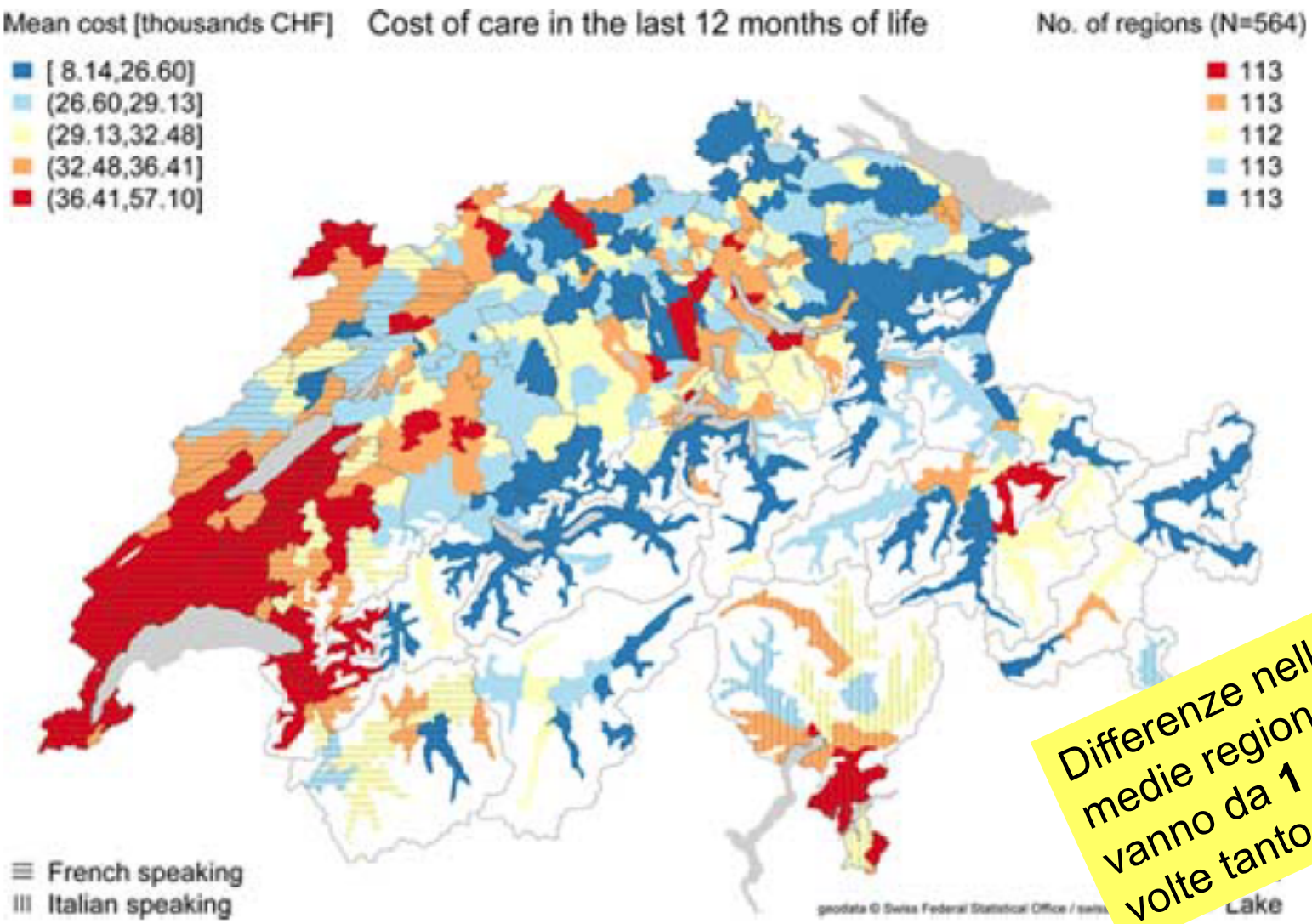
Two factors characterize the Swiss health care system: high performance and high cost. Health care expenditures (HCE) accounted for 11.4% of the gross domestic product in 2012.[1] Although advances in medicine contribute to raising health care costs, HCE are unevenly distributed across the life span and end of life (EOL) is often associated with sharp increases in spending on health in an aging poplation.[2,3] A significant proportion of health care costs can be attributed to the care of EOL patients.[4]

Differences in the use of health care between providers and regions have been widely documented.[5] However, documenting variation and identifying its causes is a nontrivial exercise.[6] Not all variation is bad or unwarranted and its systematic, routine documentation at the local level is the first step in addressing inefficiency of resource allocation and overuse or underuse of services.[5–8] Variation in intensity and cost of EOL care (EOLC) can be of particular importance in tracking regional differences in practice patterns.[9,10]

None of the previous Swiss EOLC studies[11–16] has investigated small-area variation in costs despite the importance of understanding local practice patterns, identifying unwarranted

