

JOINT SELECT COMMITTEE ON END OF LIFE CHOICES - INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS REGARDING THEIR OWN END OF LIFE CHOICES

Questions taken on notice:

1. Please provide a copy of the Minutes from the Palliative Care Advisory Committee re: feedback about gaps in accessing Commonwealth funded HACC packages (session1, pp7, 12)

A draft copy of the minutes of the Palliative Care Advisory Committee (PCAC) meeting on 29 November 2017 is attached. Note that the minutes have not been finalised as the committee has not met since this time.

2. Which of the 14 services reporting to PCOC are private and which are public? (session1, p12)

7 of the services reporting to PCOC are provided by public services (i.e. provided by Health Service Providers) and 7 of the services are provided by non-government (private) organisations. The majority of these non-government organisations provide services to public patients through contracts held with Health Service Providers and the Department of Health.

3. Which of the remaining services contracting to the DoH are private and which are public (session1, p 12)

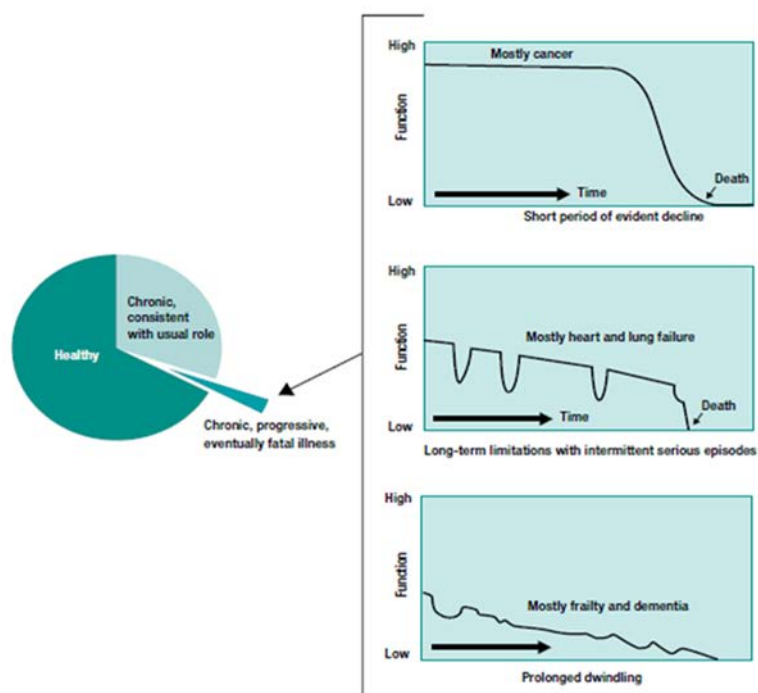
Of the remaining services (i.e. those not included in the current PCOC report), three are private and seventeen are public. Note that specialist palliative care services are counted and classified differently by PCOC and the Department of Health. Therefore these numbers need to be interpreted with caution. Also, a number of these services are currently collecting PCOC data and will be included in future PCOC reports.

4. Please provide time-lines around end of life care, and palliative care for both malignant and non-malignant disease, together with an overview of the different definitions. (Session 1, p13)

In relation to timelines around end of life care, the WA Health End of Life Framework states that people are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions such as those described above
- general frailty and co-existing conditions that meant that they are expected to die within 12 months
- existing conditions, if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events.¹

People who are at end of life can experience very different states of health, as illustrated below.



(Lynn J, Adamson D. 2003 Living well at the end of life)

For those people identified in the diagram above as experiencing chronic, progressive and eventually fatal illness a referral to palliative care is recommended. Palliative care grew out of the hospice movement and was historically based on the need to provide holistic care to patients with malignant disease. In contemporary health care there is an accepted recognition for the need to extend access to palliative care from malignant disease to all people with any life type of limiting illness.

Malignant disease continues to be a principle diagnosis in the mortality of middle aged Australians (45 to 64 years, since 2013). It is also the principle diagnosis in older Australians (over 65 years) for both hospital separations involving palliative care and death.^{2, 3} Cancer Australia estimates that currently the risk of an individual dying from cancer by their 85th birthday is 1 in 5⁴. The most common types of cancer deaths in 2017 were lung, colorectal, prostate, breast and pancreatic cancer⁴.

