

# Chapter 4

## State palliative care services

### Introduction

4.1 As noted in chapter one, the majority of palliative care funding is provided by states and territories, with services often delivered by organisations that operate in a single state or region. Despite the significance of state funding arrangements, the committee received submissions from only three state or territory governments: Tasmania, New South Wales and South Australia. The committee also found that there was relatively little discussion in other submissions of state funding arrangements. The committee did not receive submissions from the governments of those states that witnesses often regarded as having strong service delivery models: Victoria and Western Australia.

4.2 This chapter examines the funding of palliative care services in the states and territories and whether funding arrangements contribute to variations in the standard of care.

4.3 In describing these arrangements it is noted that as a result of decisions through the Council of Australian Governments, (COAG), the Commonwealth assumed responsibility for the provision of aged care health services for all non-indigenous people aged 65 and over and all Aboriginal and Torres Strait islanders aged 50 and over from 1 July 2011.<sup>1</sup> As a result of that COAG agreement, government funded services provided through the Home and Community Care program (HACC) to older people, and younger people with a disability, will transition to a 'Basic Community Services for Older People' program, with service providers being paid by the Commonwealth from 1 July 2012.<sup>2</sup> The provision of HACC equivalent services for younger people with a disability will remain a responsibility of the states and territories.<sup>3</sup>

### Services and funding provided by the states and territories

4.4 As identified earlier, (in chapter 3) at present there is no consistent reporting or data collection available that accurately sets out how the states and territories

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1 Council of Australian Governments, *National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services*, 1 January 2009, p. 2.

2 Council of Australian Governments, *National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services*, 1 January 2009, p. A1.

3 Council of Australian Governments, *National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services*, 1 January 2009, pp. A1–A2.

allocate the subacute funds they received from the federal government. The committee however received evidence which suggests that although services are provided in each jurisdiction, the complexity of funding arrangements results in variations in the standard of care provided.

### **Victoria**

4.5 Professor Rohan Vora, President of Palliative Care Australia and President-elect of the Australasian Chapter of Palliative Medicine considered that Victoria's model overall was the 'gold standard'.<sup>4</sup> Palliative Care Victoria representatives spoke on the system of palliative care that is provided in that state. Like Professor Vora, they suggested it is 'perhaps one of the most comprehensive in the country':

[t]he Victorian specialist palliative care system is well supported by the Victorian State Government...In 2011-12 expenditure by the Victorian State Government on specialist palliative care services [was] around \$108 million.<sup>5</sup>

4.6 Palliative Care Victoria suggested that the approach used in that state, the Palliative Care Resource Allocation Model (PCRAM), which is based on a model developed by Palliative Care Australia, could be applied nationally to overcome the current disparities:

The PCRAM provides a formula for more equitable allocation of new funding based on the needs of the population within defined geographical catchment areas. PCRAM takes account of changes in the population, age structure, rurality and socio-economic status and can be used to address historical funding anomalies and facilitate greater equity in funding allocation and access to services over time. Victoria is also progressing the implementation of a service capability framework for palliative care services, which, amongst other things, articulates the roles and responsibilities of each service capability level (for inpatient, community and consultancy services respectively) to support patient care, service linkages, education and research within and across regions.<sup>6</sup>

4.7 Professor Vora nevertheless indicated that the excellent general model can belie significant service variations:

Even within Victoria it is very patchy. Once you then move to Queensland or other states it gets even more patchy. Metro South is very different from Metro North. As soon as you move out of Metro-anything you suddenly start thinking that maybe you have got to a rural area. It all depends.<sup>7</sup>

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4 Professor Rohan Vora, President, Palliative Care Australia and President-Elect, Australasian Chapter of Palliative Medicine, *Committee Hansard*, 2 July 2012, p. 15.

5 Palliative Care Victoria, *Submission 108*, p. 1.

6 Palliative Care Victoria, *Submission 108*, p. 3.

7 Professor Rohan Vora, Australasian Chapter of Palliative Medicine, *Committee Hansard*, 2 July 2012, p. 15.

4.8 Professor Vora explained that the application of Victoria's model in other jurisdictions should be considered, as it would be one way of guaranteeing that 'wherever you are in Australia... you will get a high quality of palliative care.'<sup>8</sup>

4.9 Victorian Healthcare Association confirmed that a key reason for the strength of Victoria's system is not merely the quantum of funding but the delivery model:

The enablers for an efficient use of health resources arise from good governance. Victoria's devolved governance model has enabled local boards of governance to bring a community perspective to strategic decisions about health service structure and how to meet local demands with limited resources. These decisions should be based on the broad understanding of the social determinants of health and the wide range of health and community services available to address identified community needs. This has been a major strength of the Victorian health system.<sup>9</sup>