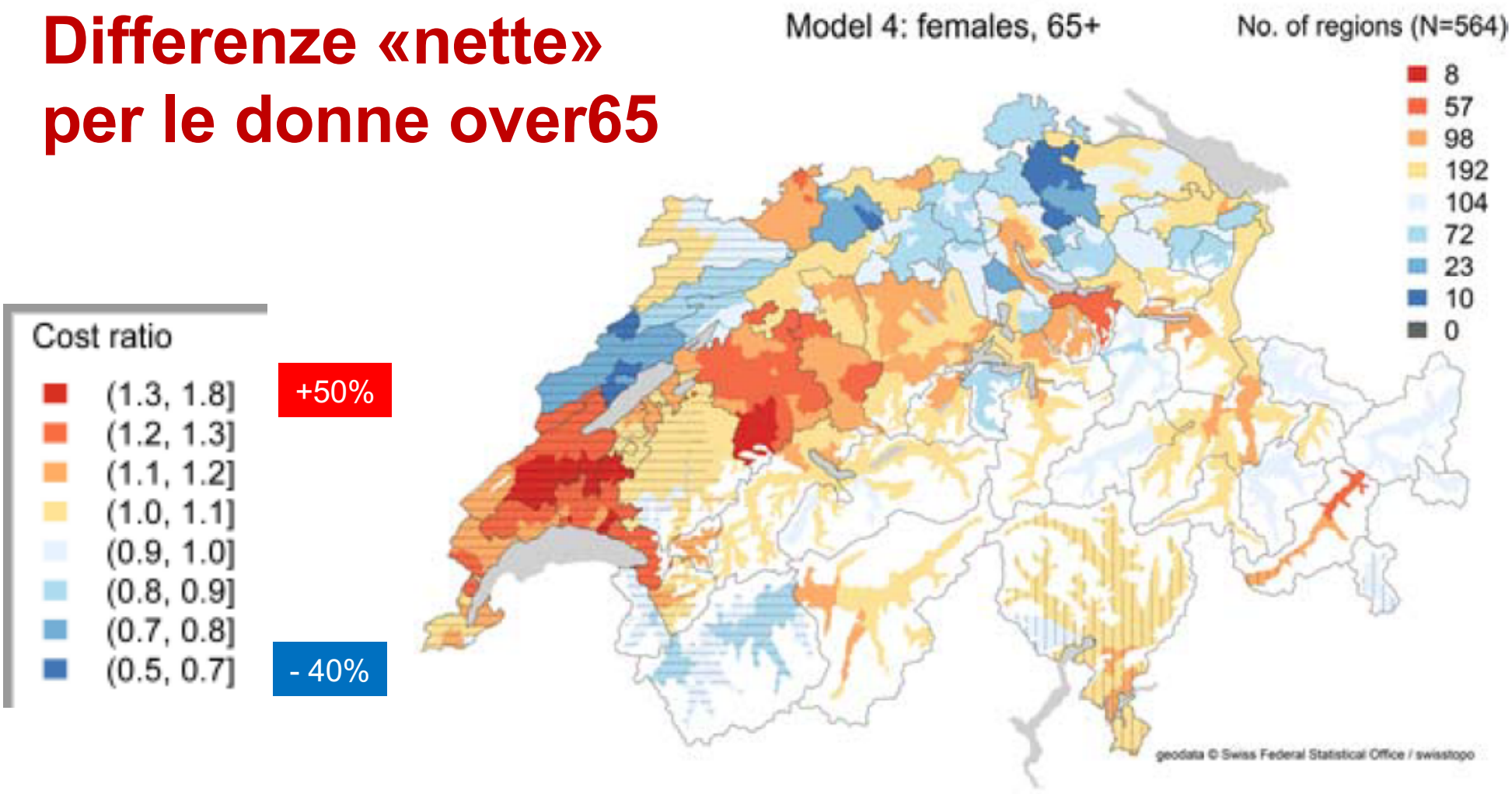
Differenze «crude» nei costi del fine vita



Differenze nelle medie regionali vanno da **1 a 7** volte tanto.

Fonte:
Panczak et al (2017)

Differenze «nette» per le donne over65



Controllando tutte le variabili individuali disponibili (causa di morte / ICD-10) e quelle relative all'offerta sanitaria nelle 71 aree ospedaliere la varianza si riduce del 51%.
Le differenze tra le donne over-65 vanno dal singolo al doppio.

Fonte:
Panczak et al (2017)

Indice della presentazione

3. Variabilità regionale nel luogo di decesso

(domicilio, casa anziani, ospedale)

- Analisi di 58'732 assicurati della cassa malati Helsana deceduti tra il 2007 ed il 2011.

A domicilio	In ospedale	In casa anziani
26.6%	38.4%	35.1%

Fonte: Reich et al (2013)

Reich et al. BMC Health Services Research 2013, 13:116
http://www.biomedcentral.com/1472-6963/13/116

BMC Health Services Research

RESEARCH ARTICLE Open Access

Place of death and health care utilization for people in the last 6 months of life in Switzerland: a retrospective analysis using administrative data

Oliver Reich[1,2*], Andri Signorell[1] and André Busato[3,4]

Abstract

Background: There is a growing interest in examining the current state of care and identifying opportunities for improving care and reducing costs at the end of life. The aim of this study is to examine patterns of health care use at the end of life and place of death and to describe the basic characteristics of the decedents in the last six months of their life.

Methods: The empirical analysis is based on data from 58,732 Swiss residents who died between 2007 and 2011. All decedents had mandatory health insurance with Helsana Group, the largest health insurer in Switzerland. Descriptive statistical techniques were used to provide a general profile of the study population and determinants of the outcome for place of death were analyzed with an econometric approach.

Results: There were substantial and significant differences in health care utilization in the last six months of life between places of death. The mean numbers of consultations with a general practitioner or a specialist physician as well as the number of different medications and the number of hospital days was consistently highest for the decedents who died in a hospital. We found death occurred in Switzerland most frequently in hospitals (38.4% of all cases) followed by nursing homes (35.1%) and dying at home (26.6%). The econometric analysis indicated that the place of death is significantly associated with age, sex, region and multiple chronic conditions.

