

# Cost Savings in Hospice: Final Results of the National Hospice Study

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*Medicare inpatient and home care costs over the last year of life of terminal cancer patients served in two types of hospices and in conventional care (CC) were compared as a part of the National Hospice Study (NHS). Both home care (HC) and hospital-based (HB) hospice patients had lower costs in the last month of life than did CC patients. HC patients substituted home care for inpatient care, yielding cost savings for lengths of hospice stay of up to 1 year. Although HB patients added home care to relatively high levels of inpatient care, their ancillary costs per inpatient day were significantly lower than those of CC patients. Thus, HB costs over the last year of life were also somewhat less than those of CC. The size of the savings associated with hospice care is sensitive to the type of hospice and the length of stay distribution of patients served; patients served longer have significantly higher costs in the last year of life.*

## INTRODUCTION

In 1982, legislation was passed providing for hospice reimbursement and predicated on the assumption that hospice care resulted in lower health care costs. Evidence before and since passage of the legislation has been mixed and largely dependent upon how costs were defined,

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what costs were included, and how the comparisons were made [1-6]. Several small studies found hospice patients to incur lower costs than the estimated costs of treatment in an acute hospital [1-3]; however, the level of estimated savings varied considerably. More recently, two population-based studies were reported which examined the costs of terminal cancer patients over the last months of life [5, 6]. Those served in a hospice at some point before their death had lower health care costs in their last month of life than those who were not. However, when total costs in the last 6 months were considered, the differences evaporated or were no longer significant. Further contradictory evidence was provided by the UCLA Veterans Administration Hospital's randomized trial of hospice, which found no difference, or even higher costs, associated with hospice over the last 3 months of life [4]. Variation in geographic region, approach to defining costs, and research designs of the studies have all contributed to the diverse estimates of the savings associated with hospice care.

In presenting preliminary data from the National Hospice Study (NHS), Birnbaum and Kidder [7] focused on understanding the *cost* of hospice care. They found that hospital-based (HB) hospice patients were twice as likely to be admitted to an inpatient setting than were home care (HC) hospice patients and that HB inpatient users stayed longer than admitted HC users. The average number of home care visits per day at home was relatively similar for HB and HC patients. Differences in utilization resulted in substantial Medicare cost differences; \$95 versus \$66 per day for HB and HC patients, respectively. The skewed length of hospice stay distribution with an average of 62.3 and 72.5 and medians of 33 and 37 days, respectively, for HB and HC were similar to that reported by other hospice studies [4, 5, 8, 9]. Final NHS data comparing patterns of utilization and cost revealed a pattern very similar to that reported by Birnbaum and Kidder. Comparisons of hospice versus conventional care based upon preliminary data were admittedly tenuous, and findings reported here differ from those preliminary results.

This paper differs from the earlier report of NHS findings insofar as it (1) uses the larger, final NHS sample; (2) focuses upon cost savings in terms of a larger sample of nonhospice patients; (3) presents estimates of savings adjusted for differences in the samples of patients, including patterns of pre-hospice utilization; and (4) focuses upon the different pattern of substitution in health services use evidenced by the two models of hospice care. The cost savings associated with hospice are particularly relevant as the merits of continuing the hospice reimbursement legislation are debated.

## METHODS

The National Hospice Study research design, including site selection and data collection procedures, has been described elsewhere [10]; the approach to defining Medicare costs also has been detailed elsewhere [7]. Data for the current report were assembled on 5,853 hospice and nonhospice patients from a population of over 10,000 terminal cancer patients identified in 25 hospices and 14 conventional oncological care settings between October 1980 and March 1983. The 25 hospices, distributed from Miami to Seattle and from San Diego to Burlington, Vermont, were selected by the Health Care Financing Administration (HCFA) by competitive bid from a pool of 233 applicants. Conventional Care (CC) settings were selected by the Brown University evaluators based upon their willingness to cooperate with the study and their ability, in the opinion of the investigators, to provide quality oncological care. The 14 CC settings were outpatient based (4) or inpatient oncology units (4), or a combination of both (6).

