



**PALLIATIVE CARE OUTCOMES COLLABORATION
AUSTRALIAN HEALTH SERVICES RESEARCH INSTITUTE**

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Commissioner Stephen King
Productivity Commission
Level 12, 530 Collins Street,
Melbourne VIC 3000
Locked Bag 2, Collins Street East,
Melbourne VIC 8003

Re: Productivity Commission 2016, Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Preliminary Findings Report, Canberra.

Dear Commissioner King

I write on behalf of the Palliative Care Outcomes Collaboration (PCOC) and ahead of our teleconference tomorrow. As you know, PCOC is a national program that utilises standardised clinical assessment tools to measure and benchmark patient outcomes in palliative care. PCOC provided much of the palliative care data you cite in your preliminary findings report.

My response is restricted to how you have reported and interpreted the data that PCOC provided. As you know, PCOC was approached by the Productivity Commission to provide it with data relevant to your terms of reference. We teleconferenced with members of the Commission to agree on the scope of the data you needed and we then provided you with:

- Summary data for the five year period 2010 to 2015 on the volume of specialist palliative care in each state by setting (inpatient or community). We excluded data from small jurisdictions. These data are available on our public website and have been for some years.
- Summary data for the five year period 2010 to 2015 on place of death in four states broken down into two categories – hospital inpatient or other.
- Summary data for the five year period 2010 to 2015 on each of six national specialist palliative care clinical benchmarks. These data were provided to you for each of five states and by setting (inpatient or other). Again, these data are available on our public website and have been for some years.
- Summary data for one state on patients receiving care in hospital as well as at home and where specialist palliative care was provided prior to the patient's death.

In all cases, the data we provided to you were at the aggregate state level only and no patients or services were identifiable. Specialist palliative care provided in both the public and private sectors were reported together in the data we gave you and it is not possible from our data to distinguish between the two sectors. Some services included in the data we provided were established through contestable commissioning and funding processes while others were not. Likewise, we aggregated care provided in rural or urban settings together and we aggregated all of the data regardless of the diagnosis, age or sex of the patient.

While your interim report makes some good points, much of the PCOC data we provided have been misinterpreted. No doubt this is due to the complex nature of the topic and the specialised data collected by PCOC.

In the section on preferences for the setting of care, the PCOC place of death information only relates to patients who died whilst in the care of a specialist palliative care service providing data to PCOC. For example, deaths are not captured in the PCOC data when a person who receives specialist palliative care in hospital is then discharged to die at home under the care of a primary health care provider or a specialist provider who is not providing data to PCOC. Place of death in different states will subsequently be influenced by the coverage of inpatient and community palliative care settings in that state. It will also be influenced by the mix of specialist and primary palliative care in each state.

You also use PCOC data to conclude that there is inadequate responsiveness with regard to patient preferences for setting of care. However, the PCOC information does not address this as it does not include an assessment of whether the patient was in their desired place of care.

In concluding that some patients '...may have no contact with specialist palliative care services until the last days of their life' (*page 102, para 2*) a statistic from the Victorian data regarding patients having one episode of care prior to death is directly followed by an unrelated national statistic regarding the length of all episodes of care. These appear to have been included to support a predetermined conclusion.

In relation to quality of the care, you have made value judgements without supporting evidence. As one example, you state (several times) that there is 'considerable variation in the quality of care' without defining what you mean by 'considerable' or 'highly variable'. These statements appear to be based on differences in the outcomes achieved in different states. But care is not delivered at the state level. Care is delivered at the local level and there is variability within every state. Quality of care needs to be assessed at the service level in order to be meaningful. However, differences in the patient casemix need to be taken into account to accurately compare service performance.

I am concerned that you have used PCOC data as though the PCOC data provide evidence to support greater competition and contestability. The PCOC data we provided you neither support nor refute the case you are putting for greater competition and contestability.

As our PCOC data demonstrate, and as we discussed with your staff at some length, there has been a statistically significant reduction in variability in patient outcomes in recent years in conjunction with statistically significant improvements in patient outcomes in both inpatient and home settings. The approach adopted by PCOC is one that fosters service collaboration, with services working together to

ensure the best outcomes for patients. PCOC benchmarking workshops bring services together to share strategies that lead to improvements in patient outcomes. PCOC facilitated service visits enable staff to visit successful services to experience and understand the strategies and processes in place. Our evidence very clearly is that, while more remains to be done, collaboration and cooperation is critical to improving palliative care patient outcomes.

Yours sincerely

Professor Kathy Eagar
Director
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