Conclusions: The importance of nursing homes and patients' own homes as place of death will continue to grow in the future. Knowing the determinants of place of death and patterns of health care utilization of decedents can help decision makers on the allocation of these needed health care services in Switzerland.

Keywords: Switzerland, End-of-life, Health care utilization, Place of death

Background

Medical care in the final months of life account for a considerable share of health care expenditures (HCE) in comparison to other years [1-6]. Therefore, issues around end-of-life health care have been gaining increasing attention among both policy-makers and researchers. Concerns have been raised over the substantial costs at the end of life and high costs are often interpreted as a result of unnecessary medical procedures trying to keep people alive, irrespective of the preferences of patients and their relatives. Previous research shows that a higher volume of care in terms of higher spending and high-intensity treatment in the last year of life does not produce better outcomes for patients [7-12]. Various studies on end-of-life care also focused on the aspect of place of death and the factors associated with the site of death [13-18]. Other studies have typically concentrated on the relationship between age and health care expenditure [19-24], partly revealing the importance of time-to-death as an important determinant of future HCE [25-29]. Besides examining the location of death and health expenditures, regional variations as well as health care settings at the end of life have also been used to reflect

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Differenze regionali nel luogo di decesso

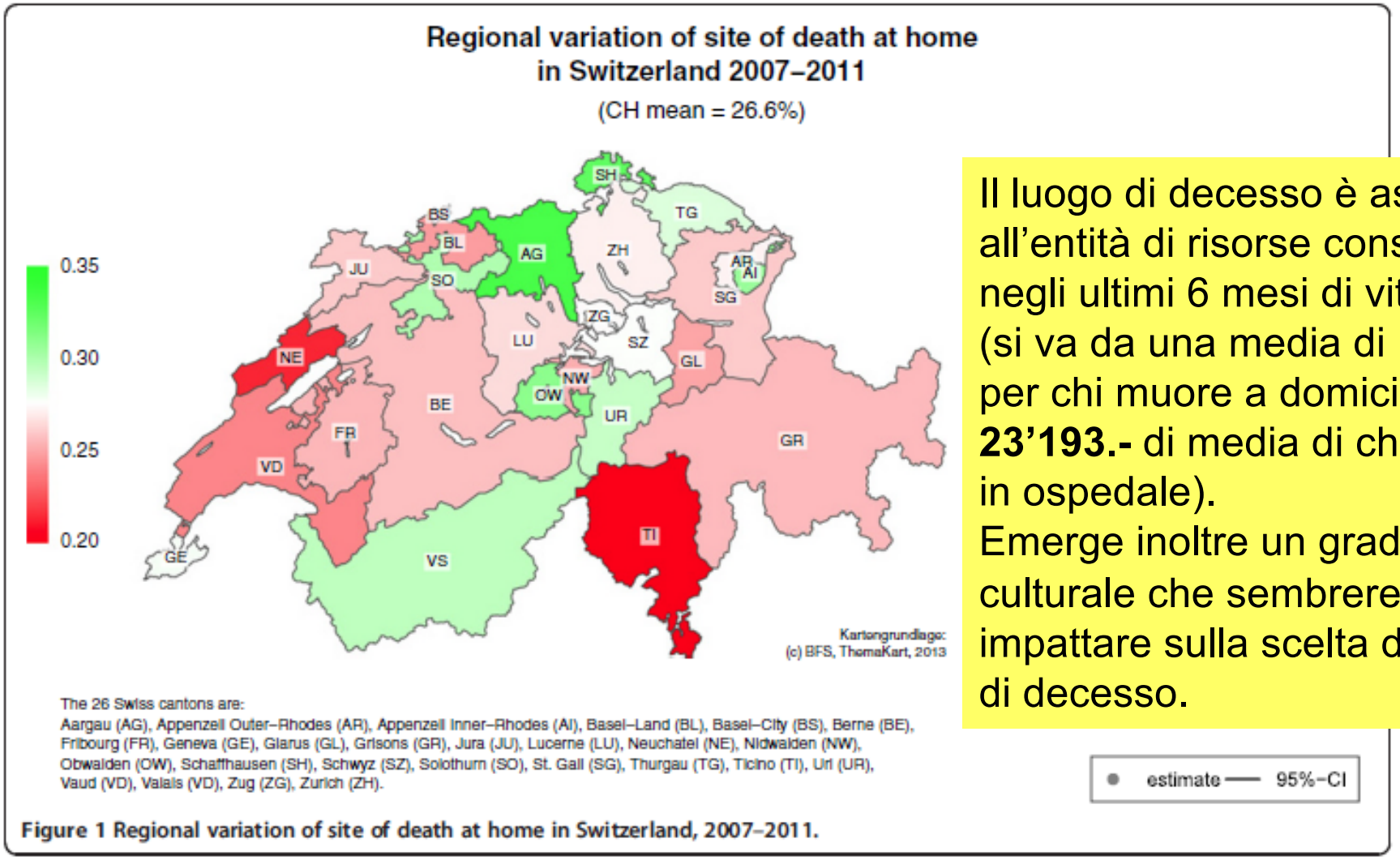


Figure 1 Regional variation of site of death at home in Switzerland, 2007–2011.