The patient sample used in these analyses includes all Medicare admissions to the demonstration hospices between October 1, 1980 and September 30, 1982, having a diagnosis of cancer, and who died by December 1983. Additionally, Medicare CC cancer patients who were served during this period and who died by June 1983 are used as the comparison sample.

Patient data include bill summaries from Medicare and patient medical and demographic data abstracted from the records of participating hospice and CC settings. Patient data include basic demographics, cancer type, and date of diagnosis. Billing data include inpatient and home health care bills received by the patient under the regular Medicare billing system up to 4 years before the death as well as bills from the HCFA Office of Direct Reimbursement (ODR), which was responsible for tracking demonstration hospice services and their costs. All billing data were in computerized form and included charge and utilization data as well as the dates on which services were delivered. No physician billing data were available from either the Medicare Bill History file or the ODR billing files. Physician services billed under Medicare part B were not included in the hospice demonstration and are not accumulated in the Bill History file. Based upon studies of Medicare and non-Medicare terminal cancer patients' health care costs, physician costs constitute only about 10-15 percent of all health care costs during the last 6 months of life [6, 11]. Thus, their absence in the NHS findings reported here is unlikely to have a major effect on

the findings, since, as earlier studies show, physician costs closely parallel hospital costs even in a terminal population.

Based upon dates of service included in the HCFA/ODR and Bill History file—bills and the dates of death obtained from patient records and validated against computerized HCFA entitlement records—measures of utilization and cost for fixed periods prior to death were created. Computer algorithms were used to allocate utilization episodes and their associated costs across the fixed periods (e.g., 0–29 days before death). Some inconsistencies in the dates of service and billing in relation to date of death made it impractical to define smaller periods.

Defining health care cost is a highly complex endeavor, generally requiring assumptions about the actual level of resource utilization involved in producing a service for a given homogeneous population of patients [12]. While charges are readily available from billing data, they reflect regional variation in labor costs and practice patterns as well as idiosyncratic pricing policies of providers, not to mention providers' reactions to their reimbursement and regulatory environment. Since the NHS had hospice and nonhospice sites distributed nationally, albeit not evenly or even randomly, we adopted an approach to defining costs that would give us the maximum ability to generalize our findings and to minimize the effect of geographic and provider variation on estimates of costs and savings. The goal was to have costs reflect differences in the intensity of resource use in care of terminal cancer patients.

A detailed description of the cost calculations used is presented in Birnbaum and Kidder [7]. Briefly, costs were defined based upon patient utilization and Medicare accounting principles derived from cost weights and provider cost reports from 1982. Nonhospice inpatient routine hospital days were calculated at the 1982 average rate of \$156, and hospice inpatient costs began with this figure and inflated it by 16 percent to reflect the average difference between a hospice inpatient unit's routine costs and those of a medical bed in its affiliated hospital (based upon our study sites). Patients' nonhospice inpatient ancillaries (consumed by either hospice or nonhospice patients admitted into a nonhospice inpatient hospital) were converted to costs by adjusting for the hospital's differential average ancillary charge when compared to the national average. This adjusted charge was then converted to cost by multiplying it by the national average Medicare ancillary cost to charge ratio. The resulting measure is indicative of the relative intensity of the service intervention provided the patient while in the hospital. Since no national norms existed, hospice inpatient

ancillaries were simply converted to cost using the hospice-specific average ancillary cost to charge ratio reported on the demonstration cost report.

Nonhospice Medicare-reimbursed home nursing and aide services were set equal to their charges since analyses revealed reimbursements to be almost always equal to billed charges. Hospice-provided home care service utilization was measured in terms of the number of hours of care provided across all home service visits. Home services included nursing, aide, homemaker, occupational therapy, social service, and nutritional visits, although the vast majority were attributable to nursing and aide services. Hours of home care were multiplied by the home care cost per hour for each participating hospice as calculated from the cost report. Both hospice and nonhospice home care costs included any supplies and equipment billed to the patient.

