3 August 20120

Mr Peter Dowling MP
Chair, Health and Community Services Committee
Parliament House
George Street
Brisbane QLD 4000
Email: hcsc@parliament.qld.gov.au

Submission 22

Dear Mr Dowling,

Palliative care services and home and community care services inquiry

Thank you for your recent invitation to make a submission to the Health and Community Services Committee's Inquiry into palliative and home and community care services.

The Australian Health & Hospitals Association is the peak body and advocate for the Australian public healthcare and Not-For-Profit sectors.

Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, universities, and individual health professionals and academics. We are uniquely placed to be an independent, national voice for universally accessible, high quality healthcare.

In responding to the Inquiry's Terms of Reference, the AHHA particularly wishes to address its comments to the issue of palliative care. This submission provides:

- some introductory and contextual comments;
- an example of best practice in community palliative care service delivery – the services provided by the Silver Chain Group in Western Australia;
- a brief outline of barriers to reform in palliative care, which currently inhibit best practice models of service delivery being adopted more broadly;
- a brief outline of current opportunities, including those provided by national health reform.

I would be pleased to respond to any queries.

Yours sincerely

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Palliative care services and home and community care services inquiry

1. Introduction and context

The AHHA supports a view of palliative care which:

- affirms life and treats dying as a normal process;
- neither hastens nor postpones death;
- provides relief from pain and other distressing symptoms;
- integrates the physical, psychological, social, emotional and spiritual aspects of care, with coordinated assessment and management of each person's needs;
- offers a support system to help people live as actively as possible until death; and
- offers a support system to help the family cope during the person's illness and in their own bereavement.[1]

Palliative care conceived in this way requires delivery by a multi-disciplinary team which may include specialist medical, nursing and allied health providers; GPs and other general primary health care professionals; and support staff, including people who provide practical support with daily living, as well as emotional and spiritual support including to family members of the person who is dying.[2]

Traditionally, palliative care was provided in hospitals and hospice settings. Now, palliative care is provided in a range of settings, including hospitals and hospices but also including community-based settings (such as nursing homes), as well as in the home.

While palliative care can be provided to people of all ages, demand for palliative care will increase as Australia's population ages, and more people are living longer with terminal illnesses.

The majority of people with terminal illness – some 70-75 per cent of them – want to die at home, yet most will die in inpatient facilities.[3]

In AHHA's view, this is the critical issue to consider in planning for palliative care service provision into the future: that is, how best to meet increasing demand for palliative care services, in a manner which best responds to the needs and wishes of people with terminal illness – to provide quality care at the end of life, and in so doing, demonstrate our society's value for the worth and dignity of every human being, at all stages of life.[4]

2. An example of best practice: Silver Chain

Silver Chain, a member organisation of the AHHA, is one of the largest in-home health and care providers in Australia. The services provided by the Silver Chain Group include specialist nursing, palliative care, home care and support services, home hospital and home therapy/allied services, such as physiotherapy, podiatry and speech pathology.[5]

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[1] Department of Health and Ageing website.

[2] Department of Health and Ageing website.

[3] Silver Chain, *Submission to the Senate Standing Committee on Community Affairs' Inquiry into Palliative Care in Australia*, March 2012, p.3.

[4] Palliative Care Australia website. The Governor-General, Her Excellency Ms Quentin Bryce AC, Patron of Palliative Care Australia, has said, "I see palliative care as an assurance to our society, at the deepest level, that we are honouring our value for the worth and dignity of every human being".

[5] Silver Chain website.

Silver Chain's Hospice Care Service in Western Australia, delivered through an interdisciplinary team consisting of specialist nurses, medical consultants, registrars, general practitioners, allied health professionals, care aides, and volunteers, is one of Australia's largest providers of specialist community palliative care services. It is widely regarded as a best practice model of specialist community palliative care provision.

The service 'admits' approximately 3,000 people annually, with more than 660 people receiving care on any given day, and an average 'length of stay' of 84 days. In Silver Chain's community palliative care service:

- sixty per cent of clients are supported to die at home (compared to the national average of 25-30 per cent);
- the majority of those who died at home (60%) had no hospital admissions during their episode of care with the service, and a further 28% had only one admission. In comparison, in a study published in the Medical Journal of Australia (2011) examining hospital and emergency department use in a comparable cohort of people, the mean number of admissions was 7.8, with the majority of these occurring in the last 3-4 months of life;[6]
- clients were 7 times more likely to die in their own home compared with general population;[7]
- client satisfaction is at 98%.

Silver Chain's service model is guided by the following principles:

- Build capacity within families to care for their own;
- Integration and service coordination;
- Interdisciplinary care planning;
- Evidence-based, client-centred care.

Silver Chain has taken a population based approach in development of its community palliative care model, together with an understanding of differing care pathways that are responsive to the needs of specific populations – with enhanced integration of services within Silver Chain to meet the needs of people with malignant and non-malignant disease. This is coupled with a workforce with skills and capabilities to meet community expectations of safe and quality care.

