Summary

Hospice at home: effectiveness, cost-effectiveness, and budget impact in Estonia

Objective
Home based hospice care is a part of palliative care that supports patients in the final phase of an incurable illness. This report aims to evaluate the effectiveness, cost-effectiveness, and budget impact of hospice at home (HH) in Estonia and provide recommendations for its implementation.

Methodology
A review of international practices revealed variability in the organization of HH. While clinical guidelines do not explicitly separate home-based hospice care from inpatient hospice care, in many countries it is a standard option. Patients are typically referred based on estimated life expectancy (commonly three to six months) regardless of diagnosis. Hospice care teams include nurses, physicians, chaplains, and other specialists. Services focus on symptom relief, especially pain management, and may include support for family members. Data from Viljandi Hospital and Estonian Health Insurance Fund (EHIF) were used for the cost-minimisation analysis (CMA), which considered two scenarios with different assumptions about service days and resource use.

Results
In Estonia, HH has been provided by Viljandi Hospital since January 2023, serving nearly 50 patients, mainly with oncological conditions. There is limited research comparing the effectiveness of home-based versus inpatient hospice care. A systematic review and one longitudinal study suggest that HH significantly increases the likelihood of dying at home. However, results are inconclusive regarding other outcomes like reduced hospitalizations or patient and carer satisfaction levels. No cost-effectiveness analyses were found in the literature, but one study exploring costs, indicated significantly lower healthcare costs in the last month of life for patients in HH, mainly due to shorter hospital stays. According to the CMA in this report, inpatient hospice care costs 177.67 euros per day per patient, while home-based care costs 41.04 and 96.50 euros per day under the two scenarios. Although HH patients had slightly longer average hospital stays (21 vs. 18 days), the total cost remained lower—by 62% and 26%, respectively. The main cost drivers were accommodation and personnel expenses. Budget impact estimates show potential annual savings for EHIF ranging from €49,678 to €482,241 depending on the share of hospice patients in home-based care (5%–20%) and costing scenario. However, wider availability may increase demand for hospice care overall.

Conclusions
HH significantly increases the likelihood of dying at home (low-quality evidence). CMA based on Estonian data, showed that HH had lower total costs than inpatient hospice care and budget impact analysis revealed a possibility of savings.

In Estonia, similar reimbursement models, quality standards, and implementation conditions should be applied to HH as those used for inpatient hospice care. A national guideline should be developed, and indications for HH—such as expected life expectancy—should be clearly defined. Consent from patients and/or their families is essential, and attention must be paid to supporting family caregivers. In the future, however, the overall concept of hospice care in Estonia should be re-evaluated, potentially shifting more focus towards supporting family caregivers, as seen in other countries.

Citation: Põld M, Koiduaru K, Nohrin LC, Oras K, Hinno S, Jürisson M. Kodune hospiitsravi: efektiivsus, kulutõhusus ja eelarve mõju Eestis, tervisetehnoloogia hindamise raport TTH76. Tartu: Tartu Ülikooli peremeditsiini ja rahvatervishoiu instituut; 2025.