Mr Peter Dowling MP
Chair, Health and Community Services Committee
Parliament House
George Street
BRISBANE QLD 4000

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Dear Mr Dowling

Re: Palliative and Home and Community Care Services

I am writing in response to the Queensland Parliament Health and Community Services Committee Inquiry into Palliative and Home and Community Care Services. AMA Queensland welcomes the opportunity to provide feedback to the Committee on this important issue. Please find AMA Queensland's submission attached.

AMA Queensland looks forward to providing further input on this issue. Please contact our policy advisor Emily Cotterill on 07 3872 2258 or at e.cotterill@amaq.com.au if you would like to further discuss the issues raised by AMA Queensland.

Yours sincerely

Dr Alex Markwell
President
AMA Queensland

Submission in response to the Queensland Parliament's Health and Community Services Committee inquiry into palliative care and home and community services

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AMA Queensland welcomes the Queensland Parliament's Health and Community Services Committee's inquiry into palliative care and home and community services.

Our health care system must give people the opportunity to die with dignity and with minimal suffering. Access to medical practitioners is a fundamental factor influencing access to and choice of appropriate palliative care. The demand for quality palliative care in all health care settings is increasing with an ageing population.

Access to and choice of appropriate palliative care

'Palliative care' is care provided for people of all ages who have a life-limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life.[1] Palliative care integrates physical, psychological, emotional and spiritual care for patients, their families and other carers. Palliative care includes respite and grief and bereavement support.

Medical practitioners play an instrumental role in all aspects of palliative care. Specialist doctors, including palliative care physicians, oncologists, geriatricians and general practitioners provide palliative care directly to patients. They work with nurses, allied health professionals, carers and families to plan, deliver and support patient care.

Every patient, along with their family and carers, should have access to adequate and appropriate medical care and support.

Educating doctors and patients

Diagnosing doctors are extremely influential to a patient's experience of death, dying and palliative care. Diagnosing doctors provide education to patients about treatment pathways available, whether that be intensive treatment aimed at cure or lengthened survival or a palliative care approach which focuses on maximising a patient's wellbeing before death.

[1]Palliative Care Australia (May 2005), 'Standards for Providing Quality Palliative Care for All Australians', 4th edition, p10.

These critical decisions made by patients, in conjunction with their doctors, can have a profound effect on a patient's experience of death and dying. All patients should be provided with the information and advice to allow them to make the best, informed choice for themselves.

Longer life expectancy means that many people are ageing with chronic disease; often experiencing frailty and increased need for care toward the end of their lives. This means that by the time many people receive a diagnosis of a life-limiting condition they may be at a high risk to receive some treatments, for example surgery or chemotherapy. Education about all health care options, including palliative care is particularly important for these patients.

As the main providers of health care information to patients, doctors must be educated about palliative care options and the palliative approach to care, so they are well-equipped to offer a choice of treatment to their patients. This allows patients to make informed choices for themselves and their families.

AMA Queensland strongly advocates for dedicated palliative care units in public teaching hospitals. These care units would be accredited to train interns and registrars which in addition to providing optimal care and appropriately supporting the provision of palliative care in the primary care setting, would promote the role and philosophy of palliative care. Into the future, it is hoped this will translate into more doctors educating patients on the choices available to them and less procedures of limited clinical value being used to treat frail and dying patients.

In addition, there should be training in grief and bereavement counselling for all health practitioners, to enable them to support both patients and their family members to cope with difficult decisions and emotions.

A functional system

Today many patients receiving palliative care, who are too ill to live in their own homes, reside in residential aged care facilities (RACFs). Feedback from AMA Queensland's General Practitioner members indicates the medical care offered to patients who move into RACFs is fractured and difficult to access.

When a patient moves into an RACF they lose a large part of their independence, including the opportunity to visit their own GP.