Silver Chain's model of care increases the provision of palliative care delivered in the home and create a shift from unnecessary and undesirable admission to acute care.

3. Barriers to reform

While Silver Chains palliative care service provides an example of palliative care being done well, there are many barriers to the adoption of best practice models of palliative care provision – and as a result, considerable inequities in access to palliative care across Australia. Some of these barriers are briefly outlined here.

Funding

There is an inequitable and haphazard approach to the funding of community palliative care service provision across the country. The outcomes that our communities want, and indeed expect of us – to be well supported and cared for at home – are at odds with how the resources are currently distributed. The provision of resources for community palliative care that are provided at a whole of population level can vary significantly.

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[6] Silver Chain, *Submission to the Senate Standing Committee on Community Affairs' Inquiry into Palliative Care in Australia,* March 2012, p.3; Rosenwax, L et al (2011): Hospital and emergency department use in the last year of life: a baseline for future modifications to end of life care. *Medical Journal of Australia,* Vol.194 No.11.

[7] Silver Chain, *Submission to the Senate Standing Committee on Community Affairs' Inquiry into Palliative Care in Australia,* March 2012, p.3; McNamara, B and Rosenwax, L (2007): Factors affecting place of death in Western Australia. *Health and Place,* 13: 356-367.

Inpatient facility capacity

Our communities require the provision of appropriately resourced palliative care beds to specifically meet the complex needs of people who are unable to be supported at home. But, how many beds does a community require? Resources to support the palliative care sector will always be limited. We need to be prudent in our allocation. Where there is not an adequately resourced community service, there is of course a greater requirement for more beds to address the unmet palliative care needs in the community.

Governance concerns

The issue of quality and safety in a community sector is a pervading concern to traditional inpatient service clinicians concerning clinical governance around complex care. Indeed, community centric services are more satisfying to clients, provide safer outcomes, and are more connected to other support services in the environment in which they operate.

The clinical governance delivered by the community clinical provider occurs within the context of the broader governance role, which includes financial and corporate functions, setting strategic direction, managing risk, improving performance and ensuring compliance with statutory requirements.

Large scale community models of care

The community infrastructure currently in place to provide palliative care services across Australia is as broad and diverse as the country itself. Whilst many services have developed in response to local community need, most have not been specifically designed in accord with a population based approach at the service level. Large scale models of care are required to enable coverage, quality, engagement, integration, and good governance – all 24/7.

4. Opportunities – national health reform

While there are currently many barriers to more widespread adoption of best practice models of community palliative care, the current reform environment presents some important opportunities.

The federal Government's $1.6 billion sub-acute care package, for example, included funding for additional palliative care services in some areas – a recognition of the importance of this area of service provision. The Queensland Government received $327 million under this initiative, which has supported investments in additional palliative care beds at the Queen Elizabeth II Hospital, the Royal Children's Hospital, and Redland Hospital, as well as supported non-admitted services in Ipswich.[8]

More generally, the introduction of activity-based funding arrangements for hospital services, whereby the Commonwealth will contribute a fixed proportion of funding for *any* service deemed 'in scope' by the Independent Hospital Pricing Authority (IHPA), provides significant opportunity for the expansion of community-based palliative care services:

> *In-scope non-admitted services do not have to be provided on the campus of a public hospital. They can be provided at a hospital, in the community, or in a person's home ... [Services may] be provided in a person's home (such as ... palliative care) and be included in-scope as eligible for Commonwealth funding.*[9]

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[8] Senate Community Affairs Committee, Answers to Estimates Questions on Notice, Health and Ageing Portfolio, Additional Estimates 2011-2012, 15 February 2012, Question: E12-143.

[9] Independent Hospital Pricing Authority, *The Pricing Framework for Australian Public Hospital Services*, 30 May 2012, p.11.

These new pricing arrangements provide opportunities for State governments and service providers to deliver more community-based care in areas such as palliative care.

5. In conclusion

To summarise, the AHHA believes palliative care is a critically important, but currently under-resourced, area of service provision within the Australian healthcare system.

The majority of people want to be cared for and die at home – yet because of inequitable access to high quality community-based palliative care services across Australia, most will die in institutional settings. This is a poor outcome for these patients and their families, but it is also an inefficient and costly outcome for our health system. As the example of Silver Chain demonstrates, as well as being better for patients and their families, community-based models of care can produce significant cost and outcome benefits.

The AHHA believes funding reform is needed to provide more equitable access to community-based palliative care across Australia, and to encourage the more widespread adoption of large scale, best-practice models of community-based palliative care such as that provided by Silver Chain in WA. In the short term, reform efforts should focus on maximizing the opportunities for expanding community-based palliative care provided by the transition to activity-based funding for public hospital services under the national health reform agenda.

The AHHA trusts the information provided in this submission is of assistance. We would be happy to elaborate on any aspects of this information should this be required.

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3 August 2012