## ANALYTIC APPROACH

To compare the costs and service-use patterns of hospice and conventional care patients given the non-random study design, costs (total, inpatient, ancillary cost per inpatient day, home care costs, etc.) and utilization (number of inpatient days and hours of home care used and the rates of use of each) were measured in terms of fixed periods of time preceding patients' deaths. This approach assured that patients were similar with respect to their proximity to death and consequently the stage of their disease, a methodological concern related to the known relationship between proximity to death and consumption of health care services [6, 11, 13]. Separate measures of cost and utilization were created for each of the last eight months of a patient's life and for the ninth through the twelfth-month period. Months were defined as 30 days, e.g., 0-29, 30-59 days. Comparisons with the conventional care sample were made for each fixed period preceding death.

Analyses removed differences due to case mix by measuring costs that would have been incurred by the average hospice patient in each of the three settings. Tests of the significance of the estimated difference on a particular dependent measure were made separately for each hospice group. Two equations, one pooling HB and CC cases and the other pooling HC and CC cases, were formed for each dependent variable. Independent variables included measures of age, sex, selected cancer type dummies, length of illness (as measured from date of diagnosis), health care costs incurred in the prior year, a dummy variable indicating that the patient was HC or HB, and all interactions of

patient independent variables with the HC or HB indicator. Additional potential independent variables such as living arrangement at time of hospice or "study" entry were also available; however, we chose not to include them in the models since they pertained to a variable point of temporal reference, generally the last months of life, and not necessarily to the last year of life. Equations were developed based upon the subset of sample members with no missing data on the independent variables. Analyses revealed no substantial differences in the cost and service-use measures between those with and those without any missing data on the independent variables. Tables summarizing all per patient cost equations are available from the authors upon request.

An estimate of the cumulative savings was also constructed. Savings attributable to hospice were defined as the average cost difference between hospice patients *in hospice* and CC patients during the last year of life. Thus, any differences in hospice and CC costs during the last month of life for hospice patients admitted in the second-to-last month of life are legitimately *in-hospice* "savings" (positive or negative). Any hospice versus CC cost differences that may exist for this cohort of patients 6 months before death are clearly not "*in-hospice*" savings.

Hospice savings were computed by first cumulating the regression-based adjusted cost differences separately for the HB and HC samples in relation to the CC sample. Cost differences for any given period were weighted to reflect the length of hospice stay distribution. The cumulative cost differences calculated over the last year of life were adjusted to reflect only savings attributable to hospice, subtracting any cost differences that existed pre-hospice. In making these adjustments, we assumed that all cost differences in the months after hospice enrollment are "*in-hospice*," and that only 50 percent of the differences observed during the enrollment month were attributable to hospice. This last assumption was adopted after inspecting the length of stay distribution for each hospice cohort; it was necessary because of the overlap in bill dates observed in the data. Thus, "*in-hospice*" savings during the last month of life were computed by cumulating cost differences across the nine hospice length of stay cohorts and subtracting 50 percent of the total monthly differences for the cohort that entered in the last month from the total. The same principle was applied to all periods, trimming pre-hospice savings from the cumulative totals throughout the last year of life.

Table 1: Medicare Cancer Costs Sample Demographic Characteristics by Terminal Treatment Setting

	<i>Home Care Hospice</i> (N = 3,641)	<i>Hospital-Based Hospice</i> (N = 1,654)	<i>Conventional Care</i> (N = 558)
Age at death			
Under 65	10.9 %	9.6 %	11.8 %
65-74	50.5	52.4	49.9
75 +	38.6	38.0	38.3
Sex			
Male	51.9	50.8	51.2
Female	48.1	49.2	48.8
Married			
Yes	61.8	54.0	57.1
No	38.2	46.0	42.9
Patient lived alone			
Yes	8.9	20.2	20.6
No	91.1	79.8	79.4
Patient's primary care person is spouse			
Yes	55.7	48.5	51.2
No	44.3	51.5	48.8
Average number of days in hospice	59.6 days	48.8 days	—
Duration of illness (months between diagnosis and death)	16.9 months	16.9 months	15.3 months

