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Human Services Inquiry
Productivity Commission
Locked Bag 2, Collins Street East
Melbourne VIC 8003

Introducing Competition and Informed User Choice into Human Services: Second Stage of Inquiry

Thank you for a further opportunity to contribute to the inquiry introducing competition and informed user choice into human services. Palliative Care Australia (PCA) response to the inquiry is attached.

Empowering individuals and their families is central to all Palliative Care Australia (PCA) activities and we wholeheartedly support one of the Commission's key points that the individual is best placed to make decisions about the services that meet their needs and preferences. However, access to high quality palliative care service is necessary before choice is possible and there is still much to be achieved in this area.

PCA also agrees that high-quality data are central to improving the effectiveness of human services and believes that the collection and analysis of reliable, relevant information should proceed in step with improvements in access to palliative care. The Palliative Care Outcomes Collaboration (PCOC) is central to improving the quality of data collected in Australia, and has already been able to demonstrate statistically significant reductions in the variability of patient outcomes along with statistically significant improvements in patient outcomes. Equally important as the collection of high-quality data is the use to which it is put. These data must be correctly understood by those wishing to use it for contestability purposes and policy more generally.

If you have any questions, please contact Liz Callaghan

Yours sincerely

Liz Callaghan
Chief Executive Officer
Palliative Care Australia

Professor Kathy Eagar
Director
Palliative Care Outcomes Collaboration,
Australian Health Services Research Institute
(AHSRI), University of Wollongong

Attachments:

- PCA Submission

PCA Submission: Introducing Competition and Informed User Choice into Human Services

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What types of services and setting should be included in the definition of end-of-life care?

- Both specialist palliative care services and primary care providers play important roles in providing palliative care. PCA's previous submission (26 October 2016) lists services and settings for inclusion in the definition of end-of-life care. Specialist palliative care is required only by people with complex or resource intensive needs, which are beyond the expertise or exceed the capacity of primary care providers.

Should services be considered as bundled or individually?

- The essential point is that an individual receiving palliative care should experience that care as a single service regardless of how it is administrated.

Information of the potential for greater contestability, particularly for service and regions where choice is not practical.

- The greatest current barrier to patients receiving their preferred care is the availability and quality of palliative care services, including those in the primary health sector. Once an individual requires palliative care the capacity of them or their family to exercise choice is negatively affected and therefore contestability has limited relevance.
- Contestability needs to be based on nationally agreed standards. While PCA is currently addressing the standards for specialist palliative care services, support is needed to identify the minimum requirements for palliative care services in the community, including non-specialist palliative care services.
- 'Palliative Care Service Provision in Australia: A Planning Guide 2nd Edition' requires revision and this could be achieved by providing Palliative Care Australia with funding to complete work on this revision.

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How could patients and carers be better supported to plan for care in advance, and better informed about end-of-life options?

- Conversations about goals of care should be encouraged and supported in the primary health sector, because individuals and families are often not well placed to process information and make decisions once palliative care is imminent.
- Initiatives that help people have conversations about their preferences for care at the end of life (e.g. Dying to Talk, Death Cafes, Compassionate Communities) need to be supported.

How could healthcare professionals be better trained, assisted or incentivised to identify, initiate and guide end-of-life conversations?

- All basic medical and nursing degrees, and every clinical and surgical specialty, should include outcomes relating to confidence in talking about dying with patients and their families, and matching the person's care plan with their goals of care.

How could barriers to implementing patients' expressed preferences be overcome?

- The greatest current barrier to patients receiving their preferred care is the availability and quality of palliative care services, including in the primary health sector. Access and quality need to be addressed before patient preferences can be implemented.

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What are the costs and benefits to the community as a whole of providing end-of-life care in different settings, and how could commissioning & funding arrangements more closely reflect population needs?

- Without comprehensive and reliable data about the provision of palliative care services it is difficult to calculate costs and benefits, and correspondingly difficult to devise suitable commissioning or funding arrangements.
- Australia needs a national data strategy for palliative care that collect key data items such as the number of people accessing palliative care, the number of episodes of care each person receives, the services provided by palliative care and the quality of their life until death. Data on whether care was available to the family and carers is also essential because palliative care provides a family-centred approach.
- Advice based on these data should provide advice to either the National Health Information and Performance Principal Committee (NHIPPC) and/or Community Care and Population Health Principal Committee (CCPHPC).