

# Costs and cost-effectiveness of adult palliative and end-of-life care

## Evidence briefing\*: summary

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## Executive summary

### What is the challenge?

Some people in the UK do not receive the care they need near the end of life, and there are inequities in access to palliative care according to socioeconomic, demographic, clinical and geographic characteristics. Serious medical illness, multimorbidity and proximity to death are key determinants of healthcare costs.

People with serious illness and their families report a wide variety of unmet needs, including distressing physical symptoms, psychological concerns, and poor-quality care including treatment that is inconsistent with their preferences. There is widespread use of acute hospitals following emergency admissions, which results in high-cost care in settings not always well-equipped to provide high-quality end-of-life care or identify and manage palliative care needs.

The UK faces challenges in increasing provision of high-quality palliative care and end-of-life care to meet growing current and future population need, reduce inequities in access, and improve the cost-effectiveness of care and treatment. For policymakers to make informed decisions about investing in palliative and end-of-life care services, they need to know the evidence for costs and cost-effectiveness of different service models.

### Which questions do we address?

This evidence briefing addresses the following key questions:

1. Where do adults receive care in their last year of life in the UK?
2. What do we know about formal healthcare costs in the last year of life for adults in the UK?
3. How do palliative care and end-of-life care interventions for adults with advanced illness impact upon costs, cost-effectiveness and healthcare utilisation?
4. What are the key issues for decisions related to allocation of resources, and scalability?
5. Where are the gaps in evidence regarding cost-effectiveness that need to be addressed?

### How do we address these questions?

To address these questions, a rapid evidence review, secondary data analysis of cost data, and expert panel consultations were carried out between August and November 2024. Evidence concerning adult patients and their family caregivers receiving palliative care or end-of-life care, or in their last year of life, was included. Evidence related to costs, cost effectiveness and healthcare utilisation from studies across a wide range of settings and models of care, including specialist, generalist or community palliative and end-

of-life care services; primary care; hospital, emergency and secondary care services; and social care was identified through consultation with experts and rapid literature searches. We then estimated costs by combining secondary analysis of the best available utilisation data with reference costs. Finally, four online expert panels were held during September and October 2024 to discuss and refine key themes and findings from the evidence.

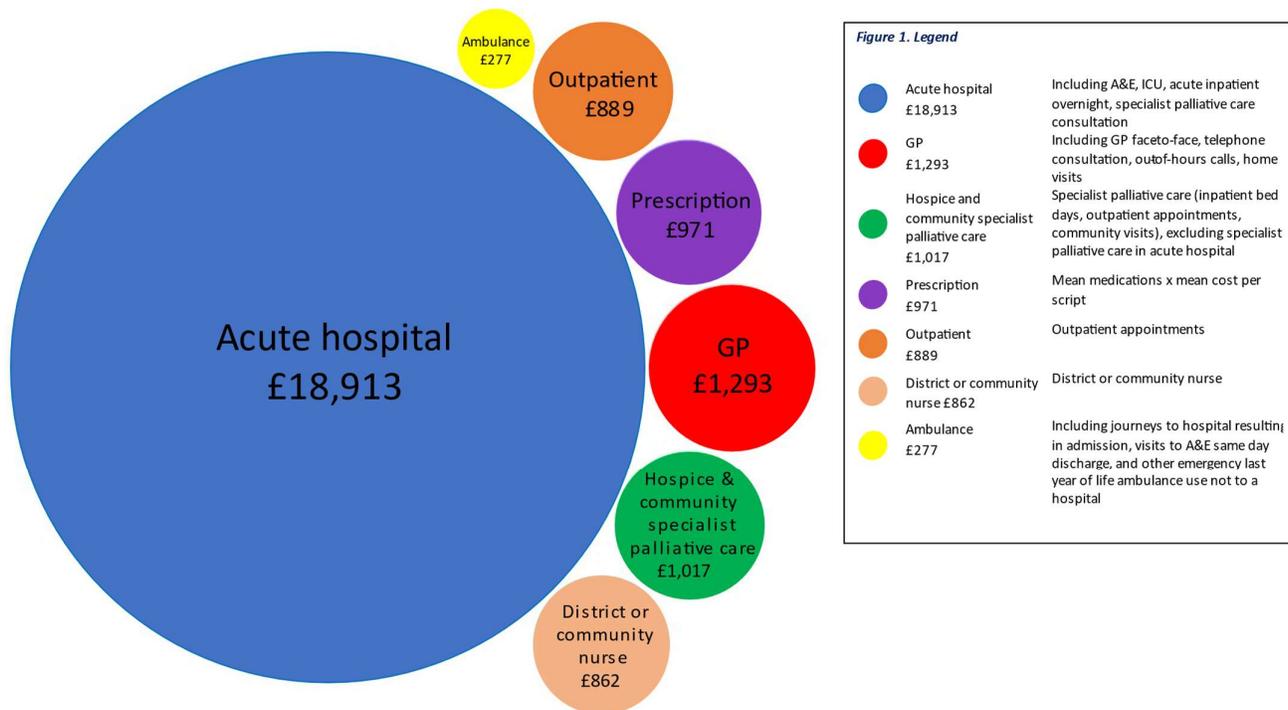
### What evidence did we find on the costs of care in last year of life?