## RESULTS

Table 1 describes the two hospice and CC samples. There were no differences in the age or sex distributions, but HC patients were significantly more likely to have been married, to live with someone, or to have a significant other identified as the spouse at the time of hospice or study entry than was the case for either the HB or the CC sample. The HC hospice sample had a longer length of stay in hospice; however, no significant differences were observed in the duration of illness of hospice and CC patients. Additionally, no difference in the distribution of cancer types was observed across the three samples [6, 11].

### COST AND UTILIZATION DIFFERENCE PER PATIENT

In the last year of life, unadjusted for differences in the samples, the HC hospice patients averaged \$10,798, HB hospice patients averaged \$12,698, and CC patients averaged \$14,799 in total Medicare inpatient, home care, and nursing home costs. Reflecting preliminary

Table 2: Estimated Total Medicare Health Care Costs per Month for Home Care and Hospital-Based Hospice and Conventional Cancer Patients over Each of the Last 6 Months of Life (Adjusted for Patient Mix)

	<i>Home Care Hospice</i>	<i>Hospital-Based Hospice</i>	<i>Conventional Care</i>
Last month of life	\$2,270‡	\$2,657‡	6,110
Second-last	1,810‡	2,563	2,546
Third-last	1,187	1,496†	1,095
Fourth-last	899*	1,260‡	718
Fifth-last	783*	1,010‡	559
Sixth-last	770	864	701

\*Hospice versus CC comparison is statistically significant at beyond .05 level.

†Hospice versus CC comparison is statistically significant at beyond .01 level.

‡Hospice versus CC comparison is statistically significant at beyond .001 level.

NHS findings [7], the longer patients were under hospice care, the higher their total costs in the last year of life. For example, the relatively few patients who were in hospice for over 9 months averaged well over \$18,000 in their last year of life. On the other hand, patients entering hospice within the last month of life averaged only \$8,233 and \$10,808 in total last-year costs for HC and HB, respectively.

Table 2 presents the total costs per month for each of the last 6 months of life for HC, HB, and CC patients adjusted for the mix of patients served in the different settings. As can be seen, both hospice groups are significantly less costly than the CC sample in the last month of life. Costs in the second-to-last month, however, are significantly lower only for the HC patients, while HB costs are almost identical to those of CC patients. From the third month of life back to the sixth, hospice patients' costs are invariably higher than CC patients', frequently significantly so.

Table 3 presents the inpatient and home care utilization data that generate the costs observed in Table 2. These, too, are adjusted for differences in the mix of patients served. As can be seen, CC patients use very little home care at any point in the last 6 months of life, while both hospice groups use substantial amounts, nearly doubling in each of the last 3 months of life. The percentage of HC patients using home care is almost 100 percent during the last month of life, as is the percentage of CC patients using inpatient services in the same period.



Table 3: Utilization of Inpatient and Home Care Services in the Last Six Months of Life by Setting (Adjusted for Patient Mix)

	<i>Home Care Hospice</i>		<i>Hospital-Based Hospice</i>		<i>Conventional Care</i>	
	<i>Inpatient Days</i>	<i>Home Care Hours</i>	<i>Inpatient Days</i>	<i>Home Care Hours</i>	<i>Inpatient Days</i>	<i>Home Care Hours</i>
Last month						
Average	6.5	31.8	9.5	21.1	17.6	1.7
(% users)	(54)	(98)	(84)	(65)	(97)	(21)
Second-last						
Average	5.4	16.3	8.7	12.9	7.6	1.7
(% users)	(45)	(62)	(57)	(51)	(59)	(17)
Third-last						
Average	3.5	9.5	4.5	7.7	3.1	0.9
(% users)	(39)	(41)	(46)	(37)	(41)	(12)
Fourth-last						
Average	2.7	6.0	3.6	5.6	2.4	0.9
(% users)	(31)	(29)	(37)	(28)	(30)	(8)
Fifth-last						
Average	2.3	3.9	3.0	3.4	1.8	0.9
(% users)	(27)	(21)	(31)	(22)	(24)	(7)
Sixth-last						
Average	2.3	2.6	2.6	2.6	2.19	0.4
(% users)	(24)	(16)	(23)	(16)	(23)	(7)

