NIHR | Policy Research Unit
Palliative and end of life care

NIHR Policy Research Unit for Palliative and End of Life Care

Costs and cost savings of specialist palliative care

Friday 10th Oct 2025

Clarke G, May P, Cook A, Mitchell S, Walshe C, Bajwah S, Yorganci E, Kumar R, Fraser LK and Sleeman KE, Murtagh FEM.

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Recent work on costs and cost-effectiveness

1. Cost analysis of the formal healthcare costs in the last year of life for adults using the best available evidence

2. Rapid evidence review of costs and cost-effectiveness of different palliative care and end-of-life care service models

3. Modelling work on current and potential cost savings for the NHS, from specialist palliative care

… with context of wider evidence

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Healthcare costs per adult decedent in last year of life (scaled to 2024 costs)

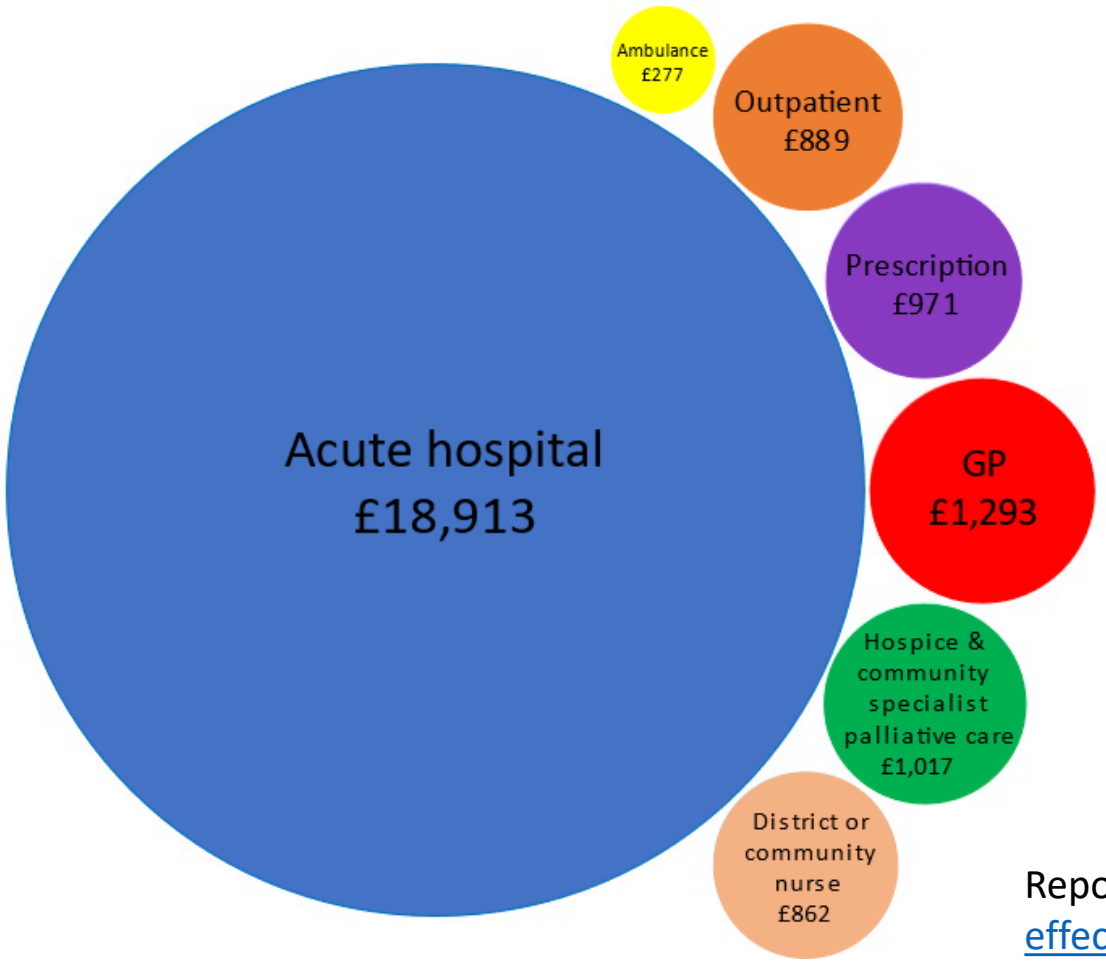


Figure 1. Legend