Non-malignant disease is a description frequently attributed to all other life limiting illness associated with a need for palliative care. These illnesses include conditions such as organ failure (including heart failure, lung failure from such causes as chronic obstructive pulmonary disease (COPD) and renal failure), neurodegenerative conditions such as Motor Neurone Disease and other conditions such as dementia and frailty. Many patients will have more than one life limiting illness – 29% of Australians aged 65 years and over report having three or more chronic diseases⁵.

Malignant and non-malignant diseases have different presentations, symptoms, sequelae and trajectory. Timelines for any individual illness including cancer can be variable at best.

This is why there has been a more recent move towards clinician assessment based on the needs of each individual according to their life limiting illness type, illness stage, morbidity, burden, carer impact, circumstances and prognosis.

Bereavement support is an important part of palliative care, however it can also be provided by other services. It is acknowledged that not everyone requires bereavement support from health services, and some people have access to their own support networks or support services.

5. Please provide details of any misconduct investigations with respect to prescribing and dispensing medications. (session 1, p14).

Health professionals are registered with relevant professional Boards (eg Medical Board of Australia, Nursing and Midwifery Board of Australia) administered via the Australian Health Practitioner Regulation Agency (AHPRA). Misconduct investigations are conducted by the professional bodies that they are registered with. If criminal activity is suspected the matter would be referred to the police, in the first instance.

Employers have processes for investigating incidents, this is an accreditation requirement. The information is held by the employer (hospital, residential facility or community service) and referred to the professional bodies if there was considered to be misconduct by a professional.

The senior investigator and chief pharmacist Department of Health have advised they are unaware of any practitioners investigated by the Medicines and Poisons Regulation Branch (MPRB) for breaches of the Medicines and Poisons legislation relating to inappropriate prescribing and dispensing of medicines to prematurely end life.

The legislation; *Medicines and Poisons Act 2014* and the *Medicines and Poisons Regulations 2016*⁶ requires a health practitioner to prescribe/dispense; “in the lawful practice of their profession.” It is the role of the relevant Registration Board to determine whether the practice was lawful or not.

6. What are the funding amounts for palliative care for the years; 2014, 2015 and 2016 (session 1, p13)

This information is being sought from the WA Country Health Service (WACHS).

7. What is the percentage funding for regional and rural palliative care – 2014, 2015, and 2016? (session1, p14)

The inpatient palliative care described in the table below is primarily delivered within WA Country Health Service (WACHS) hospitals. This also includes contracted activity funded by WACHS at St John of God Bunbury, St John of God Geraldton and at a Not For Profit managed facility in Albany.

Note: that the question sought information for the calendar years 2014, 2015 and 2016. Financial data and costing models are however aligned to financial years.

WACHS expenditure on palliative care from 2014-15 to 2016-17 is summarised in the following table.

	In Hospital Palliative Care			Programs \$	Total \$
	Encounters	Bed Days	\$		
2016-17	983	10,017	12,468,092	3,015,000	15,483,092
2015-16	713	6,876	7,692,609	3,590,000	11,282,609
2014-15	810	8,325	10,018,453	3,541,000	13,559,453

Notes

1. "In hospital Palliative Care" is defined as admitted patients with "Care Type" = "Palliative Care"
2. " Programs" relate to specific program allocations funded from Royalties for Regions and specific EERC approved initiatives.
3. "Programs" sourced from audited annual financial statements - Note "Income and Expenditure by Service Type"

8. What is the funding for the specific public palliative care and facilities, by service and provider – 2012-2016 (the last five years) (session 1, p15)

This information is being sought from the relevant Health Service Providers.

9. What is the breakdown of funding for each palliative care service – Silver Chain, SJOG, Bethesda and Ramsay Health Care – 2014, 2015, 2016 (session 1, p 15)

Total funding for the two contracts that are held by the Department of Health for palliative care service providers (Silver Chain and Bethesda) is listed below:

Year	Amount
2014	\$21,466,614
2015	\$22, 244,92
2016	\$23,718,981

*The amounts are combined to comply with *Commercial in confidence requirements*.