The HB sample uses both inpatient services and home care, although neither to the extent that CC and HC samples respectively do.

It would appear that the significant cost differences in the last 2 months of life observed for the HC sample in Table 2 can be attributed to the substitution of home care services for inpatient care. The rate of increase in the use of inpatient care is minimal from the second-to-last to the last month of life for the HC groups when compared to CC patients. At the third-to-last month, the two groups had similar rates of inpatient use. Between the third and second-to-last months, the percentage of HC inpatient users increased from 39 to 45 percent, with a relatively small increase in the number of inpatient days (3.5–5.4), while for CC patients the increase was from 41 to 59 percent, with a doubling of the average number of inpatient days (3.1–7.6). From the second-to-last to the last month, the changes in pattern of service use are even more striking. Although less dramatic, the increased use of home care also appears to reduce both the propensity for, and the duration of, inpatient stays for HB patients as well.

Use of home care is not the only mechanism for substituting a less

**Table 4: Estimated Ancillary Costs per Inpatient Day in Each of the Last Six Months of Life for Hospice and Conventional Care Patients (Adjusted for Patient Mix)**

	<i>Home Care Hospice</i>	<i>Hospital-Based Hospice</i>	<i>Conventional Care</i>
Last month	\$ 61	\$ 37	\$184
Second-last	90	77	165
Third-last	105	103	167
Fourth-last	113	127	127
Fifth-last	124	125	132
Sixth-last	133	142	147

costly service for a more costly one. The hospice philosophy advocates that the pattern of care be palliative even when the patient is in an inpatient setting. Palliative interventions are more labor intensive but may be less intensive in the use of expensive ancillary services. Table 4 presents the average ancillary cost per inpatient day for members of the three samples with inpatient stays during each of the last 6 months of their lives, adjusted for the mix of patients in the three samples. As can be seen, the relative intensity of an inpatient day experienced by hospice patients decreases substantially as death approaches, while the opposite is true of the CC patient. Thus, not only are CC patients more likely to have more days of inpatient care, but, as death approaches, the costliness of those days increases.

Recognizing that two forms of substitution appear to be operating in achieving the marked differences in costs observed for the last month of life between hospice and conventional care patients, we attempted to isolate that process while differentiating between those trends in utilization patterns that existed before hospice admission and those potentially attributable to the hospice model of care. Table 5 presents the ancillary costs per inpatient day, inpatient days per week, and home care hours per week for hospice patients admitted between 30 and 59 days before death for the months preceding hospice admission and for the last month of "pure" hospice. The table details pre-hospice utilization back to the period 1 year preceding the patients' deaths. While some preexisting difference exists in the propensity of hospice patients to use home care before admission to hospice, their level of use of inpatient care is comparable to that of the CC patients in the third through twelfth months. Use of ancillary services does appear to drop for both HC and HB patients in the month prior to hospice entry just at the time that CC patients' use of ancillary services intensifies. This

Table 5: Ancillary Cost per Day, Inpatient Days per Week, and Home Hours per Week for Hospice Patients, Length of Stay 30-59 Days, and Conventional Care Patients (Adjusted for Patient Mix)