Acute hospital	£18,913	Including A&E, ICU, acute inpatient overnight, specialist palliative care consultation
GP	£1,293	Including GP faceto-face, telephone consultation, outof-hours calls, home visits
Hospice and community specialist palliative care	£1,017	Specialist palliative care (inpatient bed days, outpatient appointments, community visits), excluding specialist palliative care in acute hospital
Prescription	£971	Mean medications x mean cost per script
Outpatient	£889	Outpatient appointments
District or community nurse	£862	District or community nurse
Ambulance	£277	Including journeys to hospital resulting in admission, visits to A&E same day discharge, and other emergency last year of life ambulance use not to a hospital

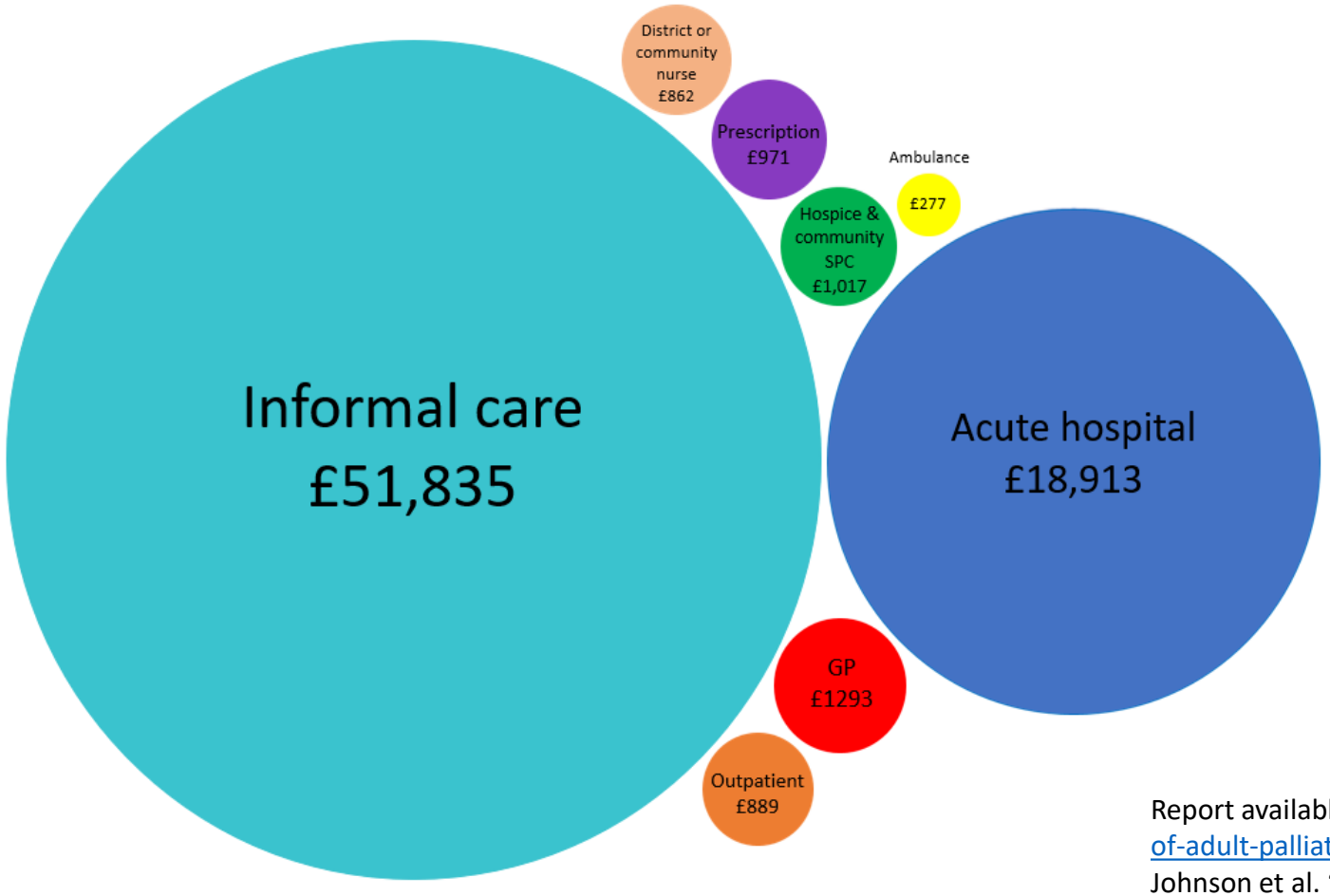
- UK 2024 formal healthcare costs for those in last year of life: mean cost per death, reflecting all deaths
- Bubble size represents the relative proportion of total formal healthcare costs per decedent in the last year of life
- Social care and informal costs (person and their family) not included