St John of God and Ramsay Health Care and a second Bethesda contract are not recorded in the table above as they are managed externally by Health Service Providers. They have been requested to provide this information to the Joint Select Committee.

10. What is the breakdown of percentage funding received for each service provider in 2013 – in relation to the total \$5.9m (session 1, p15)

This information is being sought from the relevant Health Service Providers.

11. Does the Department of Health receive notification of suicides in WA? (session 1, p22)

The Chief Psychiatrist (an independent statutory officer who holds powers and duties as prescribed by the Mental Health Act 2014⁷) receives notification of deaths (including suspected suicides) of all patients of "mental health services" (as defined by the Mental Health Act 2014⁷), and includes public sector mental health inpatient and community, private mental health hospital inpatient, and a few other providers.

The Chief Psychiatrist also receives reporting about individuals who have died (including suspected suicide, among other causes) within three months of being discharged from a mental health service. Mental health services may not always hear about a death after a patient has been discharged.

The State Coroner receives notification of all suspected suicides across WA, and makes final determination as to cause of death (suicide or otherwise). The State Coroner does not automatically provide the current figures for suspected suicides to the Chief Psychiatrist.

The Department of Health receives suicide notification through the “Datix CIMS” reporting system.

The Patient Safety Surveillance Unit is the policy custodian for the Clinical Incident Management Policy (2015). This policy requires Health Services to notify clinical incidents. Clinical Incidents, Statement of Accounting Standards 1 (SAC1) are defined as: clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient’s underlying condition.

A proportion of these clinical incidents relate to mental health services and some of these relate to the unexpected death of a mental health client. It is important to note that this reporting while it may include some suspected suicides is not the reporting of suicide as such, as the category is broader. It can include an unexpected death from a physical cause related to the person’s health.

12. Please provide details of training provided to health professionals in area of palliated starvation and dehydration in WA (Session 1, p 26)

The Palliative and Supportive Care Education service (PaSCE) provides general discussion of this topic in Foundations Module 2, with extension sessions that focus on symptom assessment and management. There is no set module that covers palliated starvation and dehydration in WA.

Health professionals are informed of how their action is protected by the law when the intent of treatment in reduction of suffering, discussion is focussed on impeccable assessment and symptom management.

13. Who is the best person in the Department of Health/elsewhere to talk to about instances of palliative starvation and dehydration in WA (session1, pg 27)

It is advised that the Joint Select Committee contact individual Health Service Providers and/or Palliative Care Physicians through the WA Palliative Medicine Specialists’ Group to gain information on this topic.

14. Are there any references in the minutes of the PCAC meetings regarding concerns raised that vulnerable people are being influenced or coerced into accepting terminal sedation (session1 p31)

A comprehensive review of all Palliative Care Advisory Committee (PCAC) minutes since the committee commenced found no references that relate to any concerns raised that vulnerable people are being influenced or coerced into accepting terminal sedation

15. Please provide a copy of the dying pathway document (session 1, p29)

Attached as a separate document.

16. Please provide a copy of the WA case where treatment must be provided in an emergency regardless of consent (Session 2, pp 10-11)

When confronted with a situation involving a patient who presents to an emergency care facility in a physical state where they are likely to die, and the patient is not known to the practitioner, the practitioner is likely to initiate resuscitative care, and then ascertain the background history and information. This background information may include a decision by the patient to not receive life-sustaining care. If, however, this information is not immediately available, or cannot be promptly corroborated, resuscitative treatment is likely to be initiated. The chain of communication is critical, and ideally these decisions are made in advance, and the patient is not taken to a setting where resuscitation will be implemented.

The other determinant in this situation is time. The opportunity for successful resuscitation is typically measured in seconds to minutes. If all the facts are not laid out to emergency services, the training and ethos of clinicians will be to preserve life, and then obtain information regard patient's wishes. The patient's wishes, and families understanding of these when the patient can no longer express them, can be explored when there is more time available for decision making.

An illustrative case relates to a four year old child who was with a paid carer when they experienced a respiratory arrest whilst being driven. The child was rapidly transported to an emergency centre where they were intubated, ventilated and successfully resuscitated. Only then, when there was the opportunity to scan the whole child and review the background history did it become apparent that this was a child with severe physical and intellectual disability with no prospects for long-term survival and normal development. Additionally he was in the temporary care of an agency that was not fully aware of the child's medical history, or of the parent's understanding of the child's illness or wishes in the event of a catastrophic illness. In these circumstances it was incumbent upon the emergency services to act, even if at some point a clearly outlined plan had been documented.

