

## Senate inquiry into palliative care

Response from the South Australia Advanced Practice Palliative Care Pharmacists

Bel Morris (Central Adelaide Palliative Care Service)

Lauren Cortis (Northern Adelaide Palliative Care Service)

Paul Tait (Southern Adelaide Palliative Care Service)

On 23<sup>rd</sup> November 2011 the Senate referred the following matter to the Senate Community Affairs Committee for inquiry and report. Further to the request for submissions in response to the full Senate inquiry; we enclose the following responses to the factors highlighted for examination.

- a) The factors influencing access to and choice of appropriate palliative care that meets the needs of the population, including:
- i. People living in rural and regional areas
  - ii. Indigenous people
  - iii. People from culturally and linguistically diverse backgrounds
  - iv. People with disabilities, and
  - v. Children and adolescents

Access to many support services, including medication listed on the Pharmaceutical Benefits Scheme (PBS) for palliative care use and equipment such as mobility aids for patients being cared for at home is dependent on a patient being listed as an active client of a palliative care service. This leads to inequity of access for many patients who, by nature of them not having complex needs (and so suitable for care in the community), may be denied basic medicines and equipment, despite them having a limited [prognosis].

The addition of pharmaceutical benefits for palliative care had improved access to a small number of listed medications for some patients. However, there is an evidence base for a number of medications for patients with some symptoms, such as neuropathic pain and bowel obstruction that are difficult or even impossible to access by many patients. The use of these medications is often endorsed by national and international professional organisations in clinical guidelines; however, health professionals can have difficulties using the guidelines as the medicines concerned are not always available to the patient.

Examples include:

- Agents for neuropathic pain. (NB – pregabalin scheduled for consideration under streamlined authority at March 2012 Pharmaceutical Benefits Advisory Committee Meeting)
- Morphine for reduction of dyspnoea.

An additional problem associated with the non-PBS listing of many relevant palliative care medications has implications for pharmacists and medication safety. The standard consumer information provided does not include non-PBS medicine use. Pharmacists have to ensure that patients and carers are provided information about medication options, benefits and associated risks in a format that meets the patients/carers needs. Where evidence is available for additional use of medicines, inclusion of expanded indications on the PBS would facilitate improved information provision.

**Recommendation:** A full review of the medications available on pharmaceutical benefits for palliative care to facilitate wider application of such medicines for symptom management.

In addition, funding arrangements in Country Health means that hospitals in rural areas cannot provide these medications to community patients in the same way that metro hospitals can (via out-patient prescriptions). Patients in these areas do not have access to unsubsidised medication via their local pharmacy.

Aboriginal and Torres Strait Islanders receive access to PBS medicines free of charge from Community pharmacies. However, this exemption from paying is not accessible for PBS prescriptions supplied from a hospital, either by out-patient or after discharge from an in-patient unit. This means that this group of patients may become reluctant to access specialist and in-patient palliative care services.

Palliative care patients will also be receiving medications from other services such as GP's and other specialists from different pharmacies. This will make their medication management issues complex, with multiple prescribers and suppliers. Pathways via PBS to access critical medications for symptom management in patients with a limited prognosis are essential to ensure more equitable management across wide social, demographic and geographical areas.

**Recommendation:** A national review of patient access to PBS medicines with the aim of streamlining and changing processes to ensure equitable access for patients, particularly patients entitled to subsidies on their costs.

- b) The funding arrangements for palliative care provision, including the manner in which sub-acute funding is provided and spent;
- c) The efficient use of palliative, health and aged care resources;

The problems with accessing medications not listed on the PBS are not restricted to financial barriers. If patients are pushed to access prescriptions from the hospital based services, then a barrier may be introduced as patients may not have the physical means to access the hospital easily for supply. This may place an additional burden on the carers, or in some cases, lead to clinical staff delivering medications to the patients home, thus acting as drug couriers.

- d) The effectiveness of a range of palliative care arrangements, including hospital care, residential or community care and aged care facilities;

There can be issues for front-line staff when dealing with patients who sit on the public/private healthcare insurance boundary. The system for accessing some medications is complex (e.g. S100) and has led to examples of several days wait for what is considered an emergency treatment.