Report available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf

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Formal healthcare costs compared to estimated informal care (family and patient) costs



Acute hospital £18,913	Including A&E, ICU, Acute inpatient overnight, specialist palliative care consultation
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Ambulance £277	Including journeys to hospital resulting in admission, visits to A&E same day discharge, and other emergency last year of life ambulance use not to a hospital
Informal care £51,835	Informal care costs (patient and family). Scaled to 2024 costs from Johnson et al. (2024)

- Bubble size represents relative cost proportion
- Social care costs not included
- Informal care costs from 2017 family carer survey analysed by Johnson et al (2024), scaled to 2024 costs

Report available at: https://www.kcl.ac.uk/nmpc/assets/research/costs-and-cost-effectiveness-of-adult-palliative-and-end-of-life-care-evidence-briefing-summary.pdf

Johnson et al. 'The cost of providing care by family and friends (informal care) in the last year of life: A population observational study', *Palliative Medicine*, 2024. 38(7):725-736.

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Themes from the evidence on costs, cost-effectiveness & healthcare utilisation

Three areas with evidence to support beneficial change
1. Improved **out of hours** care to prevent crisis admissions and better support people to stay at home – including designated telephone support lines
2. **Earlier** identification of, discussion about approaching end of life, and referral for palliative care in acute hospitals
3. Good **models of integrated palliative and end of life care** delivered in the home – these already exist and deliver well where they are in place, are known to be effective, have associated cost savings, but need scaling up

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1. Out of hours palliative care (including designated telephone lines)

Out of hours care in-person and telephone (as part of 24/7 care):

- Components of effective care were **integration of services** with access to 24/7 care with timely **out of hours crisis visits** when needed
- Some evidence of reduced healthcare utilisation

Out of hours telephone support:

- Designated palliative care telephone lines (not 111) staffed by people who are experienced and trained in palliative care (both specialist and generalist) – associated with cost savings and overall reduction in healthcare utilisation

2. Specialist palliative care in acute hospitals

- UK evidence and high-quality international systematic reviews show **hospital-based palliative care** is associated with:
  - Improved quality of life including reduced pain and symptom burden
  - Fewer tests, interventions, and treatments, especially those with little or no benefit
  - Expedited discharge and shorter length of stay
  - Fewer days in intensive care
- International evidence shows **timely referral** for specialist palliative care consultation during a hospital admission has greater cost saving effects
- Will also support a more equitable approach to care

3. Palliative care delivered in the home

- UK home palliative care models are already well integrated between general practice, district and community nursing, and specialist palliative care
- Strong evidence of effectiveness: Improved wellbeing and symptom control
- Healthcare utilisation evidence shows home-based services reduce reliance on acute hospital care
  - ➢ Healthcare system cost savings include reduced use of the emergency department, and decreased inpatient stays

Policy recommendations

1. Ensuring **robust out of hours care with prompt home visits for crisis care**, and **dedicated palliative care telephone support lines** in all areas, staffed by professionals with experience and training in palliative care, as recommended in NICE guidance since 2011