Days Before Death	Home Care Hospice (N = 1,100)			Hospital-Based Hospice (N = 403)			Conventional Care (N = 558)		
	Ancillary Costs/ Inpt. Day	Inpt. Days/ Week	Home Care Hr./Week	Ancillary Costs/ Inpt. Day	Inpt. Days/ Week	Home Care Hr./Week	Ancillary Costs/ Inpt. Day	Inpt. Days/ Week	Home Care Hr./Week
0-29	\$ 98	1.24	11.12	\$ 67	1.92	7.23	\$184	4.10	.44
Entry	-	-	-	-	-	-	165	1.76	.41
60-89	127	1.21	.42	127	1.33	.66	167	.73	.23
90-119	132	.68	.20	152	1.01	.28	127	.55	.18
120-149	121	.53	.18	144	.77	.17	132	.42	.15
150-179	121	.43	.14	159	.37	.14	147	.51	.11
180-209	130	.46	.14	145	.38	.14	142	.46	.09
210-239	135	.37	.07	163	.52	.24	116	.40	.10
240-364	132	.22	.04	148	.33	.13	137	.30	.08

may reflect a decision-making process that occurs as patients and their families debate the appropriate treatment modality. It is the CC sample's use of ancillaries that appears to change substantially at this juncture. Why these prehospice cohorts did not follow suit before entering hospice could reflect subtle preexisting differences in their orientation toward health care.

#### ESTIMATING HOSPICE SAVINGS

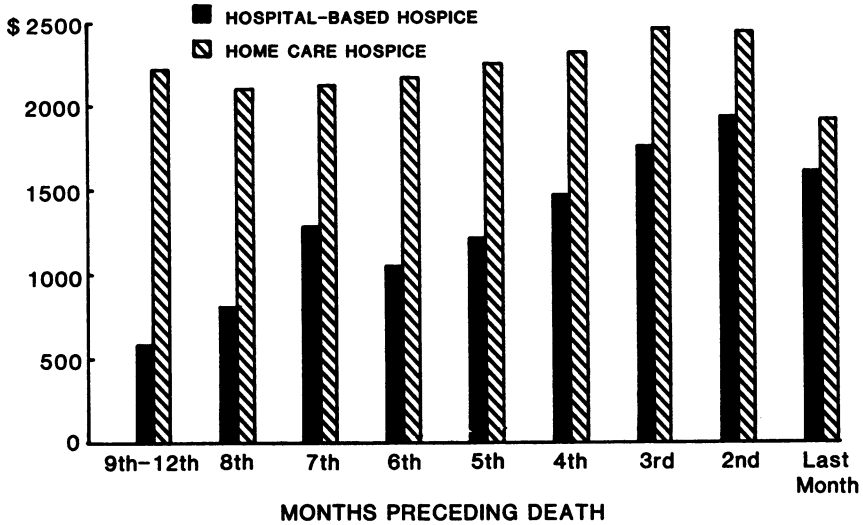
The data presented above reveal that hospice patients are consistently less costly than are CC patients during the last month of life. The longer that patients remain in hospice, however, the more likely it is that any differences in hospice versus CC costs will be offset by increased costs in earlier months. There has also been some indication that hospice patients had different styles of health service utilization than CC patients even before their entry into hospice. If observed cost differences are largely attributable to a predisposition to utilize medical care, then the case for a hospice effect on total health care costs is weakened. Consequently, we compared cohorts of hospice patients with varying lengths of hospice stay to conventional care patients' costs in order to identify where savings, if any, and additional costs occurred. We then accumulated savings and costs under relatively conservative assumptions to arrive at a "net" hospice effect in the last year of life.

Despite the high costs associated with the entry of patients into hospice relatively early in the course of the terminal phase of their disease, the size of the cost differences in the last month or two before death more than make up for the extra costs of extended stay in hospice. Figure 1 reveals that the hospice savings accumulated in the first month for HC patients persist and are even increased somewhat over the last year of life. Based upon the conservative estimates employed and adjusting for the mix of patients and the length of stay distribution observed in this study of HC patients, there is a per patient savings of \$2,221 in the last year of life. The initial savings observed in the HB setting are considerably reduced to the point that the per patient savings for the last year of life for HB patients is only \$585, out of over \$12,000 in total costs.