17. Please provide structure and process of clinical incident reporting to the Peak Incident Review Committee (Session2, p 17)

The Peak Incident Review Committee (PIRC) provides oversight and monitors compliance with the requirements of the Clinical Incident Management Policy and the Review of Death Policy. This is with a particular focus on Severity Assessment Code (SAC) 1 events whereby health care could have or did lead to serious harm or death of a patient.

Members of the PIRC include Department of Health Chiefs; Chief Medical Officer (CMO), Chief Nursing and Midwifery Officer (CNMO), Chief Health Profession Officer (CHPO), Executive Director Patient Safety & Clinical Quality, Assistant Director and Senior Clinical Advisors Patient Safety Surveillance Unit, Health Service Provider Executive Director Medical Services or Safety and Quality, Mental Health Unit representative, St John Ambulance Service representative and a consumer representative.

The Committee is advisory, meets quarterly and is administered by the Patient Safety Surveillance Unit, Department of Health. The PIRC reviews SAC1 trends and rates at aggregate level and events at case level associated with thematic topics.

The PIRC is currently under review in relation to the changed governance model associated with the implementation of the *Health Services Act (2016)*⁸.

The Coronial Review Committee (CRC) purpose is to provide oversight and monitor the state-wide implementation and response to coronial inquest findings and recommendations. Members of the CRC include Department of Health Chiefs (CMO, CNMO, CHPO) Executive Director Patient Safety & Clinical Quality, Assistant Director and Senior Clinical Advisors Patient Safety Surveillance Unit, Health Service Provider Executive Director Medical Services or Safety and Quality, Mental Health Unit representative.

The Committee is advisory, meets monthly (dependent on inquest findings release) and is administered by the Patient Safety Surveillance Unit, Department of Health. The CRC reviews all health related coronial inquest cases and provides advice on reporting to the Office of the State Coroner about implementation of recommendations.

18. Please provide a copy of the PaSCE curriculum module that covers the doctrine of double effect. (session 2, p17)

The Palliative and Supportive Care Education service (PaSCE) has advised that there is general discussion of this topic in Foundations Module 2. There is no set module that covers the doctrine of double effect. PaSCE extension sessions in relation to symptom assessment and management discuss the doctrine of double effect.

Health professionals are informed of how their action is protected by the law when the intent of treatment is reduction of suffering. Discussion and education relates primarily to impeccable assessment and symptom management.

19. Could you provide the number of referrals to the state wide paediatric palliative care consultancy by year since it was established (session 3, p9)

Referrals to the state wide paediatric palliative care consultancy service are listed below. Note that some children will be supported via oncology, neonates and the Paediatric Intensive Care Unit and are not included in the data below.

Currently the state wide paediatric palliative care consultancy service is also providing bereavement support to approximately 15 families.

Year	No of Referrals	Number of Deaths	No of Discharges	No Current Patients
2008	22	5	2	15
2009	19	15	6	14
2010	27	18	6	17
2011	23	23	5	12
2012	21	15	3	15
2013	21	12	3	21
2014	29	17	8	25
2015	19	12	10	22
2016	31	13	6	34
2017	28	14	3	45
	240	144	52	220

20. Could you provide the year when the perinatal model of palliative care was implemented (session 3, p13)

The perinatal model of care was endorsed by the State Health Executive Forum (SHEF) in September 2014. The document was revised in August 2015 with minor edits.

References

1. The End-of-Life Framework A state-wide model for the provision of comprehensive, coordinated care at end-of-life in Western Australia WA Cancer and Palliative care Network Department of Health 2015.

