“The assumption that everything is fine: no everything is really not fine. Come and do a ward round with me and see, even in a well-resourced service that really cares about these patients, where all the holes are, where all the resource gaps are, all those people that fall through the cracks and where all the opportunities are for us to do that extra bit.”
Why improve PC?

- The number of deaths will DOUBLE by 2061.
- Only 14% die at home but most people want to.
- PC is 50%-300% less expensive than acute or intensive care.
- HALF of those who would benefit from PC receive it.
Models of Palliative Care (PC)

- Specialist inpatient
- Non-designated inpatient
- Outpatient
- Community incl. RACF and home
- Primary
The Catholic Sector is a major provider of PC
CHA Inpatient Beds

- WA: 46 beds
- SA: 15 beds
- QLD: 60 beds
- NSW: 117 beds
- VIC: 84 beds
- Tas: 36 beds
- ACT: 19 beds

30% of CHA private inpatient PC is in a regional hospital
18% of CHA public inpatient PC is in a regional hospital
CHA Community Services
(people, capacity at any given point)
PC Outcomes - Death

Most people want to die at home or in the community, but most die in hospital.
Timeliness and Responsiveness of Service

- CHA tertiary services are timely and responsive
- Community PC is timely but struggles to meet responsiveness benchmarks
Community PC struggles to meet benchmarks

– funding
– equipment/medications are not available
– availability of nursing and medical support 24-7
– the ability to respond rapidly to changing needs
– symptoms exceed the level of care
– choices/preferences regardless of problems
– skill of phone assessors
– data recording issues off-site
Barriers

Funding

Medicare Benefits Schedule (MBS)

Aged care funding instrument (ACFI)

Payment models public system

Private health insurance

State vs federal

Between sectors (e.g. primary/community)

Multiple clinicians or providers but no continuity

Geographical

Fragmentation
Barriers

- Workforce
  - Specialists
  - Nursing workforce shortage
  - Geography
- Staff training and engagement
- Knowledge
  - Advance care planning
  - Research
- Community perceptions

CATHOLIC HEALTH AUSTRALIA
Enablers

- Research
- Education programs
- Partnerships
- Community empowerment
- Goodwill
- Volunteers
Innovative PC Programs

- Improving equity of access
- Enabling at home death
- Improving evidence

- Aged care needs identification programs
- Hospice within RACF
- Supportive care clinics for non-malignant disease
- Aboriginal and Torres Strait Islander partnerships
- CALD programs

- Single provider continuum of care
- Private health insurance funded community PC
- Needs identification programs
- PC networks

- Research
- Collaboration
Improving Equity of Access-Aged Care

• 90% of people in an RACF die within the first 2.5 years
• 1 in 50 have a funding needs assessment (ACFI) that indicates the need for PC
• Generally late referral to PC in RACF driven by funding model and lack of needs identification skill in staff
• Workforce training an issue
Hospice within a RACF
Comfort Care Centre
Catholic Homes

- 6 bed hospice facility within a 73-bed RACF
- 43 admissions since February 2018
- Average length of stay 38 days
- Referrals from private/public hospitals as well as Silver Chain community services.
- Access to PC trained multidisciplinary staff including GP specialist, PC nurse, a registered nurse on site 24 hours per day and a clinical nurse. Specialists and consultants accessible.
- Home-like surroundings
Comfort Care Centre

• Currently being independently evaluated for economic benefit to attract funding.
• Overwhelmingly positive feedback:

(Daughter) “Words cant ever express what you have done for me and my Mum, in looking after my Dad. I cant think of any words that are enough to say how I feel about all the wonderful staff in the Comfort Care Centre. Thank you”

(Wife) “Thank you for everything, I could not have managed on my own. You made us both feel like family. I really appreciated everyone’s help through this process. Thank you, Thank you, and Thank you.”
Recommendations: CHA and Members

CHA and its members can also contribute to improving PC by:

1. Continuing to **advocate** for improvements to PC in Australia.

2. Establishing a **Catholic Palliative Care Alliance** to facilitate knowledge exchange.

3. Engaging with members to facilitate a **PC awareness campaign**.

4. Developing and communicating **VAD position statements** and disseminating staff educational resources.
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