2. Investment in **timely (earlier) identification of palliative care needs in acute hospitals**, and earlier referral for specialist palliative care during an acute hospital admission

3. Inclusion of palliative care and end-of-life care in **national policy and contractual levers** to drive ICB investment into equitable palliative care and end-of-life care, delivered by generalist- and specialist-integrated neighbourhood teams

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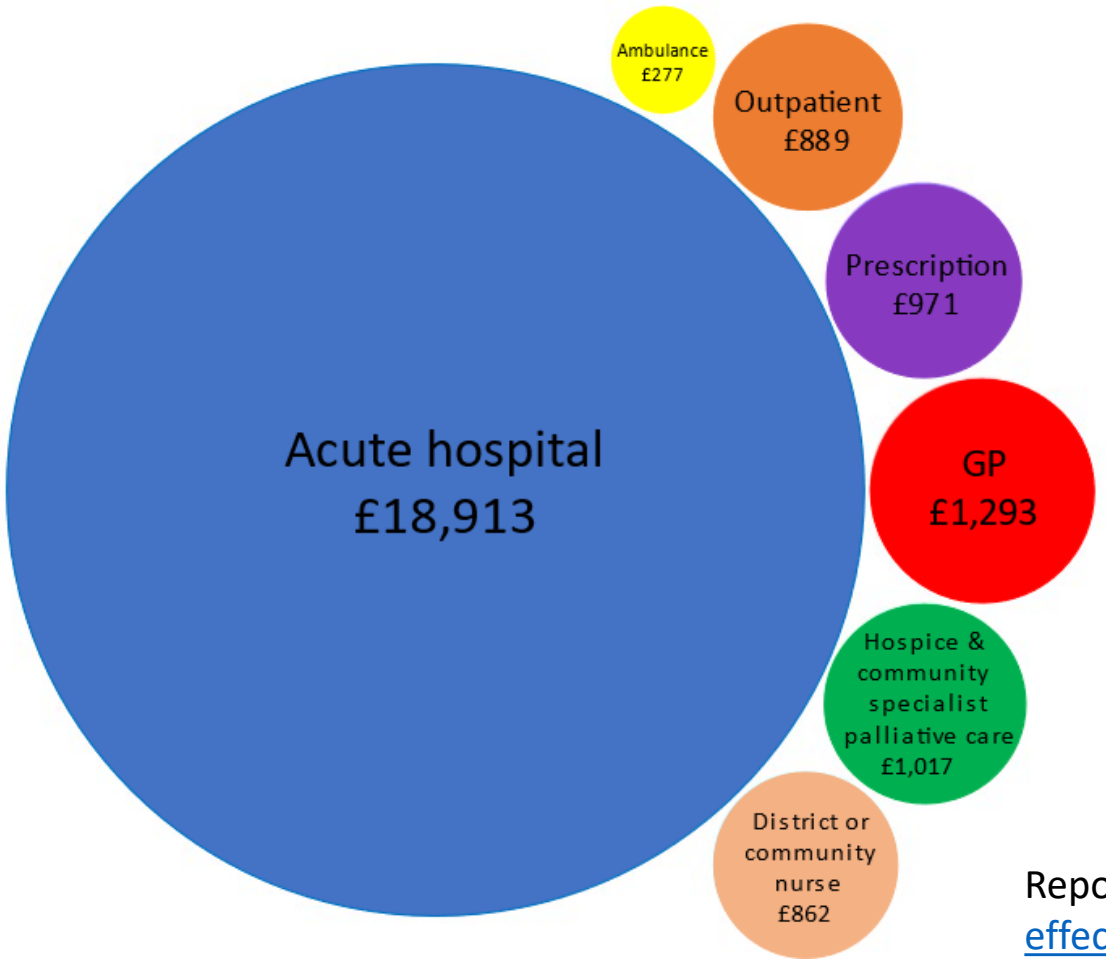


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The system-wide need for integrated community-based care

