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Is It Better to Die in America or in England?

By EZEKIEL J. EMANUEL and JUSTIN E. BEKELMAN JAN. 19, 2016

WE frequently hear complaints about how people near the end of life are treated in America. Patients are attached to tubes and machines and subjected to too many invasive procedures. Death occurs too frequently in the hospital, rather than at home, where the dying can be surrounded by loved ones. And it is way too expensive. Each year, the care of dying seniors consumes over 25 percent of Medicare expenditures.

Death in America is frequently compared unfavorably with death in other countries, where people may not be as focused on extending life with every possible intervention. As Ian Morrison, the former president of the Institute for the Future, once wrote: “The Scots see death as imminent. Canadians see death as inevitable. And Californians see death as optional.” He added, “Americans and the American health care system are uncomfortable with the inevitability of mortality.”

But is it actually true that end-of-life care in America is more invasive and expensive than in other countries?

We just published in the Journal of the American Medical Association the first systematic international comparison of end-of-life care for patients dying with cancer. We focused on cancer because, in developed countries, it is the second leading cause of death and the most expensive per patient. The good news is that, despite perceptions, the United States is actually not the worst when it comes to caring for these patients. In fact, on some important measures, we provide the best in end-of-life care.

We found that in 2010, the most recent year with available data, just 22 percent of Americans dying with cancer died in the hospital, a lower rate than in Canada, England, Norway, the Netherlands, Belgium and Germany, the six other nations we studied. (If we include patients dying in skilled nursing facilities, the rate rises but is still under 30 percent.) Similarly, in the last six months of life, Americans spent the fewest days in the hospital, on average about a week and a half, compared with nearly four weeks in some other countries.

In Canada, 52 percent of patients with cancer died in the hospital, and in the last six months of life, nearly 90 percent were admitted to the hospital for an average of around three weeks.

But in other areas, the United States doesn't look so good. Take admissions to the intensive care unit. In 2010, over 40 percent of Americans dying with cancer were admitted to the I.C.U. in the last six months of life — more than double any of the other countries we studied. On average, Americans dying with cancer spent twice as many days in the I.C.U. as patients from any other country.

Similarly, Americans received more chemotherapy near the end of life, even though research shows that it may not improve the quality or length of life at that point. In their last six months, nearly 40 percent of Americans received at least one episode of chemotherapy. Only Belgium came close to this figure, at 33 percent.

Perhaps most surprising, America was not the most expensive country in which to die. On average, \$21,840 was spent on the last six months of hospital-related care for dying cancer patients in Canada and \$19,783 in Norway. In the United States, the bill was \$18,500 per patient. (That figure does not include physician costs, which are part of hospital spending in other nations. Including them brings America's costs up by about 10 percent, leaving us still below Canada and about equal with Norway.)

So what can be learned from our study? First, all countries have room to improve. In the United States, the next step needs to be empowering patients to make realistic choices that are consistent with their hopes for how they want to live near the end of life and where they want to die. This means having candid conversations about when chemotherapy or I.C.U. admissions are no longer helpful, and increasing palliative care, which has been shown to improve both the

quality and length of life. This can best be achieved by making access to palliative care the default, instead of just an option, for all patients with advanced and incurable cancer.

Our study also has implications for cost control. It shows that **end-of-life care is not the main contributor to higher health care costs in the United States**; some countries with considerably lower overall costs still spend more on end-of-life care. So as the nation works to slow the growth of American health care spending, the focus should be less on reducing end-of-life spending and more on moving away from fee-for-service medicine, which incentivizes more care rather than better care.

Last, and most important, there is a reason for hope. While the process has been slow, the United States has improved care at the end of life. In the mid-1980s, more than 70 percent of American patients who died with cancer did so in the hospital. We have cut that number by over two-thirds. And the use of chemotherapy near the end of life, while still high, is also lower than in the past. Interestingly, the trends we observed suggest improvement in what the United States does well, but also some worsening in using the I.C.U. more.

But we can and should do better. **We should start by providing universal access to the highest-quality palliative care as the default for all Americans near the end of life.**

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