COUNTRY REPORTS

AM

United States

General data

POPULATION, 2024
340,110,988

SURFACE KM², 2022
9,831,510

PHYSICIANS/1000 INH, 2021
3.61

NURSES/1000 INH, 2021-2022
11.88

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
17

GDP PER CAPITA (US$), 2023
82,769.41

HEALTH EXPENDITURE PER CAPITA (US$), 2021
12,012.24

UNIVERSAL HEALTH COVERAGE, 2021
86

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

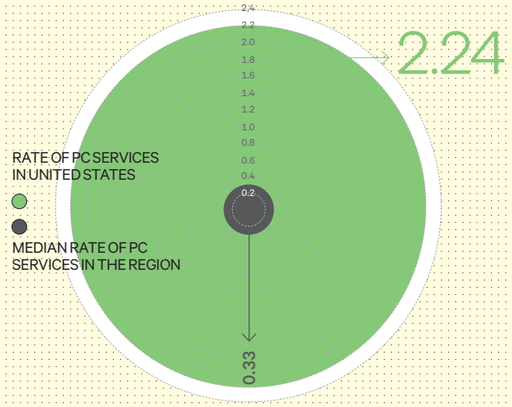
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

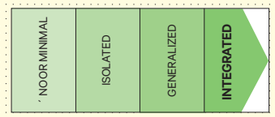
Total number of Specialized PC services: **7,627**

Rate of PC services per 100,000 inhabitants: **2.24**

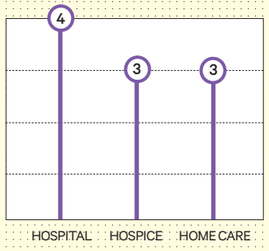
United States in the context of the region



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

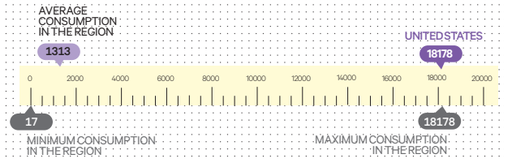
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 3

TOTAL NUMBER: **120**

Ⓓ Use of essential medicines

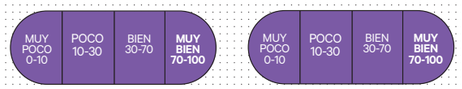
Opioids consumption (excluding methadone): **18,178** S-DDD/MILL INHABITANTS/DAY

United States in the context of the region



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level



Ⓒ Research

PC-related research articles: 4

Existence of PC congresses or scientific meetings: 4

Consultants: Stephen Connor, Sean Morrison, Kristina Newport.

National Association: National Hospice and PC Organization, American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, Center to Advance PC, National PC Research Center.

Data collected: October 2024 - December 2024

Report validated by consultants: Yes

Endorsed by National PC Association: No

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: –

Nursing schools with mandatory PC teaching: –

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 2

Inclusion of PC in the basic health package at the primary care level: 4

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 4

Advanced care planning-related policies: 4

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People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

4

Strong national and sub-national presence of palliative care advocacy and promoting patient rights (as a professional association of Palliative Care, i.e.).

Since the 1970s, the United States (U.S.) has had a strong presence of PC advocacy organizations. Key organizations include the NHPCO, AAHPM, HPNA, the Center to Advance PC, the National PC Research Center, and the American Cancer Society, along with state-level hospice and PC organizations across all 50 states. Pediatric PC is also well-represented through organizations like Children's PC International and NHPCO ChiPPS. Additionally, the National Coalition of Hospice and PC, which comprises 14 leading advocacy organizations, and the Patient Quality of Life Coalition work to promote the rights of patients in need of PC, caregivers, and disease survivors at the national, state, and local levels.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

4

There is a national policy on advance care planning.

In the United States (U.S.), medical care is primarily the responsibility of individual states. All 50 states have legislation and policies ACP, with legally recognized forms. The NHPCO Caring Info program facilitates access to these legal forms for each state. While the process is well established, challenges remain regarding compliance among healthcare providers. At the national level, ACP is guided by ACP Guidelines, the National POLST Collaborative, and CPT codes for advance care planning, which serve as official policies supporting its implementation.

Policies

Ind 3

3.1. There is a current national PC plan, program , policy, or strategy.

1

Not known or does not exist.