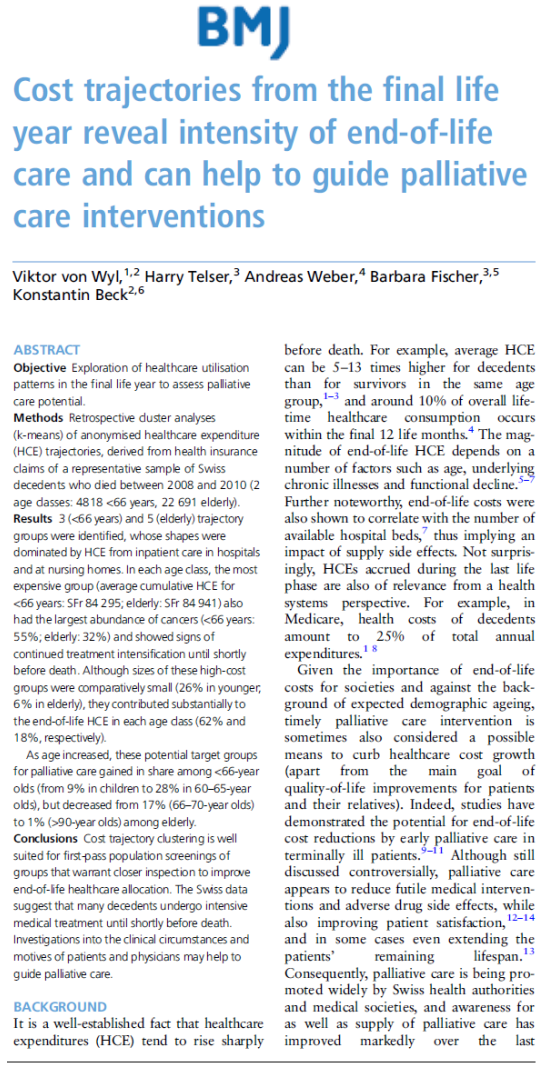
Il luogo di decesso è associato all'entità di risorse consumate negli ultimi 6 mesi di vita (si va da una media di **11'194.-** per chi muore a domicilio ai **23'193.-** di media di chi decede in ospedale).
Emerge inoltre un gradiente culturale che sembrerebbe impattare sulla scelta del luogo di decesso.

Fonte: Reich et al (2013)

Indice della presentazione

4. Scomposizione dei costi dell'ultimo anno di vita

- Analisi del profilo di spesa di circa 27'000 assicurati presso la CSS, deceduti tra il 2008 ed il 2010.
- Separazione della banca dati in due gruppi:
  - GIOVANI (persone decedute in età ≤ 65 anni)
    4'800 individui; costo medio dell'ultimo anno di vita: **36'000 franchi**
  - ANZIANI (persone decedute in età > 65 anni)
    22'000 individui; costo medio dell'ultimo anno di vita: **30'000 franchi**
- Analisi cluster retrospettiva (*k-means*) per suddividere i soggetti in clusters con traiettorie di spesa comparabili → **3 clusters** per i GIOVANI e **5 clusters** per gli ANZIANI



BMJ

Cost trajectories from the final life year reveal intensity of end-of-life care and can help to guide palliative care interventions

Viktor von Wyl,[1,2] Harry Telser,[3] Andreas Weber,[4] Barbara Fischer,[3,5] Konstantin Beck[2,6]

ABSTRACT

Objective Exploration of healthcare utilisation patterns in the final life year to assess palliative care potential.

Methods Retrospective cluster analyses (k-means) of anonymised healthcare expenditure (HCE) trajectories, derived from health insurance claims of a representative sample of Swiss decedents who died between 2008 and 2010 (2 age classes: 4818 <66 years, 22 691 elderly).

Results 3 (<66 years) and 5 (elderly) trajectory groups were identified, whose shapes were dominated by HCE from inpatient care in hospitals and at nursing homes. In each age class, the most expensive group (average cumulative HCE for <66 years: SFr 84 295; elderly: SFr 84 941) also had the largest abundance of cancers (<66 years: 55%; elderly: 32%) and showed signs of continued treatment intensification until shortly before death. Although sizes of these high-cost groups were comparatively small (26% in younger; 6% in elderly), they contributed substantially to the end-of-life HCE in each age class (62% and 18%, respectively).

As age increased, these potential target groups for palliative care gained in share among <66-year olds (from 9% in children to 28% in 60–65-year olds), but decreased from 17% (66–70-year olds) to 1% (>90-year olds) among elderly.

Conclusions Cost trajectory clustering is well suited for first-pass population screenings of groups that warrant closer inspection to improve end-of-life healthcare allocation. The Swiss data suggest that many decedents undergo intensive medical treatment until shortly before death. Investigations into the clinical circumstances and motives of patients and physicians may help to guide palliative care.

