Public Health Association of Australia submission on Palliative Care Services Review - Queensland

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia.

The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Introduction

PHAA welcomes the opportunity to provide input to the review of palliative care services in Queensland. Palliative care services are a vital and often neglected area of health care services. PHAA believes that the beliefs of the individual who is dying should have primacy in order to respect their autonomy. Access to palliative care and structured end of life communication such as advance care directives is therefore an imperative. Advance Care Planning and Directives help patients to overcome communication barriers and provide a structure for ensuring their wishes, values, beliefs and preferences are clearly outlined and respected.  

Multifocal interventions which may include lists of questions to be discussed, facilitated discussions and feedback, and group-based education as well as advance care planning may be the most successful in promoting end of life communication. It is important that emergency services have access to Advance Care Plans and Directives where possible, to inform care at the point of emergencies.

Palliative care aims to help people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness. Palliative care holistically identifies and treats symptoms which may be physical, emotional, spiritual or social, and is based on individual and family needs. Palliative care can be provided in a variety of settings, including primary care, residential aged care, in-patient settings, and at home through community care. Support needs to be provided within all of these settings to have the best outcomes for palliative care patients.

With rates of chronic conditions and the ageing population increasing demand for palliative care services, this review will be important in securing access to high quality, person-centred and culturally appropriate care for people throughout Queensland.

PHAA Response to the consultation paper

How well are palliative care services meeting the demand and service setting preferences for patients and their carers and families in your local area?

Inequity exists in Australia in relation to people’s access to appropriate palliative treatment and care. This is particularly true of access to high quality end of life care which may be affected by location (there is reduced or lack of access in regional and remote areas), education and knowledge of health professionals, and funding mechanisms which do not support holistic care. This review must prioritise equity of access to services.

What changes could be considered to palliative care service delivery in your area that would improve the experience of patients and their carers and families?

The access to services in regional and remote areas being a source of inequity, and difficult to solve with the demographics and geography of the Queensland, increased use of telehealth may provide a part of the solution. Telehealth is used in a range of palliative care services including specialist palliative care, hospices, primary care settings, nursing homes and hospitals for out-of-hours telephone support; advice services for palliative care patients, carers and health professionals; videoconferencing for interactive case discussions, consultations and assessments; and training and education of palliative care and other health-care staff. Studies of the effectiveness of telehealth in palliative care are in their infancy in Australia and have methodological difficulties in establishing effectiveness with scientific rigour. However, some supportive
findings so far include reductions in anxiety, enhanced communication between clinicians and families, and decreases in unplanned admissions to hospital and health care utilisation.\(^4\) Indications are that telehealth has a potential role to play in reducing costs, aiding symptom control, providing support for nonphysical issues such as emotional distress, and results in high rates of patient satisfaction.\(^6\) Efforts to increase use of telehealth to improve access to palliative care should also ensure barriers to telehealth access (for example, due to poor digital health literacy or lack of home internet services) do not further impede palliative care service access.

**What types of palliative care services do you think will be required in your local area of across the state to meet future demand? Will different services be needed in the future to those provided today?**

Medical advances in the last century have increased longevity and changed end of life processes, while simultaneously there has been a move within medical ethics towards patient centred care.\(^7\) A person-centred care model is important so that family, loved ones and carers can receive practical and emotional support.\(^8\)

As noted in Palliative Care Australia’s Service Development Guidelines, population-based planning for palliative care services requirements needs to be based on analysis of local patterns of morbidity and death, and an understanding of illness trajectories.\(^3\) The model of 3 broad groups of people living with a life-limiting illness, proposed in the Guidelines may provide a useful basis for future planning in Queensland. These groups are:

- People with straightforward and predictable needs generally able to be managed through their own resources or with the provision of palliative care by their existing health care providers
- People with intermediate and fluctuating needs who experience intermittent onset of worsening symptoms that might result in unplanned and emergency use of hospital and other health services. This group may require access to specialist palliative care services for consultation and advice
- People with complex and persistent physical, psychological, social and/or spiritual needs that are not able to be effectively managed through established protocols of care. People in this group will require more ongoing direct care by specialist palliative care providers, which should occur in partnerships and shared care models with existing health care providers.

PHAA notes that this model relies heavily on having some palliative care services provided by general (non-specialist) health care providers. This may require additional education, training and funding to ensure that all palliative care in Queensland is accessible, person-centred, appropriate, high-quality and culturally safe.

While many people in Australia express a preference for dying at home, few are able to achieve this.\(^9\) Some of the factors associated with increasing the likelihood of a home death are early referral to palliative care, a multidisciplinary home palliative care team, and having informal carers and community support networks at home.\(^10\)-\(^12\) A pilot study on use of General Practice Registrars in rural NSW to manage continuity of care for palliative care patients reduced hospital admissions and bed days, and increased the likelihood of dying at home according to preference.\(^13\)

The provision of culturally safe palliative care services is essential, and requires flexibility and understanding of the needs and preferences of different cultural groups and individuals. For example, some commonly stated preferences from Aboriginal and Torres Strait Islander people include to die on country, to have family involved, good communication, and for cultural practices to be integrated.\(^14,15\) Palliative care services for Aboriginal and Torres Strait Islander need to coordinate with Aboriginal community controlled health organisations and medical services, and Aboriginal health workers. Local service models are needed, and with the challenges involved in integration with mainstream services, few have been developed to
Australia has many significant minority populations, with an accompanying variety of cultures represented. Issues such as religion and spirituality, experiences of refugees, and different cultural practices as well as individual preferences are all influential in end of life care. Difficulties of language provide further complications in effective communication and recognition of individual patients’ values and needs. This complexity has to be understood within the context of Queensland, for the development of culturally safe services. The Productivity Commission Inquiry Report “Introducing competition and informed user choice into Human Services” included some key recommendations about palliative and end of life care, including some directly relevant to State and Territory responsibilities.

Conclusion

PHAA supports the broad directions of the review into palliative care services in Queensland. Access issues in regional and remote areas means that the models of providing palliative care services should consider increasing the utilisation of telehealth. In line with the general recommendations of Palliative Care Australia, palliative care services should be better integrated across health care services generally. The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to improved palliative care services in Australia.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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24 August 2018

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References