There is no overarching national PC strategy in the U.S., but hospice care is integrated into federal programs like Medicare and Medicaid Hospice Benefits. CMS has dedicated staff for hospice policy and oversight, while HHS lacks an overall mandate for PC. Private insurance generally covers hospice at Medicare/Medicaid levels, and most uninsured patients qualify for Medicaid when they need hospice. Additionally, national plans for Cancer, HIV, and Non-Communicable Diseases (NCDs) include PC. While CMS regulates hospice care, there is no unified national strategy for broader PC services. The Hospice Compare system helps consumers assess providers, and each state licenses hospices under federal conditions of participation. Despite this, more people receive PC through hospice benefits in the U.S. than anywhere else. Despite the lack of a formal national strategy, more people receive PC through hospice benefits in the U.S. than in any other country.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

Not known or does not exist neither standalone nor is included in another national plan.

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Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

4

Palliative care is included in the list of health services provided at the primary care level in the General Health Law.

While PC is often delivered at the primary care level in the U.S., it is not explicitly mandated under federal law. There are no national policies requiring its integration into primary care services, even though PC is recognized both as a specialty and as part of generalist care. Hospice care is covered through Medicare and Medicaid, and insured patients can access palliative support, with children eligible for both curative and hospice services simultaneously. However, PC is not formally incorporated into the U.S. primary care framework as a required or standardized service.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

2

The authority for palliative care is defined but only at the political level (without a coordinating entity defined).

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

The U.S. lacks a clearly defined national authority for PC, though some coordinating entities exist. However, these lack a dedicated scientific or technical division, making the structure incomplete. The Department of Health and Human Services (HHS), through CMS, ensures Medicare and Medicaid hospice benefits for eligible patients, but no national authority is solely dedicated to PC. An interagency task force exists for hospice, but PC remains partially integrated. The hospice benefit, covering patients with a prognosis under six months who forgo curative treatment, often leads to late referrals. Non-hospice PC is available in most hospitals, but no standardized federal benefit package exists. The system prioritizes hospice over comprehensive PC, and while policies and funding exist, there is no coordinated national strategy. In 2023, the U.S. Senate allocated 2024 funds to the National Institute on Aging (NIA) for a nationwide PC research initiative. The NIH will establish a multi-Institute and multi-Center program to expand research, training, and implementation efforts.

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Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC .

4

At least one national conference specifically dedicated to palliative care every 3 years - At least one national conference specifically dedicated to palliative care every 3 years.

The U.S. hosts multiple national, regional, and state conferences on PC annually. Major national events include: Annual Assembly of Hospice and Palliative Care, hosted by AAHPM and the Hospice and Palliative Nurses Association; State of the Science in Hospice and Palliative Care Conference, held every two years by AAHPM; Additional conferences organized by NHPCO, state associations, and events focused on pediatric PC and volunteer initiatives. These conferences ensure ongoing scientific exchange and professional development in PC across the country.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

4

Denotes an extensive number of articles published on the subject.

The U.S. has a high volume of peer-reviewed publications on PC, with numerous articles, books, and reports. Key journals include: Journal of Pain and Symptom Management (AAHPM Journal) Journal of Palliative Medicine (HPNA Journal). Other peer-reviewed journals that either focus on or regularly include PC content. This reflects a strong research presence in PC within the U.S. academic and clinical communities

Medicines

Ind 8

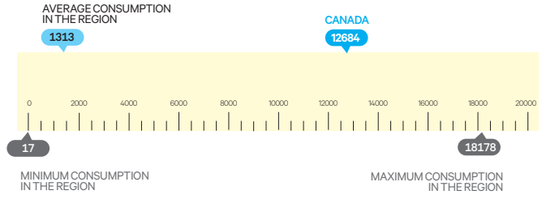
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day.

18,178

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



AM United States

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

In urban areas, access to pain and PC medications is high (90–100%). All essential PC medicines listed in the WHO Model List of Essential Medicines can be prescribed at the outpatient level in the U.S. by any licensed physician registered with the DEA. Opioid access has been restricted for patients outside PC, hospice, or end-of-life care, though recent regulatory changes have eased some restrictions for chronic pain patients unresponsive to non-opioid treatments. In rural areas, availability of PC medications is lower but still significant (70–80%). Most rural residents live within an hour of a Level III or higher hospital or emergency department, ensuring pain management access. However, remote and frontier regions (e.g., Alaska's North Slope or Texas' Big Bend) have limited facilities, impacting access to medications. Pharmacies play a crucial role in dispensing opioids at the primary care level, helping maintain broad access to essential pain medications in both urban and rural areas.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

4

Very good: Between 70% to 100%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

4

Very good: Between 70% to 100%.