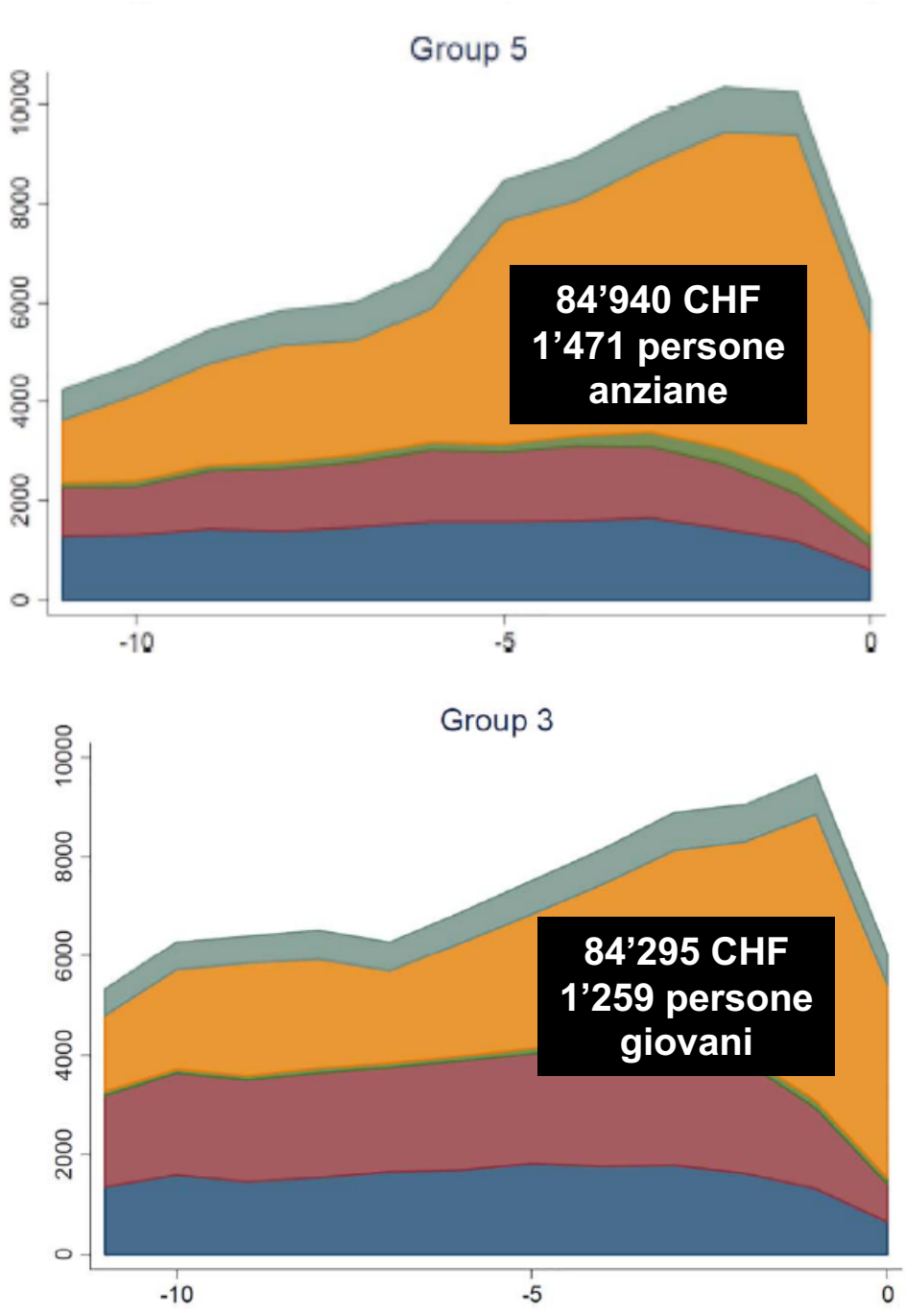
BACKGROUND

It is a well-established fact that healthcare expenditures (HCE) tend to rise sharply before death. For example, average HCE can be 5–13 times higher for decedents than for survivors in the same age group,[1–3] and around 10% of overall lifetime healthcare consumption occurs within the final 12 life months.[4] The magnitude of end-of-life HCE depends on a number of factors such as age, underlying chronic illnesses and functional decline.[5–7] Further noteworthy, end-of-life costs were also shown to correlate with the number of available hospital beds,[7] thus implying an impact of supply side effects. Not surprisingly, HCEs accrued during the last life phase are also of relevance from a health systems perspective. For example, in Medicare, health costs of decedents amount to 25% of total annual expenditures.[1 8]

Given the importance of end-of-life costs for societies and against the background of expected demographic ageing, timely palliative care intervention is sometimes also considered a possible means to curb healthcare cost growth (apart from the main goal of quality-of-life improvements for patients and their relatives). Indeed, studies have demonstrated the potential for end-of-life cost reductions by early palliative care in terminally ill patients.[9–11] Although still discussed controversially, palliative care appears to reduce futile medical interventions and adverse drug side effects, while also improving patient satisfaction,[12–14] and in some cases even extending the patients' remaining lifespan.[13] Consequently, palliative care is being promoted widely by Swiss health authorities and medical societies, and awareness for as well as supply of palliative care has improved markedly over the last

von Wyl V, *et al*. *BMJ Supportive & Palliative Care* 2015;**0**:1–10. doi:10.1136/bmjspcare-2014-000784

