

# Separated at birth?

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It is time hospice and palliative care grew up. We can no longer expect governments to treat them as a charity case, with just enough funding to avert adverse newspaper headlines. Increased financial pressure from the global economic recession and fiscal crisis on already stretched budgets means tough decisions have to be made about where to invest limited health funds. Consequently, we need to demonstrate the value of hospice and palliative care's contribution to improving health.

Five years ago, the *Journal of Pain and Symptom Management* special issue editorial on health economics in palliative care concluded evidence of cost-effectiveness is 'relatively weak' and there are 'too few evaluations and cost-effectiveness studies of palliative care treatments and services'.<sup>1</sup> The global provision of hospice and palliative care is hampered by the absence of health economic research. Have things changed? Despite burgeoning signs in the literature<sup>2,3</sup> and presentations at international palliative care conferences, little obvious progress is being made.<sup>4</sup>

Health economics and palliative care are relatively young academic fields. Five decades ago, Kenneth Arrow published his seminal article on the welfare economics of medical care<sup>5</sup> and gave birth to the discipline of health economics. Palliative care emerged almost simultaneously, and yet, our discipline has not been informed by its twin.

Why so little headway? The rise of applied health economics in the 1980s spawned controversy in the

popular medical press, touted as 'the end of clinical freedom',<sup>6</sup> and health economics continues to be vilified even today.<sup>7</sup> Such entrenched and negative views impede the maturation of health economics in our subject and more informed discussion is needed to overcome attitudinal barriers to change. Second, there is an urgent need for education about the benefits of health economics research in palliative care, a Herculean task. Third, conducting health economics research adds extra challenges and complexity to trials in the hospice or palliative care setting,<sup>8</sup> including choosing the preference-based outcome measure, incorporating spillover effects such as informal carer costs and outcomes, and capturing and costing resource use.<sup>9</sup> The lack of consensus and guidance on carrying out such evaluations further hinders progress in our field.<sup>10</sup>

A common misconception is that health economics is only concerned about costs, leading to ethical objections about the role of health economics in healthcare. However, measuring outcomes is intrinsic to health economics to inform choices about which courses of action maximise benefits from budget-constrained funds, alongside equity considerations. Even in hospices, ignoring the cost consequences of healthcare decisions is unethical as every expenditure has an opportunity cost—the value of alternative choices that were not pursued. Finally, health economists are scarce and demand for their services is high. Sufficient, targeted investment in palliative care research is required to support high-quality teams including a health economist whenever interventions or service models are being evaluated.

As palliative care clinicians, researchers and administrators, we ignore health economics at our peril.

Ultimately, patients and families receiving our care will be disadvantaged without such evidence, allowing other disciplines to secure an even greater share of limited health resources. If hospice and palliative care services are to compete successfully with the bigger boys like cardiovascular disease for a larger slice of the finite healthcare pie, then we need to justify how such funds will grow services and provide better outcomes for patients and families, providing the best available clinical and cost-effective arguments to meet funders and policymakers' information needs. To see a change 5 years hence, work is urgently needed now. Separated at birth, it is time to reunite palliative care and health economics. What are we waiting for?

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