Including pharmacists on the multi-disciplinary team is effective in reducing these problems and has worked well in areas where this has occurred. However, resourcing of pharmacy support in rural/remote areas can be sporadic, with little or no provision of out-of-hours support.

**Recommendation:** Provision of a financial package to support an on-call service that would liaise with specialist services such as palliative care to ensure that unnecessary hospital admissions can be avoided would prove a cost-effective measure.

- e) The composition of the palliative care workforce, including:
- i. Its ability to meet the needs of the ageing population, and
  - ii. The adequacy of workforce education and training arrangements

There is funding provision planned for the reform of the aged care workforce and this will assist in developing strategies to up-skill staff working in aged care, particularly those working in residential aged care facilities, however, palliative care is not restricted to those with cancer and the elderly. Resources and support are required for all healthcare staff to provide a palliative approach to their care for any patient who needs it, regardless of race, gender, age or disease.

**Recommendation:** That provision of palliative care education must be made available in any healthcare training course leading to a formal qualification in a healthcare profession are essential to improve care, because the numbers of people who have palliative care needs far exceeds the numbers that could access specialist services at this time.

- f) The adequacy of standards that apply to the provision of palliative care and the application of the Standards for Providing Quality care to all Australians

A lack of standardisation in prescribing practices across Australia has significant flow on effects to other aspects of the patient management, including supply and administration of medicines in a timely way. Palliative care is a predominantly community based discipline. Prescribing is not limited to specialist practitioners but is also carried out by others such as the patient's General Practitioner. The National Safety and Quality Health Services Standards recommend that agreed and documented clinical guidelines and/or pathways are available to the clinical workforce (1.7.1) and the use of agreed clinical guidelines by the clinical workforce is monitored (1.7.2). The aims of comprehensive medication guidelines are to:

- Ensure consistency in practice
- Promote rational use of medicines
- Encourage practical prescribing for medications that are more readily available in the community

Provision of specific palliative care standards to ensure that services prioritise the development, implementation, education for and maintenance of up to date and evidence-

based clinical guidelines will assist in development of a supportive culture for enabling and up-skilling of all staff working with palliative care patients and their carers.

**Recommendation:** That national Prescribing Guidelines for Palliative Care be developed within an Australian Context.

- g) Advance care planning, including:
- i. Avenues for individuals and carers to communicate with health care professionals about end of life care
  - ii. National consistency in law and policy supporting advance care plans, and
  - iii. Scope for including advance care plans in personal electronic health records

Community and hospital pharmacists are able to provide a patient with a Home Medication Review (HMR) or Residential Medication Management Review (RMMR) after referral by a GP. An HMR involves the patient's GP and a community pharmacist of their choice. The GP sets up the review by writing a referral to the pharmacist. A pharmacist conducts an interview, and then writes a report back to the GP. The GP will discuss any recommendations with the patient and may make appropriate changes to the patient's medication regimen.

However, Medicare funding for a HMR or RMMR restricts this to once a year, and the bureaucratic system leads to delays in service provision. This lack of flexibility in the system can lead to poor outcomes for palliative care patients. Patients can deteriorate quickly and without warning. Lack of access to a HMR at short notice or a second HMR within a year means that medication management problems can be missed and not acted on, which in turn may lead to poor outcomes for the patient.

**Recommendation:** The application for funding for HMR's and RMMR's for palliative care patients should be streamlined to allow for faster access for deteriorating patients and for access to a second review within 12 months if the patient begins to deteriorate after a period of stability.

- h) The availability of funding of research, information and data about palliative care needs in Australia

*References:*

*National Safety and Quality Health Service Standards, September 2011*

*Pharmaceutical benefits for Palliative Care: Preparations which may be prescribed for patients receiving palliative care: <http://www.pbs.gov.au/browse/palliative-care>*

*Standards for providing Quality Palliative Care for all Australians, Palliative Care Australia, May 2005*

*A guide to palliative Care Service Development: A population based approach, Palliative Care Australia, February 2005*

*Palliative Care Service Provision in Australia: A planning guide, Palliative Care Australia, September 2003*