<http://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/End%20of%20Life/PDF/The-End-of-Life-Framework.pdf>

2. Australian Institute of Health and Welfare. Cancer incidence projections: Australia, 2011 to 2020. Cancer Series no 66. [pdf online]. Canberra: AIHW; 2012 [cited 2016 Sep12]. Available from:

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3. Australian Institute of Health and Welfare. Admitted patient care 2015-2016. Australian hospital statistics. Health Services series no. 75. [pdf online]. Canberra: AIHW; 2017 [cited 2017 May 18]. Available from:

<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559534>

4. Australian Government Cancer Australia <https://canceraustralia.gov.au/affected-cancer/what-cancer/cancer-australia-statistics>

5. Australia's Health, 2016, Australian Institute of Health and Welfare.

6. Medicines and Poisons Act 2014 and the Medicines and Poisons Regulations 2016

https://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13861_homepage.html

7. Mental Health Act 2014 https://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13534_homepage.html

8. Health Services Act 2016

[https://www.slp.wa.gov.au/pco/prod/filestore.nsf/FileURL/mrdoc_29646.pdf/\\$FILE/Health%20Services%20Act%202016%20-%20%5B00-e0-03%5D.pdf?OpenElement](https://www.slp.wa.gov.au/pco/prod/filestore.nsf/FileURL/mrdoc_29646.pdf/$FILE/Health%20Services%20Act%202016%20-%20%5B00-e0-03%5D.pdf?OpenElement)

Questions deferred from public hearing:

Palliative care for older people with chronic diseases

1. A recent report (Dr Jessica Borbasi, Life before Death: Improving Palliative Care for Older Australians, November 2017) states that:

Access to palliative care in Australia is suboptimal, and is limited or non-existent for the majority of Australians who do not die from cancer but from 'diseases of ageing' each year. Patchy provision of palliative care, and inadequate access based on location, diagnosis, background, and doctor, is due to a range of historical cultural and institutional barriers within the health system, the medical profession, and in the community and across government, including persistent workforce and funding challenges.

Could you comment on whether that is an accurate assessment?

This research is based on US and UK data and US models are often not comparable to Australia.

The 2015 Quality of Death Index Ranking for palliative care published by the Economist Intelligence Unit (EIU) 2015¹ assesses individual countries using a Quality of Death Index. This index ranks the UK first and Australia second and New Zealand 3rd. The index includes 20 indicators in 5 categories including palliative and healthcare environment, human resources, affordability of care, quality of care, community engagement and demand vs supply.

2. The report states that as a consequence of the achievements of modern medicine, the majority of Australians now die at very old ages from chronic disease. If that is correct, has palliative care in WA responded sufficiently to these changes?

The Australian Institute of Health and Welfare report on deaths in Australia (2017)² states that *"in general, chronic disease causes of death feature more prominently among people aged 45 and over..."*

The report shows that in 2014 the leading underlying causes of death were

- 1) Coronary heart disease,
- 2) Dementia and Alzheimer's disease;
- 3) Cerebrovascular disease;
- 4) Lung cancer;
- 5) Chronic obstructive pulmonary disease.

All of these diseases were the leading cause of death for Australians aged 65 and over. Four of the five are classified as chronic disease, including lung cancer. For people with chronic disease and particularly frail older people, best practice care includes managing deterioration over a period of time preceding their death. This includes the period of time that the person is considered as requiring palliative care.

In support of this continuum approach the WA Department of Health has rolled out education and training regarding developing Goals of Patient Care to identify the wishes of patients, including those with chronic diseases, well in advance of their deterioration and need for palliative care. This approach can link with formal Advance Care Planning.

The ways in which WA has responded include initiation of the Metropolitan Palliative Care Consultancy Service (MPaCCS) and the Residential Care Line (RCL). Current models of care and the draft 2018-2028 Specialist Palliative Care and End of Life strategy include priorities relating to care for people with chronic disease, specifically in

relation to rural and remote populations. The Talking About End Of Life (TAEOL) program has been provided to regional centres.

The WA Metropolitan Palliative Care Consultancy Service (MPaCCS) model with its focus on consultancy and capacity building is well placed to respond to the needs of people with chronic disease in old age, as care is provided where the patient is rather than requiring transfer to inpatient palliative care.

3. The report also claims that the current health system is not fit for purpose in managing older Australians with chronic diseases, citing back-to-back re-admissions into hospitals, with an emphasis on prolonging life instead of reflecting patients' values and choices.

a. Do you agree that is true, at least to some extent?