GPs report that they find it extremely difficult to treat their patients in RACFs due to limited organisational support at some RACFs and poor financial incentives. Many GPs are forced to relinquish giving care to these patients. Other GPs provide extra, unpaid, work to patients and their families by writing prescriptions out of hours and providing bereavement support.

This is not a sustainable model of care. GPs need to be supported to provide care to patients in RACFs. The Queensland Government should lobby the Commonwealth Government for increased Medicare payments for GPs and other allied health groups to provide palliative treatment to patients in RACFs. Increased medical treatment in RACFs is an efficient way of treating patients

and will relieve pressure on acute treatment beds in hospitals.

The Queensland Government should also assist GPs by passing legislation which would allow chart-based prescribing in RACFs. Commonwealth legislation has been passed to support PBS subsidies for prescriptions made in this way and trials are currently underway in NSW.

Allowing chart-based prescribing in RACFs would relieve a significant burden on general practice and allow more streamlined and efficient care. These changes will benefit patients through giving patients more time with their GP rather than losing hours a week to an unnecessary administrative task.

Advance care planning

AMA Queensland supports advance care planning, through the use of Advance Health Directives (AHDs), as an important element to patient self-determination. AHDs benefit patients by providing them with a means of informing health care decisions, including the withholding and/or withdrawing of life-sustaining measures, in the event of losing decision-making capacity in the future. AHDs also benefit surrogate decision-makers (SDMs), medical practitioners, and other health care providers by alleviating the stress of trying to make treatment decisions that reflect the person's wishes. AHDs can also advance the rational use of health resources and encourage the provision of care in the most appropriate environment.

National consistency in law and policy

AMA Queensland supports the work undertaken by the Australian Health Ministers' Advisory Council in setting out the principles that should underpin a National Framework for Advance Care Directives.[2]

This Framework should guide development of nationally consistent legislation. Medical practitioners in Queensland would be able to confidently carry out an AHD of a patient from another state (for example a patient who became ill whilst on holiday in Queensland) without fear of inadvertently contravening the law.

The Queensland Government should work with other state governments to further integrate and provide mutual recognition of advance care directives from all states and territories. Ideally, this integration and recognition will result in nationally consistent legislation which will provide certainty for both patients and doctors.

AMA Queensland suggests that if AHDs are to attain widespread acceptance then medical practitioners and other health care providers need to be provided with education about AHDs and how to get quick access to legal certainty – for example through the Office of the Adult Guardian or QCAT – and the circumstances under which they will be protected from criminal and civil liability and from disciplinary proceedings if they act in accordance with the AHD.

[2] The Australian Health Ministers' Advisory Council (September 2011), 'A National Framework for Advance Care Directives'.

Avenues for communication about end of life care

Medical practitioners play a key role in assisting patients to develop an AHD by discussing treatment issues related to incapacitating conditions and/or future health care options. Such discussions are an accepted part of good clinical care and the doctor-patient relationship.

Where engaged in developing an AHD, medical practitioners have a responsibility to ensure that patients:

a) are competent to do so;
b) are fully informed and have had an adequate opportunity to receive advice on various health care options pertaining to their current and possible future condition/s;
c) understand and appreciate the information, including medical concepts and terminology contained in the advance care document;
d) have the capacity to understand the decisions they have made; and
e) are acting voluntarily (as best as the medical practitioner can determine this).

Despite being a clinically relevant professional service, there is currently no financial assistance to patients for such discussions. AMA Queensland believes it is important for the Medicare Benefits Schedule (MBS) to provide patients with a rebate for the time that it takes for medical practitioners to undertake consultations to assist patients in preparing AHDs.

If the Queensland Government wishes AHDs to be more widely utilised by patients it is vital that it lobbies the Commonwealth Government for MBS assistance to patients to complete their AHD.

This assistance should be preferably through an explicit change to current MBS explanatory notes to clarify which existing MBS items can be used in respect of these consultations rather than through the addition of a specific new MBS item.