### *Western Australia*

4.10 Like Victoria, palliative care services in Western Australia are well supported by government funding. Silver Chain, a Western Australian community based service provider, explained that 'probably 95 per cent or a little bit above' of its funding is provided by the Western Australian (WA) state government.<sup>10</sup>

4.11 Aged and Community Services WA described the Western Australian system, agreeing that services were of a high standard, but that the system did limit the availability of some:

Community palliative care services are provided in WA by visiting specialist teams, including Silver Chain Palliative Care and Palliative Ambulatory Services. The Ambulatory Service, funded by the WA Department of Health, can provide consultancy advisory support, on-site patient reviews and consultations regarding complex palliative care needs, and staff education services to support clinical staff in various settings including residential aged care. It is however only accessible from Monday to Friday during normal working hours.

Silver Chain in WA also receives state government and Department of Veterans Affairs funding (with additional bequests and donations), for home palliative care, and is widely acknowledged as the benchmark for quality community palliative care services.<sup>11</sup>

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8 Professor Rohan Vora, Australasian Chapter of Palliative Medicine, *Committee Hansard*, 2 July 2012, p. 15.

9 Victorian Healthcare Association, *Submission 57*, p. 4.

10 Mr Mark Cockayne, General Manager, Health and Director, Hospice Care Service, Silver Chain, *Committee Hansard*, 5 July 2012, p. 32.

11 Aged and Community Services WA, *Submission 66*, p. 3.

4.12 Silver Chain, which now has operations in South Australia and Queensland, explained the differential they have observed between the level and standard of care in the different states in which they operate. In respect of its operations in Queensland they identified that at present community based palliative care is quite limited and the majority of services are provided through HACC:

The resources in Queensland in terms of specific community based palliative care are very limited. It is probably a differential of about 1000 per cent ...in comparison to what is provided in Western Australia. The majority of services for people in terms of the care that they are receiving is supported predominantly through HACC funding. That provides a level of nursing care and support, but probably not the level that people require at the end of life.<sup>12</sup>

### *Queensland*

4.13 Silver Chain's observations of the Queensland system were echoed by Palliative Care Queensland (PCQ) which stated in its submission to the committee that:

The current situation in relation to palliative care service provision in Queensland is dire and requires immediate review and attention. Overall, the system lacks coordination at all levels:

- There is no state-wide plan for palliative care service delivery;
- Access to palliative care is inequitable;
- Services are poorly funded and inadequately resourced;
- There are severe shortages of specialist doctors, nurses and allied health staff;
- There are significant gaps in education and research at local level, and
- No Queensland specific awareness raising/community education initiatives exist.<sup>13</sup>

4.14 The committee acknowledges that the provision of palliative care in Queensland is currently the subject of a Queensland Parliamentary Committee inquiry. Although the committee did not receive evidence from the Queensland Government to its inquiry, the Queensland Government's submission to that current state inquiry into palliative care services and home and community care services, detailed the palliative care services the state government provides in Queensland:

Palliative care in Queensland is provided in hospital (private and public) and nonhospital environments (including residential facilities, hospices or in a person's home) via a complex service network of providers with multiple funding sources (including the State Government, Australian

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12 Mr Mark Cockayne, General Manager, Health and Director, Hospice Care Service; Mr Stephen Carmody, Chief Operating Officer, Silver Chain, *Committee Hansard*, 5 July 2012, p. 38.

13 Palliative Care Queensland, *Submission 130*, p. 3.

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Government and private contributions) and diverse governance structures. It is an intrinsic component of health and human service care delivery.<sup>14</sup>

4.15 The Minister explained that palliative care is provided both in the community and in the hospital (in-patient) setting and that in addition to community palliative care, specialist in-patient palliative care services were provided:

...in designated units which are located at the following hospitals: Bundaberg, Caloundra, Gold Coast, Gympie, Ipswich, Logan, Mt Isa, Redcliffe, Rockhampton, The Prince Charles Hospital in Cherside, Toowoomba and Townsville.<sup>15</sup>

4.16 The Minister also identified that in addition to the statewide paediatric palliative care service operating from the Royal Children's Hospital, palliative care is also delivered in 'non-designated areas of hospitals':

...data for 2010/11 shows that a further 18 hospitals ...also delivered services under what is termed a designated palliative care program... [a]ll remaining Queensland public hospitals provided some type of palliative care subacute service where palliative care type was the principal clinical intent [and that] Queensland Health has increased the number of admitted patient episodes for palliative care in Public Acute Hospitals by 66% since 2004/05 and non-admitted occasions of service for palliative care nearly four-fold since 2006/07.<sup>16</sup>