In last year of life, hospital use is high, admission from home occurs by default, and those in acute hospital need to be managed differently:

- 1 in 3 of all inpatients in acute hospitals are in last year of life
  - (Clark et al, 2014 https://journals.sagepub.com/doi/full/10.1177/0269216314526443)
  - 10,743 hospital inpatients in the acute hospitals in Scotland on one census date (excluding maternity and psychiatry); of these 10,743 patients, 2.9% died within 7 days of the census date, 8.9% by 30 days, 16.0% by 3 months, 21.2% by 6 months, 25.5% by 9 months and **28.8% died within 12 months**
- Work in England shows very similar 30-day mortality
  - (Conway et al, 2023 https://academic.oup.com/qjmed/article/116/10/850/7234622)
  - 35,140 hospital patients, 30-day mortality was 10.4%

Considerable use of acute services, with high levels of unplanned hospital admissions for those in last year of life

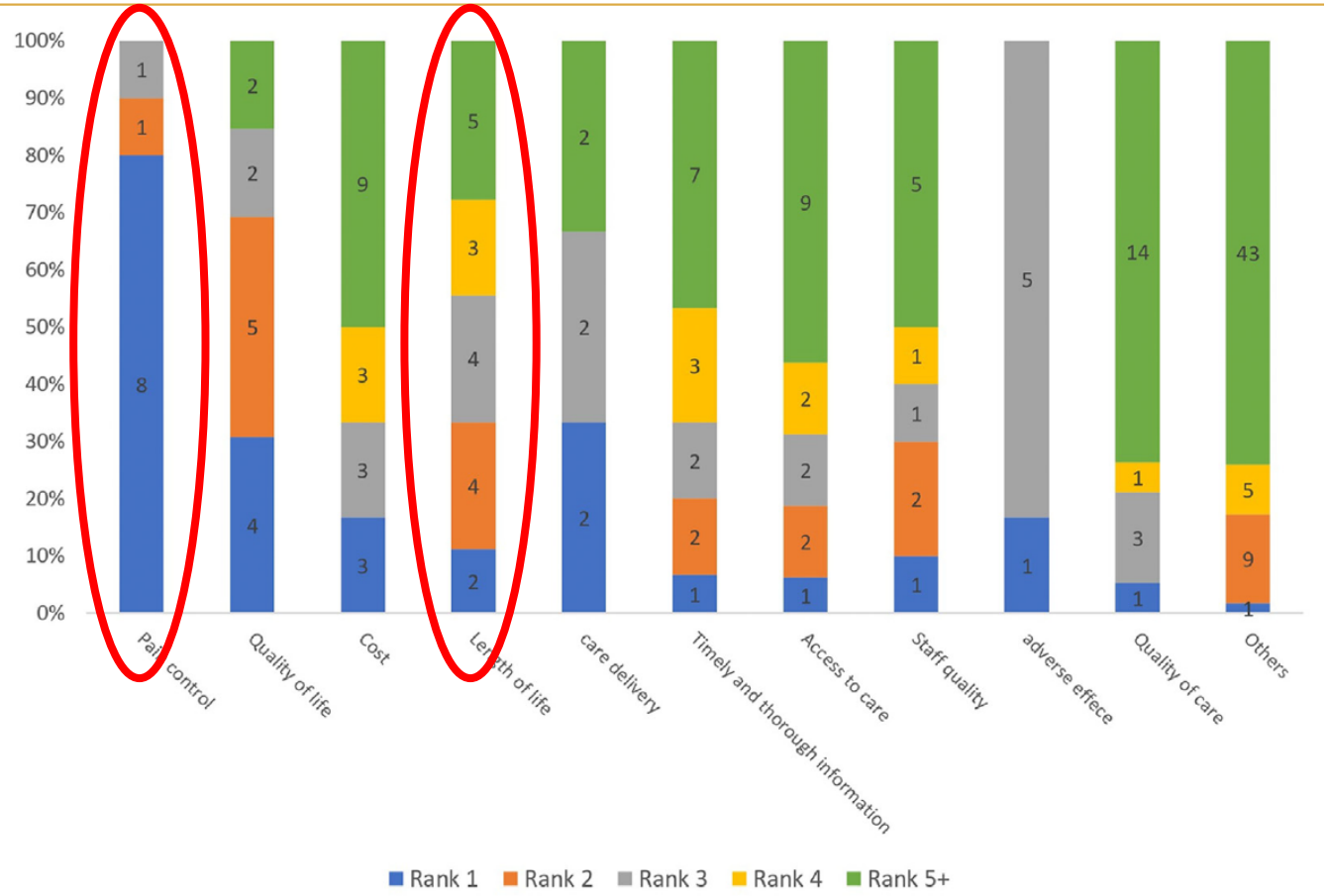
- In England in 2022/23, 44% of deaths in hospital, 56% in the community (of these, 28% were at home, 21% in a care home, 5% in a hospice)