Recent research by the Productivity Commission³ into reforms to human services (October 2017), identifies similar issues and gaps.

The Productivity Commission report states that end of life care in Australia is often excellent but that services perform less well on equity considerations and that too often people are transferred to acute hospitals for pain management or to die, due to a lack of palliative care expertise and qualified staff to administer pain relief in residential aged care.

b. If so, how is the Department responding?

The Department of Health is contracting services like Silver Chain home palliative care to assist in meeting patient's choices about their care:

In 2016-17 in metropolitan Perth there were 224,888 days of clinical specialist care delivered to people in the community.

- Of the 2,163 occasions of death for this group, 1,620 or 75% occurred in the client's home
- 20% occurred in a public or private hospital
- 5% occurred in a hospice

The Department is also funding other innovative service models such as Metropolitan Palliative Care Consultancy Service (MPaCCS), Talking About End of Life (TAEOL), Palliative and Supportive Care Education (PaSCE), Rural Palliative Care Program RPCP) and developing Models of Care that have a strong focus on building capacity of acute and community health and aged care, to provide end of life care.

The Department of Health is translating fixed term election commitment funding to recurrent funding to sustain services like MPaCCS, the paediatric palliative care program and the RPCP.

In addition, the Department is developing a 10 year strategy from 2018 that establishes priorities for palliative care and end of life care.

4. The report states that patients with non-malignant chronic conditions are less likely to have conversations with their doctors about their prognosis and survival, in part because their deaths are more unpredictable.

a. Do you think that is accurate?

The predictability of death within a particular time period varies for non-malignant conditions (Swerrisen and Duckett, *Dying Well Grattan Report 2014*)⁴ but there have also been improvements in predicting prognosis for some non-malignant conditions.

Another contributing factor is lack of awareness by health professionals that non-malignant conditions (especially dementia) can also benefit from timely palliative care referral.

b. If yes, how is the Department responding?

The WA palliative care model is well placed to respond to these needs due to the strong focus on consultancy and capacity building.

Specific initiatives include: Advance Care Planning program, Rural Palliative Care Program, and hospital based palliative care consultancy teams. These teams tend to see a higher proportion of patients with non-malignant conditions.

2018-2028 Specialist Palliative Care and End of Life strategy specifically refers to needs of patients with non-malignant chronic conditions, and the need for stronger referral relationships.

5. Other studies have indicated those with chronic diseases are less likely to be referred for palliative care and one study, in WA, found that of the 61% of people who died in hospital in 2005-6, a greater proportion were non-cancer sufferers and were from rural areas. The report states that this demonstrates reduced access to palliative care for those groups.

a. Do you think that is a fair assessment?

It is important to note in response to this question that the article states that the cohort chosen was not representative of the whole population (eg. there was a limited range of diagnoses included, patients had to have a carer to be included in the study and patients who lived in an RACF were excluded). The findings of the research need to be considered accordingly.

The Rosenwax study does not state that this research demonstrates reduced access to palliative care, this is the author (Borbasi's) interpretation of the study. However, the groups nominated as having reduced access to palliative care are consistent with other evidence about groups that are less likely to be able to access palliative care.

WA Country Health Service (WACHS) response - Since 2005/6 the rural palliative care model has been introduced, which included specialist nursing and allied health positions, and access to palliative care specialists with extensive education and resources to support the model of care.

Progress has been made in the management of chronic disease patients within the palliative care spectrum from early diagnosis offering support with self-management, respite and carer support and advice throughout the disease trajectory to end stage.

The data provided is now more than 10 years old, it may have been a fair assessment at the time but service provision has changed significantly. The latest report by Rosenwax et al⁵ showed a marked increase in non-malignant referral for palliative care services. There is reduced access to palliative care services in rural areas compared with the metropolitan area for all the reasons stated above. For this reason, care needs to be aligned to the Department of Health Clinical Service Framework⁶.

b. Are you confident a similar study conducted now would have a different outcome?

A study conducted now would show different outcomes, partly due to the changes in population level needs in this time.

Since 2005-06 there is growing awareness in the community regarding palliative care. A similar study would show improvements from 2005 in rural access. Decedents living in outer regional areas now have similar access to specialist palliative care as those living in major urban areas although access for those in inner regional and remote areas is still reduced compared to those living in major cities⁵.