End of Life
National Research Programme NRP 67



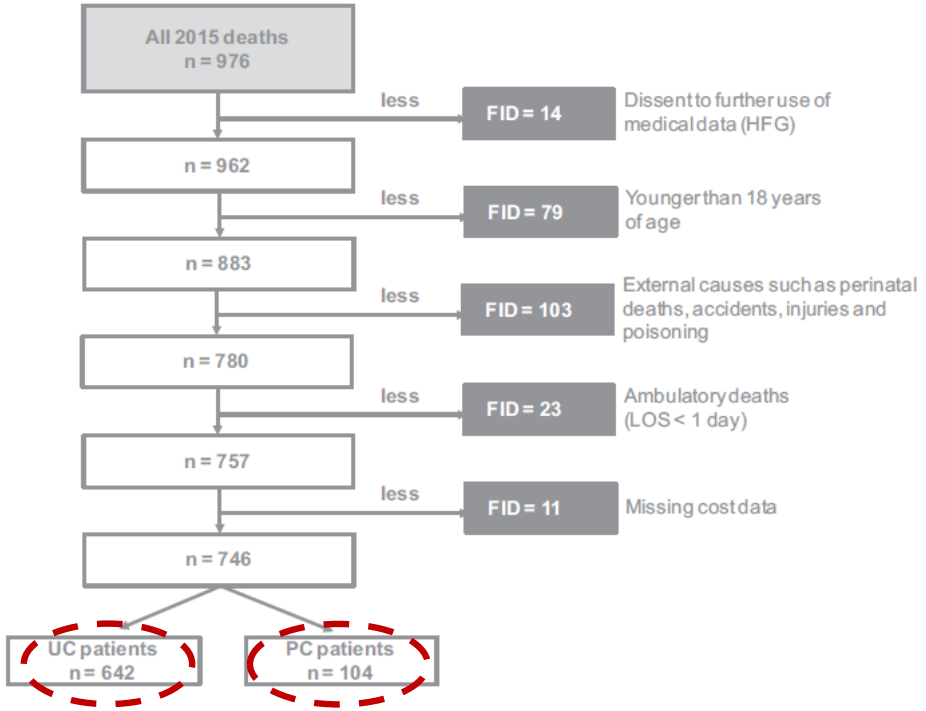
L’ultimo anno di vita di queste 2730 persone è costato 231 milioni di franchi. Si tratta in prevalenza di persone che decedono in ospedale e per le quali sussiste l’indizio di **accanimento terapeutico**, interrotto verosimilmente nell’ultimo mese.

Domanda: quali effetti sul **decorso della spesa** potrebbe determinare un intervento precoce nell’ambito delle cure palliative?

Fonte: von Wyl et al (2015)

Costi dell'ultima ospedalizzazione (prima del decesso) a confronto

- Raffronto tra pazienti CP e UC deceduti nel corso del 2015 all'**Inselspital** di Berna (analisi retrospettiva)



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Original Article

Which Cost Components Influence the Cost of Palliative Care in the Last Hospitalization? A Retrospective Analysis of Palliative Care Versus Usual Care at a Swiss University Hospital

Monika Hagemann, MSc, Sofia C. Zambrano, PhD, MGPCC, Lukas Bütikofer, PhD, Antje Bergmann, PhD, MD, Karen Voigt, PhD, MPH, and Steffen Eychmüller, PhD, MD
University Center for Palliative Care (M.H., S.C.Z., S.E.), Inselspital, Bern University Hospital, Bern; CTU Bern (L.B.), University of Bern, Bern, Switzerland; and Department of General Practice (A.B., K.V.), Medical Clinic III, University Hospital Carl Gustav Carus, Technische Universität Dresden, Germany

Abstract

Context. Although the number of studies on the economic impact of palliative care (PC) is growing, the great majority report costs from North America.

Objectives. We aimed to provide a comprehensive overview of PC hospital cost components from the perspective of a European mixed funded health care system by identifying cost drivers of PC and quantifying their effect on hospital costs compared to usual care (UC).

Methods. We performed a retrospective, observational analysis examining cost data from the last hospitalization of patients who died at a large academic hospital in Switzerland comparing patients receiving PC vs. UC.

Results. Total hospital costs were similar in PC and UC with a mean difference of CHF −2777 [95% CI −12,713 to 8506, $P = 0.60$]. Average costs per day decreased by CHF −3224 [95% CI −3811 to −2631, $P < 0.001$] for PC patients with significant reduction of costs for diagnostic intervention and medication. Higher cost components for PC patients were catering, room, nursing, social counseling, and nonmedical therapists. In sensitivity analyses, when we restricted PC exposure to three days from admission, total costs and average costs per day were significantly lower for PC.

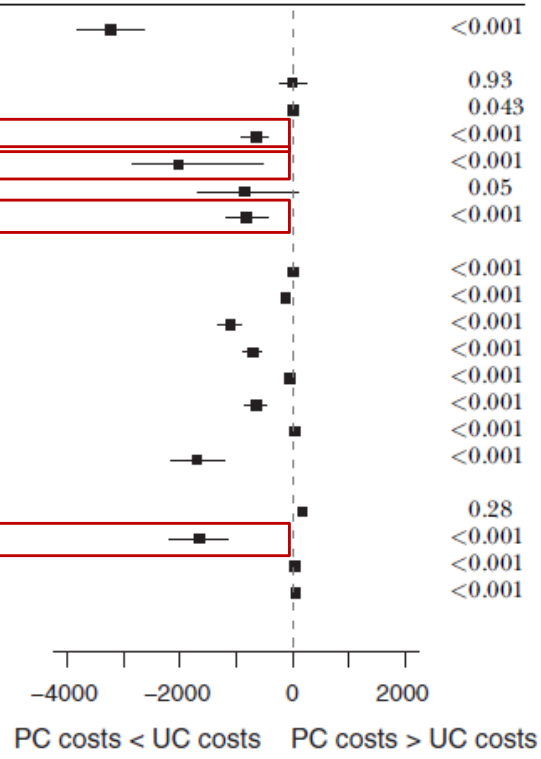
Conclusion. Studies measuring the impact of PC on hospital costs should analyze various cost components beyond total costs to understand wanted and potentially unwanted cost-reducing effects. An international definition of a set of cost components, specific for cost-impact PC studies, may help avoid superficial and potentially dangerous cost discussions. J Pain Symptom Manage 2019;■:■–■.