In rural areas of the U.S., the availability of immediate-release oral morphine (liquid or tablet) depends on the type of healthcare facility. If Level III (or higher) hospitals and emergency departments are included, availability remains high (70-100%). However, most primary care clinics do not stock or dispense opioids, as these medications are typically obtained through pharmacies rather than clinics. Due to the structure of the U.S. healthcare system, opioids are not commonly stored in primary care clinics, and prescribing is regulated through state-level prescription drug monitoring programs. Consequently, the interpretation of "primary care level" affects reported availability, as hospitals and pharmacies ensure access, while standalone clinics typically do not dispense opioids.

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Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	N/A	Most recent data are 10 years old. A minority of U.S. medical schools require formal training in PC, though most include PC topics within broader courses. The LCME, which accredits U.S. medical schools, does not mandate dedicated palliative medicine or end-of-life care courses or rotations. The Palliative Care and Hospice Education and Training Act, a pending bill in Congress, aims to increase faculty training in PC across medical, nursing, and social work schools. While end-of-life care is mandated in some form, implementation varies widely. No reliable survey data exist on how many schools offer optional PC education. Most nursing schools in the U.S. do not require a PC curriculum. There is no federal mandate for PC education in medical or nursing schools, though end-of-life care is variably required. The AACN includes PC as one of the four essential nursing domains, but it is unclear how many programs require it. Betty Ferrell notes 1,260 undergrad and 450 grad nursing schools use the ELNEC curriculum, though it's not confirmed as mandatory.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	N/A	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	N/A	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	N/A	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognised by the competent authority in the country.	4 — Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.	The American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME) formally recognized Hospice and Palliative Medicine as a medical subspecialty in 2006. The American Osteopathic Association (AOA) followed in 2007. To become certified, physicians must complete a one-year fellowship in palliative medicine and pass the initial certification exam, which was first offered in 2008. Certified physicians must maintain their certification through continuing education and assessments.

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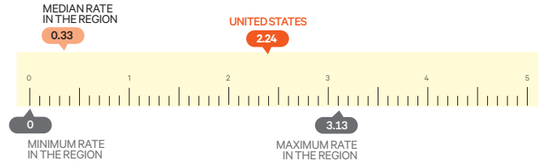
Provision of PC / Specialized Services

Ind 13

13.1. There is a system of Specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	4 — Are part of most/all hospitals in some form.	The United States U.S. has a well-established system of specialized PC services with broad geographic reach and multiple delivery platforms. These are integrated into hospitals, free-standing hospices, and home care teams, though gaps remain. Hospital-Based PC: PC teams are available in most hospitals—94% of those with at least 300 beds and 72% with at least 50 beds offer PC services. Free-Standing Hospices: Widely available across the country, though access may be limited in certain regions. Home-Based PC: Specialized home care teams exist but vary in availability, with more structured services in urban and well-resourced areas than in rural or underserved regions. Total Estimated PC Services: As of 2022, there were 5,899 Medicare-certified hospices. Estimates add at least 1,728 hospital-based PC teams, totaling approximately 7,627 specialized PC services nationwide. While PC services are broadly available, integration, accessibility, and scope differ significantly between urban and rural areas.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	4 — Are part of most/all hospitals in some form.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	3 — Found in many parts of the country.	
13.4. HOME CARE teams (Specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	3 — Found in many parts of the country.	
13.5. Total number of Specialized PC services or teams in the country.	7,627 — SPECIALIZED PALLIATIVE CARE SERVICES	

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of Specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	3 — Generalized provision: palliative care specialized services or teams for children exist in many parts of the country but with some gaps.	The U.S. has an established system of specialized PPC services, but gaps remain in accessibility and distribution. These services are primarily concentrated in large pediatric academic medical centers, with fewer options in rural areas, where telemedicine helps bridge access. Hospital-Based PPC: 80% (119 of 148) children's hospitals offer a PPC program. Standalone Pediatric Hospices: There are three purpose-built children's hospices (George Mark, Ryan House, Crescent Cove) and at least three adult hospices with designated pediatric beds (Ladybug House, 2 VIA Health Partners). Adult Hospices Serving Children: Some adult hospices provide PC for children, though their exact number is not well documented. Rural and Remote Areas: Families face longer travel distances and often rely on telemedicine for PPC support.
14.2. Number of pediatric Specialized PC services or teams in the country.	120 — PPC TEAMS	