

# End of life care for cancer patients differs in US and Canada

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In the United States, older patients with advanced lung cancer make much less use of hospital and emergency room services at the end of life than their counterparts in Ontario but use far more chemotherapy, according to a study published May 18th online in the *Journal of the National Cancer Institute*.

Government-financed health care covers elderly patients in both Canada and the U.S., but coverage at the end of life differs. In the U.S., Medicare covers [hospice care](#) for qualified patients. Ontario, the most populous Canadian province, has no hospice program comparable to what exists in the U.S. but provides palliative care through inpatient acute care units, outpatient services and home health care.

To compare end-of-life care between the two systems, Joan L. Warren, Ph.D., of the National Cancer Institute and colleagues used U. S. Surveillance, Epidemiology, and End Results (SEER)-Medicare data and data from the Ontario Cancer Registry. They identified patients age 65 and older who died with non-small cell lung cancer (NSCLC) during 1999-2003 and reviewed [health claims](#) from their last 5 months of life to collect data on chemotherapy, emergency room use, hospitalizations, and supportive care in both short-term (less than 6 months) and longer-term (6 months or more) survivors.

Patients in both countries used health-care services extensively, particularly in the last month of life. Ontario patients had [hospital admissions](#) and used emergency room services at rates that were

statistically significantly greater than those of U.S. patients. More than twice as many Ontario patients died in hospital (e.g., 48.5% of short-term survivors compared to 20.4% in the U.S.) even though a majority of Ontario patients have reported that they would prefer to die at home. In each of the last 5 months, chemotherapy rates were statistically significantly higher among SEER-Medicare patients than among the Ontario patients.

The authors note that these findings partly support the commonly held view that U.S. physicians have a more aggressive attitude toward treatment and that patients in the U.S. tend to receive more intensive [health-care services](#). However, U.S. patients can enroll in hospice services, an option not readily available in Ontario. The authors conclude that the lack of hospice services contributes to higher rates of hospital and [emergency room](#) visits and in-hospital deaths among Ontario patients.

The findings, they write, "will inform health planners and policy makers in each country regarding current patterns of end-of-life care and where there may be opportunities for changing practice patterns or programs."

In an editorial, David Goodman, M.D., of the Dartmouth Institute for Health Policy and Clinical Practice, notes that end-of-life care varies not only between the U.S. and Ontario, but also from region to region within the U.S. and Canada. Even more important, he writes, patient preferences varies from one individual to another and these preferences are often unheard: "Quality in end-of-life care will continue to elude us if we assume that societal average preferences indicate the care individual patients want and need," he writes.

Goodman argues that the best care at the end of life is care in which the patient participates in the decision-making. "The solution...is not to blindly drive systems towards greater use of hospice and palliative care

services. It is to improve decision quality so that [patients](#) can make an informed choice with an understanding of the patient experiences associated with active curative care, with supportive care, or with concurrent [palliative and curative] care."

Provided by Journal of the National Cancer Institute

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