Using 2017 data, we estimate that, per decedent (and based on all adult deaths), mean total formal healthcare costs in the last year of life were £19,051. The dominant component of formal healthcare costs was the acute hospital setting (£14,796, 78% of formal healthcare costs).

If this data is scaled to 2024 costs, mean total formal healthcare costs in the last year of life are £24,222.

Specialist palliative care, comprising consultation teams in acute hospitals and specialist palliative care in the community and in hospices, accounts for only 6% of formal costs. Overall, less than 1% of the population dies annually but this group accounts for approximately 8% of NHS spending.

*Figure 1. Composition of total formal healthcare costs per decedent in the last year of life, based on 2017 costs and adopting standard inflation to 2024 costs. (Bubble area represents the relative proportion).*



### What evidence did we find on effectiveness and cost-effectiveness?

This evidence briefing provides strong evidence that palliative care and end-of-life care delivered through multi-disciplinary teams, with specialist palliative care integrated alongside specialist and generalist teams, is effective, leading to improved outcomes for patients and their family caregivers. These services are associated with reduced avoidable healthcare utilisation and cost savings, including through reduced use of urgent and emergency care and reduced length of inpatient stays.

### What are our policy recommendations?

While evidence of cost-effectiveness of palliative and end-of-life care interventions is limited to date, we identify three key areas with the greatest weight of evidence of effectiveness and overall potential cost savings to consider providing and scaling up across England. We make the following policy recommendations:

#### **Policy recommendation 1: Investment in timely (earlier) identification of palliative care needs in acute hospitals, and earlier referral for specialist palliative care during an acute hospital admission**

This has strong potential for cost savings through expedited discharge, fewer tests and treatments, and reduced intensity of stay, while improving effectiveness of care through improved quality of life including pain and symptom burden. International evidence demonstrates that timely (earlier) referral for specialist palliative care consultation during a hospital admission is likely to bring overall cost savings. Identifying palliative care needs in acute hospitals is also likely to better address current inequities in access to palliative and end-of-life care given the high prevalence of acute hospital use in the last months of life, particularly by groups least likely to access palliative care.

#### **Policy recommendation 2: 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**

This aligns with the strategic shift of care from hospital to community, and resonates strongly with the recent *Neighbourhood health guidelines 2025/26* (NHS England, 2025). Strengthened generalist- and specialist-integrated neighbourhood teams would deliver potential for cost savings through reduced use of the emergency department and decreased inpatient stays. To be effective, key components of such models must include: meaningful and effective integration and coordination to avoid fragmentation of services for patients; sufficient time to provide relational person-centred care; continuity of care including out of hours; staff training and development of expertise; agility to respond rapidly to changing patient needs; and support for family carers. Home palliative care is already delivered, but is currently provided very inconsistently (and sometimes not at all).

**Policy recommendation 3: 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**

Dedicated palliative care telephone support lines, as part of robust out of hours care, have the potential for cost savings through reduced hospitalisations, emergency department use and reduced face-to-face consultations. They could better support families and carers with reliable support to cope when their loved one has palliative care needs or is dying. This includes 24/7 out of hours care, which needs to involve: prompt home visits for crisis care, and dedicated palliative care telephone support lines staffed by professionals with experience and training in palliative care and end of life care (either generalist or specialist). Out of hours palliative care is already delivered in some areas, but is currently provided very inconsistently.

**What are our recommendations for research?**

The compilation of this report highlighted multiple important gaps in our understanding of costs and cost-effectiveness of palliative and end-of-life care that can inform future research. We make the following research recommendations:

**Research recommendation 1:** Quantify descriptive costs of formal health and social care for people with palliative care needs in the UK (including informal family caregiver costs), and conduct economic evaluations of the key models of integrated and specialist palliative care in the NHS.

**Research recommendation 2:** Extend the individual treatment appraisals and combined modelling exercises proposed in research recommendation 1 above to take account of new models of care and technologies, and an understanding of care quality, patient experiences and outcomes.

**Research recommendation 3:** Engage in projections work that estimates the future number of people in the UK with palliative care needs, quantifies the prevalence of complex needs including multimorbidity and disability, and establishes the distribution of need and complexity across different demographic, socioeconomic and geographic groups. Consider the implications of outputs from recommendations 1 and 2 in the context of these dynamics.

**Research recommendation 4:** Build a robust evidence base on the costs and cost-effectiveness of care for children and young people living and dying with serious illness, taking into account the different trajectories of illness, range of providers, types of care needs.