- In England in 2022:
  - 61% of all people who died had one or more emergency admissions in the last 3 months of life and 69% spent time in hospital during the 6 months before they died: this represents 8.4 million hospital days (www.gov.uk/government/statistics/palliative-and-end-of-life-care-factsheet-patterns-of-care-england-2022)
- An analysis of 2021 hospital admissions in England of those who died found
  - 30.5 million hospital days followed emergency admission, and 31% (9.5 million bed-days) involved people in their last year of life: almost one third of hospital days following emergency admissions involved people in last year of life

    (Pring et al. BMJ Supp & Pall Care, 2024. A20-A21. https://spcare.bmj.com/content/14/Suppl_1)

Often not what people with advanced illness want …

Figure 3. Frequencies of attribute importance ranks by attribute type (top 10 attributes).



- Discrete choice experiments to elicit what matters most to those with advanced illness
- International, but most from UK, Europe, Australia
- 17 papers reporting discrete choice experiments included (2005-2022)
- The figure shows frequencies of attributes of care
- Pain control and quality of life most often ranked top priority
- Length of life is prioritised less than expected

Xia et al Value in Health, Volume 26, Issue 12, 2023: https://www.sciencedirect.com/science/article/pii/S1098301523030711

Community-based care is integrated but not enough …

- Nationally-representative survey to 3,000 adults who registered the death of an adult family member Aug-Dec 2022 (exclusion: sudden/unexpected deaths) – data collected May-Sept 2023. 1,179 surveys returned by the end of September 2023, response rate almost 40%
- 952 (80.7%) had contact with a GP (median 2 contacts in last 3 months, IQR 1-4)
- 629 (53.4%) had contact with a district or community nurse (median 5 contacts in last 3 months, IQR 2-10)
- 343 (29.1%) had contact with specialist palliative professionals (median 4 contacts in last 3 months, IQR 2-8)
- Free text responses: difficulty with accessing primary care and out of hours services
- Out of hours access to help was especially difficult

Full report available at:
https://www.mariecurie.org.uk/document/experiences-at-the-end-of-life-in-england-and-wales

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Communication, identification of deterioration, discussion of preferences not enough nor early enough …