4.17 PCQ explained their view that remoteness and distance impact on the allocation of funding and suggested that the current bundling of funding for subacute care meant that the area was not getting sufficient money. PCQ explained that ring-fencing of palliative care is necessary to ensure adequate funding, and to prevent patients who require palliative care from ending up in the acute care setting:

When the first lot of the equivalent of NPA subacute care funds came out we knew that 99 per cent of it was spent in rehab. The next time it came out we gained probably around 10 per cent. Geriatrics, geriatric evaluation and management, and psychogeriatrics also do badly. What tends to happen is the idea is that it goes to rehab because everybody wants to get everybody better—which is fine. The problem is that not everybody does get better. So what happens to those people who do not get better? They end up taking up

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14 Minister for Health, Queensland Health, *Submission 35* (to Queensland Parliamentary inquiry into palliative care services and home and community care services in Queensland), 4 August 2012, p. 3.

15 Minister for Health, Queensland Health, *Submission 35* (to Queensland Parliamentary inquiry into palliative care services and home and community care services in Queensland), 4 August 2012, p. 4

16 Minister for Health, Queensland Health, *Submission 35* (to Queensland Parliamentary inquiry into palliative care services and home and community care services in Queensland), 4 August 2012, p. 4.

acute care beds. That is where they end up: in emergency and acute care beds.<sup>17</sup>

4.18 PCQ reiterated that implementation of the Victorian approach, PCRAM, should be considered:

To go back to Victoria again, look at the Victorian palliative care resource allocation methodology. They look at population size. They look at the socioeconomic profile, the age profile and the remoteness factor. Queensland remoteness factor is a whole different ballgame again.

Those are the things you need to look at. When you block grant someone you say, 'What is your population' and all that. If that money goes to the health and hospital service, it will be spent on something. It may be spent in subacute care, but whether or not it gets spent in palliative care is going to be an issue of the transparent service agreement between the service manager and the hospital service. That is why I am saying we need to have some ring fencing or idea about how much needs to be allocated for palliative care.<sup>18</sup>

4.19 They suggested that of the current funding allocated to subacute care, 25 per cent should be dedicated to palliative care:

The last payment of subacute funding was \$327 million for Queensland... We believe that we need 25 per cent of the \$327 million... We did not get any in the last round and all we have got in this round is less than 10 per cent. It is impossible for services to keep being funded if we do not get any money federally.<sup>19</sup>

4.20 In addition to the need for ring fencing of palliative care from subacute care, PCQ also explained that the money provided under the NPCP to support community based care needs to increase as populations in service areas grow:

...there is this thing called palliative care program funding in Queensland, and that is an amount of money that is given from the Commonwealth to the states each year. We are unsure how much Queensland gets, but that money is given to all of the health service districts and used for home based palliative care. In talking to the services in each region, we can see that that money has never been increased—or at least no-one has ever seen an increase in that money. That means that you have populations that are growing by as much as 25 per cent a year and the money not growing to

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17 Professor Rohan Vora, Palliative Care Queensland, *Committee Hansard*, 2 July 2012, pp. 30–31.

18 Professor Rohan Vora, Palliative Care Queensland, *Committee Hansard*, 2 July 2012, pp. 30–31.

19 Mr John-Paul Kristensen, Chief Executive Officer, Palliative Care Queensland, *Committee Hansard*, 2 July 2012, pp. 30–31.

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look after them... Their referral rate is growing significantly, and the money has just not kept pace.<sup>20</sup>

4.21 Blue Care is one of Australia's largest not-for-profit providers of residential aged and community care, which supports community based clients, residents of aged-care facilities and families throughout Queensland and northern New South Wales. It was also of the view that Queensland's current system of funding palliative care, which involves secondary funding through hospitals, requires reform. Blue Care explained that in Queensland:

[t]here is no specific funding available for early intervention, after hours on-call services or grief recovery programs. End of life services are funded by Queensland Health and managed by the local health service districts. Community care providers, which include not-for-profit providers such as Blue Care, apply to the hospitals for funding when they determine that the person may be entering the terminal stage of their illness and within the last three months of their life. As it is difficult to determine when someone will die, people with life-limiting illnesses often receive significantly less than the allocated three months available; or, occasionally, they just run out of funding at the very end stage of their lives.