Key Words
Palliative care, hospitals, financial impact, cost components

A fronte di costi totali non statisticamente diversi (CHF 38'381 per PC versus CHF 41'158 per UC, p=0.60), i costi medi per giornata sono inferiori presso pazienti che hanno ricevuto cure palliative (la durata di degenza di questi pazienti è però più lunga).

Table 6
Average Daily Costs

Cost Components	Usual Care [95% CI]	Palliative Care [95% CI]	Mean Difference (in %) [95% CI]	*P*-value
Total costs	5530 [5141, 5988]	2306 [1924, 2808]	−3224 (−58%) [−3811,−2631]	<0.001
Cluster 1: Organizational unit				
Emergency room costs	652 [605, 704]	642 [429, 888]	−10 (−2%) [−232, 245]	0.93
Hotel costs	155 [149, 161]	171 [156, 185]	16 (10%) [1, 33]	0.043
Radiology costs	1154 [957, 1386]	510 [399, 631]	−644 (−56%) [−896, −426]	<0.001
ICU costs	3063 [2763, 3398]	1048 [308, 2502]	−2015 (−66%) [−2837,−511]	<0.001
Surgery room costs	2235 [1883, 2661]	1379 [695, 2−331]	−857 (−38%) [−1670, 111]	0.05
Ward costs	2537 [2339, 2779]	1723 [1466, 2038]	−814 (−32%) [−1176, −444]	<0.001
Cluster 2: Cost type				
Catering costs	20 [19, 22]	37 [29, 44]	16 (80%) [8, 24]	<0.001
Laboratory costs	292 [263, 326]	165 [136, 196]	−128 (−44%) [−173, −84]	<0.001
Material costs	1245 [1051, 1462]	140 [106, 191]	−1105 (−89%) [−1328, −914]	<0.001
Other costs	916 [781, 1085]	211 [134, 294]	−705 (−77%) [−892, −543]	<0.001
Patient management costs	66 [62, 72]	20 [16, 27]	−47 (−70%) [−53, −38]	<0.001
Pharmacy costs	775 [623, 976]	130 [81, 203]	−645 (−83%) [−845, −477]	<0.001
Room costs	68 [64, 72]	114 [106, 122]	46 (68%) [37, 56]	<0.001
Staff costs	3755 [3521, 4026]	2061 [1682, 2534]	−1694 (−45%) [−2169, −1196]	<0.001
Cluster 3: Staff detail				
Nursing costs	1228 [1169, 1298]	1408 [1101, 1783]	180 (15%) [−137, 550]	0.28
Physician costs	3513 [3236, 3809]	1869 [1440, 2339]	−1644 (−47%) [−2177,−1139]	<0.001
Social counseling costs	28 [24, 33]	76 [57, 94]	48 (169%) [28, 66]	<0.001
Therapist costs	59 [54, 66]	119 [93, 165]	60 (101%) [33, 105]	<0.001



ICU = intensive care unit.

Indice della presentazione

Impatto delle cure palliative sui costi (in generale)

Constatazione nr. 3:

A prescindere dal contesto in cui sono erogate (a domicilio, in casa anziani, in ospedale, in unità specializzate) l'integrazione delle cure palliative risulta meno costosa rispetto ai percorsi terapeutici tradizionali.

- Le CP integrate nei servizi di cure acute sono da promuovere dal momento che, oltre a ridurre i costi, favoriscono il fine vita in una casa anziani (Yoo, Nakagawa, & Kim, 2012).

Systematic Cochrane Review del 2013

Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers (Review)

Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ

THE COCHRANE COLLABORATION®

L'evidenza relativa al **rapporto costo-efficacia** delle cure palliative (6 studi) è inconclusiva

Dei 1.426 articoli identificati, 21 articoli basati su 19 studi hanno soddisfatto i criteri di inclusione (92.000 partecipanti). Sia nei pazienti oncologici che in quelli non oncologici, le cure palliative domiciliari hanno costantemente ridotto il numero di visite ospedaliere e la loro durata, così come i costi di ospedalizza-zione e i costi complessivi dell'assistenza sanitaria. Benché i pazienti trattati a casa consumino più risorse ambulatoriali, un maggiore risparmio nei costi ospedalieri ha controbilanciato questo effetto. La riduzione dei costi sanitari complessivi è più evidente quanto più ci si approssima alla morte.

Revisioni sistematiche più recenti sulle cure palliative domiciliari

Review Article *2020*

PALLIATIVE MEDICINE

Economic evaluations of palliative care models: A systematic review

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Le cure palliative domiciliari **sono costo-efficaci**, ma il numero di studi è limitato, di breve durata e in 3 casi su 5 include un campione di pazienti piuttosto limitato. C'è un potenziale, ma **sono necessarie maggiori evidenze**.

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Impact of home-based palliative care on health care costs and hospital use: A systematic review

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Evidenza basata sui risultati di 19 studi (molti dei quali successivi alla Cochrane review): sia per pazienti oncologici che per quelli non oncologici si assiste ad una riduzione nelle ospedalizzazioni e nella loro durata, così come nei costi ospedalieri e in quelli totali.

Cure palliative in ospedale e costi delle cure

- Meta-analisi pubblicata su JAMA Internal Medicine il 30 aprile 2018.
- Il ricorso a cure palliative (entro tre giorni dal ricovero ospedaliero) non solo impatta la qualità di vita del paziente ma determina pure una **riduzione dei costi diretti di cura** (l'effetto è maggiore sui pazienti tumorali e sui pazienti polimorbidi).