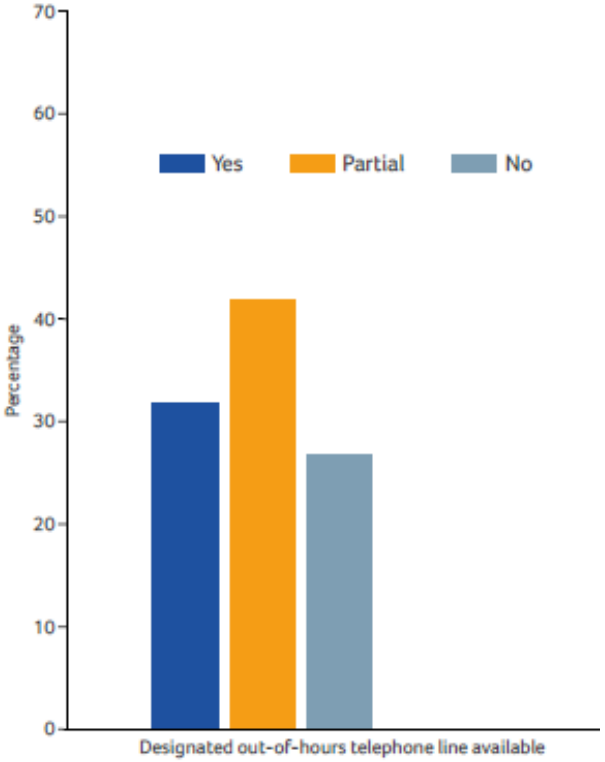
- Recognition of deteriorating health, identifying palliative care needs, communication, planning ahead was often reported as too late (free text)
- 946 (80.2%) had been aware that their relative might die
- But 206 (17.9%) reported being unaware.
- 146 (15.6%) of those who were aware had only become aware in the last week of their relative's life
- We asked if the possibility of dying was ever discussed with the person themselves:
- 446 (37.8%) reported that, to the best of their knowledge, no such conversation had taken place
- It was more common for respondents to report that healthcare professionals had discussed the possibility of dying with family members (n=777, 65.9%), though more than a quarter (n=349, 29.6%) had not ever had such discussions

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Integrated home-based palliative and end of life care works well

- Evidence shows models of integrated palliative care at home across specialist and non-specialist providers **are** very effective. https://journals.sagepub.com/doi/10.1177/026921632513625 67
- core components of effectiveness are:
  - sufficient staff and time to provide person-centred, relational care
  - continuity of care including out of hours
  - good staff knowledge and training
  - agility to respond rapidly to changing patient needs and prevent crisis admissions
  - support for family carers
- They do need designated (not generic) palliative care telephone support lines, as part of robust out of hours care, which have the potential for cost savings through reduced hospitalisations, reduced ED use, reduced face-to-face consultations.
- 24/7 out of hours care needs to involve prompt home visits for crisis care
- https://www.mariecurie.org.uk/globalassets/media/documents/policy/beol-reports-2022/better-end-of-life-report-2022.pdf



2022: Is a designated palliative care phone line available? >25% of areas said ‘no’. >40% said partial.

Potential for cost savings – modelling work led by Peter May

- Both home and hospital specialist palliative care deliver improved wellbeing near end of life, and reduced costs.





- But currently, only a minority who might benefit receive specialist palliative care get it.
- Specialist palliative care supports over 20,000 people to die outside of hospital each year, saving approximately 1.5 million hospital bed days and reduced system expenditures by £817 million.
- Expanding access to and resources for specialist palliative care would likely yield further gains.

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Pre-print is available at:
May et al. (2025)
https://tinyurl.com/2p82xvew

Proposed solutions…

1. **A radical shift in recognition, planning ahead and communication:**
   - Recognition that older people with multiple conditions will have less benefit from acute interventions and treatment: provide realistic hope, parallel planning, ‘what if …’ conversations, naming uncertainty
2. **Earlier and more frequent identification of palliative care needs among those in acute hospital beds bringing:**
   - reduced length of stay and reduced re-admissions in last year of life, especially in last three months
   - fewer tests and treatments, improved quality of life with reduced pain and symptom burden
   - better matching of care with the preferences for those with advanced illness and their families
3. **Investment in integrated palliative and end of life care (at home) which works well:**
   - GPs, district and community nurses, family support, specialist palliative care, hospices
   - Existing successful models of integration with primary and community care, including care homes, community geriatrics, and hospital services – a ‘reforming palliative and end of life care’ programme
4. **This needs to include sufficient urgent crisis care out of hours at home:**
   - Designated 24/7 telephone support lines for palliative patients; not to the level of 2011 NICE guidance
   - Prompt visits from skilled professionals out of hours to prevent crisis admission

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This work was undertaken by Clarke G, May P, Cook A, Mitchell S, Walshe C, Bajwah S, Yorganci E, Kumar R, Fraser LK and Sleeman KE, Murtagh FEM

Thank you to the whole Policy Research Unit team – especially Gemma Clarke and Peter May

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