Telehealth has also improved and changed rural access since 2005-06. Further work needs to continue and be ongoing to sustain continuous improvements.

6. The report challenges the frequently cited research which found 70% of Australians would choose to die at home, pointing out that this was a survey conducted in only South Australia, included people as young as 15 and was conducted more than 10 years ago. The report claims that later research indicates that most patients with chronic disease and their carers would prefer to be cared for at home until death is imminent, and then access a more supported environment. Would you comment on whether that is an accurate representation of your experiences of people with chronic diseases?

This information is not specifically referenced in the Borbasi research so it was not possible to assess the accuracy of the survey.

Swerrissen and Duckett, in the *Dying Well Grattan Report 2014*⁴ note that surveys consistently show that between 60 and 70 per cent of Australians would prefer to die at home.

Clinical experience shows that patients and carers may have different views throughout the patient's illness about preferred place of death⁷.

Agar et al. conducted an Australian longitudinal study in which they delineated between asking patients and their carers where they would prefer to be 'cared for' and where they would prefer to die⁸.

In response these types of research findings there has been a policy shift to focus on preferred place of care rather than preferred place of death.

Funding for palliative care services in WA

2. On what basis is the funding for regional and rural palliative care allocated relative to the funds for metropolitan based services? **Commercial in confidence and requires consultation with providers*

Legal advice: unable to respond due to Commercial in Confidence requirements.

Health professionals working in palliative care

1. What proportion of palliative care to the community is provided by volunteers, charitable groups and other non-government agencies?

All specialist palliative care services that have a DOH contract to deliver care in the community are hospitals or have hospital level accreditation.

A significant proportion of these services will have a volunteer program in addition to employing qualified specialist palliative care health professionals.

Volunteer roles are primarily in relation to respite, transport, carer support etc. It is not possible to provide an exact proportion of the care provided by volunteers.

2. What are the challenges facing the palliative care workforce in Western Australia?

The current medical workforce report⁹ specifies palliative care physicians. The report anticipates that 8.7% of palliative care physicians are likely to retire in the short term and that 9% of palliative care physicians are situated in rural areas.

To address projected demand and anticipated retirements the report estimates that 3.2 new vocational trainees would need to be trained each year until 2025.

There is no specific palliative care level data available for nursing or allied health in WA.

a. Could current professional training be improved?

The Department of Health currently contracts the Palliative and Supportive Care Education service (PaSCE) through the Cancer Council of WA to provide education and training about palliative and end of life care across WA.

A comprehensive program of education is available across metropolitan and rural areas and via a range of modalities including video conference.

3. How can palliative care be better coordinated and integrated with other health services in Western Australia?

Health Services in Western Australia are well integrated and coordinated. As part of implementing the 2018-2028 Specialist Palliative Care and End of Life Strategy (draft) the Department will work to strengthen relationships between end of life and specialist palliative care services.

5. Some submissions received have set out harrowing and protracted deaths, with authors expressing concern for the staff involved (as well as others), and other submissions have reported alarming differences of opinion between health professionals about whether palliative interventions are appropriate or are criminal.

a. Are there additional supports made available for health professionals working in palliative care?

Employee Assistance Programs are available to all health employees, as well as Peer support models for rural palliative care nurses and social workers. The Palliative and Supportive Care Education service is also contracted by the Department of Health to provide education and development for health professionals working in palliative care. This workforce is identified as a priority in the draft *2018-2028 Specialist Palliative Care and End of Life Strategy*.

b. Is it difficult to attract and retain palliative care staff?

Difficulties in attracting and retaining palliative care staff are similar to other parts of the health workforce. The palliative care workforce is characterised by a higher proportion of part time medical staff, which may also impact on attraction and retention of staff.⁹ Further studies are needed at a national level to provide more information on this topic.

References

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2. The Australian Institute of Health and Welfare report on deaths in Australia (2017) <https://www.aihw.gov.au/>
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4. Swerrisen and Duckett, Dying Well Grattan Report 2014 <https://grattan.edu.au/wp-content/uploads/2014/09/815-dying-well.pdf>
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6. Department of Health Clinical Service Framework 2014-2014
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