JAMA Internal Medicine | Original Investigation

Economics of Palliative Care for Hospitalized Adults With Serious Illness
A Meta-analysis

Peter May, PhD; Charles Normand, DPhil; J. Brian Cassel, PhD; Egidio Del Fabbro, MD; Robert L. Fine, MD; Reagan Menz; Corey A. Morrison; Joan D. Penrod, PhD; Chessie Robinson, MA; R. Sean Morrison, MD

IMPORTANCE Economics of care for adults with serious illness is a policy priority worldwide. Palliative care may lower costs for hospitalized adults, but the evidence has important limitations.

OBJECTIVE To estimate the association of palliative care consultation (PCC) with direct hospital costs for adults with serious illness.

DATA SOURCES Systematic searches of the Embase, PsycINFO, CENTRAL, PubMed, CINAHL, and EconLit databases were performed for English-language journal articles using keywords in the domains of palliative care (eg, *palliative*, *terminal*) and economics (eg, *cost*, *utilization*), with limiters for *hospital* and *consultation*. For Embase, PsycINFO, and CENTRAL, we searched without a time limitation. For PubMed, CINAHL, and EconLit, we searched for articles published after August 1, 2013. Data analysis was performed from April 8, 2017, to September 16, 2017.

STUDY SELECTION Economic evaluations of interdisciplinary PCC for hospitalized adults with at least 1 of 7 illnesses (cancer; heart, liver, or kidney failure; chronic obstructive pulmonary disease; AIDS/HIV; or selected neurodegenerative conditions) in the hospital inpatient setting vs usual care only, controlling for a minimum list of confounders.

DATA EXTRACTION AND SYNTHESIS Eight eligible studies were identified, all cohort studies, of which 6 provided sufficient information for inclusion. The study estimated the association of PCC within 3 days of admission with direct hospital costs for each sample and for subsamples defined by primary diagnoses and number of comorbidities at admission, controlling for confounding with an instrumental variable when available and otherwise propensity score weighting. Treatment effect estimates were pooled in the meta-analysis.

MAIN OUTCOMES AND MEASURES Total direct hospital costs.

RESULTS This study included 6 samples with a total 133 118 patients (range, 1020-82 273), of whom 93.2% were discharged alive (range, 89.0%-98.4%), 40.8% had a primary diagnosis of cancer (range, 15.7%-100.0%), and 3.6% received a PCC (range, 2.2%-22.3%). Mean Elixhauser index scores ranged from 2.2 to 3.5 among the studies. When patients were pooled irrespective of diagnosis, there was a statistically significant reduction in costs (−$3237; 95% CI, −$3581 to −$2893; $P < .001$). In the stratified analyses, there was a reduction in costs for the cancer (−$4251; 95% CI, −$4664 to −$3837; $P < .001$) and noncancer (−$2105; 95% CI, −$2698 to −$1511; $P < .001$) subsamples. The reduction in cost was greater in those with 4 or more comorbidities than for those with 2 or fewer.

CONCLUSIONS AND RELEVANCE The estimated association of early hospital PCC with hospital costs may vary according to baseline clinical factors. Estimates may be larger for primary diagnosis of cancer and more comorbidities compared with primary diagnosis of noncancer and fewer comorbidities. Increasing palliative care capacity to meet national guidelines may reduce costs for hospitalized adults with serious and complex illnesses.

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Supplemental content

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Evidenze sull'impatto di cure palliative ospedaliere precoci (SENS RCT Trial)

Original Article

Single early palliative care intervention added to usual oncology care for patien with advanced cancer: A randomized controlled trial (SENS Trial)

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Abstract

Background: International oncology societies recommend early palliative car

the secondary outcome, was assessed by the Functional Assessment of Cancer T

Results: The results showed no significant effect of the early palliative care int related quality of life.

Conclusion: The addition of an early intervention to usual care for patients with of life. Thus, patients may need more intensive early palliative care with continu palliative needs early.

Nessun effetto significativo in termini di riduzione dell'angoscia e di qualità di vita del paziente

Original Article

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An early palliative care intervention can be confronting but reassuring: A qualitative study on the experiences of patients with advanced cancer

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Buona soddisfazione dei pazienti nell'affrontare precocemente una discussione sul fine vita

Is early palliative care associated with reduced costs and utilisation of care at the end of life in patients with advanced cancer? A randomised trial

Authorship in alphabetical order for draft ve

Steffen Eychmüller[1], Monica C Fliedner, Brigi

Nessun impatto significativo in termini di utilizzo delle risorse sanitarie e dei costi

Conclusione

Si sta gradatamente consolidando l'evidenza che le cure palliative (a domicilio e in ospedale) siano costo-efficaci. Occorre tuttavia affinare le analisi, con campioni più grandi e **distinguendo meglio per tipologia di presa in carico** (generale vs specialistica) e di **contesto clinico indicato** (cfr. indicazioni BAG/GDK e progetto nr. 11 del PNR74).

Complessità	Instabilità	Rete privata di supporto	Presa in carico ottimale
bassa	bassa	buona	A domicilio
elevata	elevata	buona	A domicilio, con unità mobile di cure palliative
elevata	molto elevata	limitata	Reparto specializzato di CP
elevata	elevata	scarsa	Hospice di lunga durata
intermedia	bassa	scarsa	Casa per anziani

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