The average Blue Care hospital funded palliative admission for 2011 covered only 20 visits, which represented less than three weeks of seven days a week service. At the other end of the scale, where time until death is unpredictable, the client lives longer than the three-month time frame and funding may be ceased. Funding can often be limited to one hour of care per day. However, one nursing visit for an unstable, deteriorating or terminally palliative client can take up to three hours. Personal care, domestic assistance and allied health services and respite support are often not funded.<sup>21</sup>

### ***South Australia***

4.22 The South Australian government funds palliative care using a casemix approach:

All inpatient activity is funded as sub-acute on the casemix funding model using the diagnostic related group codes. All out of hospital (community) and outpatient activity is currently funded through weighted outpatient occasion of service.

As a result of implementing the [*South Australian Palliative Care Services Plan 2009-2016*], sub-acute funding is now being directed to expand the community based component of palliative care services and is enabling

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20 Mr John-Paul Kristensen, Palliative Care Queensland, *Committee Hansard*, 2 July 2012, pp. 30–31.

21 Mrs Marie Robinson, Community Care Adviser, Blue Care, *Committee Hansard*, 2 July 2012, pp. 1–2.

increased numbers of people, if they choose, to remain at home at the end of their life.<sup>22</sup>

4.23 At the committee's hearing in Adelaide, The South Australian Department of Health provided an overview of their palliative care program:

SA Health has fostered a very solid framework for palliative care on two fronts. One was the launch of the statewide Palliative Care Services Plan, which runs from 2009 to 2016.

Also, the development and endorsement of the clinical network for palliative care came into effect in February 2010 to support the plan, which provided a whole lot of strategies around how we can move palliative care forward, taking into account the ageing population and the factors that we are going to have to deal with as we move forward.

...[W]e have had to rework the way in which business is done, moving away from local palliative care services towards regional palliative care services, with greater requirements to partner with country services in particular. This is so that the choice of people who want to die at home can be realised, so that they have services that are equipped and able to provide the care that they need.

The structure of the palliative care plan looked at palliative care services in terms of their levels of expertise and what they offer. They were designated as level 6, level 4 and level 2, which kind of correlate with Palliative Care Australia's level 3, 2 and 1 services. So you just multiply those levels by two and you get the equivalent. Level 6 services are full tertiary palliative care services, regionalised with requirements to be engaged in providing research evidence and input into the education programs across the undergraduate and postgraduate curriculums as well as primary health care. They support level 4 services, which are largely based in the peri-urban parts of Adelaide but are now also in four of the major country hospitals—Whyalla, Port Lincoln, Riverland at Berri and Mount Gambier.

They would then have a responsibility, as their capacity builds, to invest in services to support the smaller services that exist out there, like in Kangaroo Island or out on the Eyre Peninsula, where the distance and remoteness is quite a factor. There has been a clinical network to support the rollout of this plan. The clinical network, until very recently, was largely the palliative care clinicians... We have broadened that out to include our community partners so that district nursing, domiciliary care and Indigenous health will be represented at the steering committee level. It will be broadened out so it really works with partners' right across the whole healthcare arena.<sup>23</sup>

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22 South Australian Government, *Submission 27*, p. 5.

23 Ms Kate Swetenham, SA Health, *Committee Hansard*, 5 July 2012, p. 22.

4.24 Unlike the 'dire' situation in Queensland,<sup>24</sup> the committee heard from stakeholders that the palliative care services being provided in that state were effective.

4.25 Silver Chain was complimentary in the observations it made of the South Australian system in which they now operate:

Community based care is predominantly a nursing led service, with support from the in-patient environment and consultancy services that feed back into the community ... the difference with that model is that it has a very clear focus on beds and consultancy services and outreach then into the community. So the expertise sits in those environments in trying to outreach back into the community, rather than being based in the community itself, and giving true community based solutions to the problems that arise for people at home.<sup>25</sup>

4.26 Professor Vora considered that elements of South Australia's system based on their palliative care plan are admirable.<sup>26</sup> Similarly, Resthaven, which employs approximately 4,000 staff, has 1,000 residential beds and supports 'around 7,000 people a year and around 3,000 people at any given time',<sup>27</sup> explained that in South Australia, the expert and specialist care and intervention that is required for palliative patients 'is not directly funded into the aged-care system' but relies instead on 'good relationships with the public health system' which is a responsibility of the state government.<sup>28</sup>

4.27 Resthaven went on to explain this situation to the committee suggesting that it was this systemic issue that needed to be recognised – the fact that there are no 'natural linkages' between aged care and specialist palliative care as aged care is 'predominantly outsourced by governments to the non-government sector, whereas predominantly the funding for any form of specialist palliative care service is retained within the public system.' In South Australia this care is provided through community palliative care teams, staffed by public sector employees:

The natural connections in the system are with the health system, not with the aged-care system. We have very good relationships with some general medical practitioners who have taken a special interest in palliative care, but there are not a lot of general medical practitioners who are in that space.

