Supply of hospice services strongly associated with local area's median household income

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Wealth, population size, race and age associate with the supply of hospice care available in a county, according to a study published in the *Journal of Pain and Symptom Management* this month.

Local availability is an important predictor of use of hospice programs, which are end-of-life services that have been shown to improve pain control, maintain patients' independence and even extend life, says lead author Maria Silveira, M.D., M.P.H., of the Veterans Affairs Ann Arbor Healthcare System and assistant professor in the Department of Internal Medicine at the University of Michigan.

This study is the first to examine geographic variation in the supply of hospice services and its association with community wealth.

The researchers found that for every $1,000 increase in median household income in a county, the supply of hospice services increased by 3 percent.

Hospice supply also was larger in counties with larger populations, more African Americans and people over the age of 65.

But hospice supply decreased in larger geographic counties and those with more Hispanic residents.

More research is needed, says Silveira and her co-authors, but these study results indicate the traditional model for structuring and financing

hospice needs to be re-designed. The building of community hospices is often funded through charity and this is one possible explanation for the disparities seen in the study.

"Wealthy communities can afford large amounts of charitable giving and thus have the resources to build local hospices; whereas poorer communities may not be able to donate in the amounts necessary to do the same," says Silveira.

While the amount of hospice use has increased tremendously in the last twenty years, most Americans die without using hospice care. In 2002, only 28.6 percent of Medicare beneficiaries who died had enrolled in hospice.

To improve the feasibility of hospice in poorer communities, Silveira and her co-authors suggest that Medicare provide assistance or incentives for building hospices in poorer communities, in addition to making sure that reimbursement for hospice services match its cost.

"Since most hospice care in the US is paid for with public funds via Medicare- the government has a responsibility to ensure that access to hospice is equitable," says Silveira.

Silveira and her co-authors stressed that more research is needed to find out how patient preferences Influence access to hospice by underserved communities.

"The relationship between community affluence and supply of hospice services could reflect community values about hospice and indicate that hospice, as a business, merely follows the demand for its services," Silveira says.

"Given the tremendous, proven benefit of hospice programs, supply of

these services needs ongoing study."

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