#### DISCUSSION

We have seen that hospice patients in both the HB and the HC setting are less costly than their CC counterparts, particularly in the last

Figure 1: Cumulative Savings Associated with Hospice Relative to Conventional Care Costs over the Last Year of Life



months of life and overall in the last year of life. The ostensible mechanism for this difference in costs is via the substitution of home care services for inpatient care and, equally important, a relative reduction in the intensity of ancillary service use when in an inpatient setting. We are confident of these findings insofar as the assumptions behind the cost calculations were conservatively weighted toward relatively higher hospice costs; routine hospice costs were assumed to be 16 percent higher than hospital routine costs, and home care hospice costs were loaded to include more intensive case management [14], bereavement counseling, and other services not available under the regular Medicare program.

On the other hand, there is reason to believe that some of the observed differences in costs reflect the different styles of health care utilization of the three groups of patients being compared. Hospice admission may be partially a manifestation of earlier choices made about the style of care desired. As such, observed differences in cost cannot be unequivocally attributed to the hospice model of care; rather, the differences may be a function of the choice to seek a match between desires and treatment modality.

Despite the potential confounding factors that serve to qualify the

meaningfulness of the findings, we have shown that savings in the last month of life are large and statistically significant across both types of hospice settings. While patients with longer stays added costs in both hospice settings, the fact remains that most patients in the hospice program were less expensive to care for. Was hospice a less costly method of care for terminally ill cancer patients under the demonstration, or was it merely able to attract individuals prone to low utilization? Despite the ambiguities we have noted in our findings, we believe that a pure hospice effect did operate. While we cannot determine the precise size of this effect due to the limitations of the study design, we believe it is not dissimilar to that presented in Figure 1.

Moving from a discussion of cost savings to one focusing upon the cost-effectiveness of the hospice intervention requires knowledge that the hospice and conventional models of terminal care yield similar results with respect to patient outcomes. The multisite National Hospice Study and results of a single-site randomized clinical trial concur in the finding that hospice has no negative consequences on the quality of life of patients, on the symptoms experienced, or on their survival [4, 15]. If anything, both studies found small but significant benefits in the area of patient satisfaction, and, in our study, small benefits in favor of the HB hospice model in pain and symptom management. Since in no case was hospice harmful or more costly, we can conclude that hospice is a cost-effective alternative to conventional care for terminally ill cancer patients.

It must be emphasized, however, that any estimates of the size of the hospice effect on reduced per patient health care costs is highly sensitive to the length-of-stay distribution. The higher the proportion of long-stay patients, the lower the savings will be. The applicability of our findings to the current and future Medicare hospice program may be somewhat limited. As has been described elsewhere [7], the Tax Equity and Fiscal Responsibility Act and its associated regulations differ substantially from the conditions that prevailed under the demonstration. If hospice follows the well-worn path of health care systems by becoming an "industry," the commitment, integrity, and restraint that was observed in the demonstration may diminish. New provider types and institutional arrangements may differ markedly from patterns observed to date. Already over 3 percent of the estimated 1,100-plus hospices reported to be operating in the United States today are proprietary, and the percentage of hospices operating out of a nursing home base is also apparently increasing [16]. Since estimates of cost savings are so sensitive to length of stay, any shifts in time of entry into

hospice or in the mix of patients being admitted could also affect the future cost-effectiveness of hospice.

Over the coming years, the Health Care Financing Administration is charged with continuing to monitor the costs of hospice under the Medicare benefit. The authorizing legislation contains a "sunset" provision which will be invoked unless Congress acts to renew the law. The decision of Congress will be facilitated by an evaluation of the effects of the current benefit structure, as mandated by the legislation. It may be wise to withhold the final judgment about cost savings in hospice until such time as we have seen the implications of the current benefit on the growth of hospice providers and the cost of serving terminal cancer patients in the United States.

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