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24 Palliative Care Queensland, *Submission 130*, p. 3.

25 Mr Mark Cockayne, Silver Chain, *Committee Hansard*, 5 July 2012, p. 38.

26 Professor Rohan Vora, Australasian Chapter of Palliative Medicine, *Committee Hansard*, 2 July 2012, p. 15.

27 Ms Susanne McKechnie, Executive Manager, Community Services, Resthaven Inc., *Committee Hansard*, 5 July 2012, pp. 9–10.

28 Ms Susanne McKechnie, Resthaven Inc., *Committee Hansard*, 5 July 2012, p. 10.

That definitely makes a difference to how easy it is for aged-care staff to effectively manage an individual who has high palliative care needs.<sup>29</sup>

### *New South Wales*

4.28 NSW Health explained that at present in that state palliative care services 'are provided at primary, specialist, and paediatric care levels, within both metropolitan and rural service models':<sup>30</sup>

Primary palliative care services cover the continuum of care for all people who are experiencing a life limiting illness with little or no prospect of cure. This service incorporates general practitioners, community nurses, allied health staff, and other specialist services such as oncology and aged care professionals, working in the community, residential aged care or acute care facilities. These professionals may have existing relationships with the patient, or be providing interventional care in conjunction with more palliative approaches.

Specialist palliative care services include clinicians with recognised skills, knowledge and experience in palliative care. This level of service is appropriate for patients with a life limiting illness whose conditions have progressed beyond curative treatment, or patients who choose not to pursue curative treatment. Specialist teams include Directors of Palliative Care, medical practitioners with qualifications in palliative medicine, clinical nurse consultants with qualifications in palliative care nursing, palliative care nurse practitioners and social workers with experience in palliative care. Formalised bereavement support and pastoral care is also provided within the specialist team.

Palliative care services in metropolitan NSW Local Health Districts typically include patient beds in acute or sub-acute public hospitals or in a third schedule hospital, inpatient consultations, and community medical and/or nursing services. In rural Local Health Districts palliative care services comprise nursing services, fly in/out doctors are funded through the Medical Specialist Outreach Assistance Program. Inpatient beds are provided on a clinical needs basis. There are particular challenges for rural and regional palliative care services where there is no locally based specialist medical palliative care service. To attempt to address this shortfall medical specialists from metropolitan Local Health Districts make regular visits to some regional/rural areas.

Specialist paediatric palliative care is provided by metropolitan Children's Hospitals, each offering an integrated palliative care service in the home, hospital and respite/hospice care through the NSW statewide children's hospice.<sup>31</sup>

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29 Ms Susanne McKechnie, Resthaven Inc., *Committee Hansard*, 5 July 2012, pp. 9–10.

30 New South Wales Health, *Submission 71*, p. 2.

31 NSW Health, *Submission 71*, p. 2.

4.29 In its submission to the inquiry New South Wales Health (NSW Health) informed the committee that it is in the process of mapping 'palliative care services against population needs and investigat[ing] appropriate palliative care population planning tools used in other jurisdictions to assist in future service planning' to ensure that adequate services are provided across the state.<sup>32</sup>

4.30 Despite NSW Health's statement that palliative care is currently being delivered at all levels to all parts of the state, palliative care service providers operating in the state suggested to the committee that funding from the state government was lacking.

4.31 HammondCare is a service provider specialising in dementia care, palliative care, rehabilitation, older persons' mental health and other health and aged services. It explained that, although demand for services had increased, funding from the NSW state government had not:

Sub-acute funding from the NSW Government for inpatient palliative care services has not kept up with demand. Activity targets for sub-acute hospitals have remained unchanged for too long, despite an increase in the number and acuity of palliative care patients as the population ages, and there is no mechanism for adjusting ongoing funding to meet these challenges.<sup>33</sup>

4.32 HammondCare told the committee that over the past three years they had increased the number of palliative care beds at their facility by '47 per cent' yet had not received any additional funding to support the extra services. They also suggested that there is a need for government funding to be provided for capital works in addition to operational expenses:

...the funding that is available only covers operational costs, with no provisions for construction work or building depreciation. An additional source of funding in this area is crucial, given that the National Health and Hospitals Reform Commission (NHHRC) identified sub-acute services as the 'missing link' in the health system and called for a "major capital boost" for these facilities.<sup>34</sup>

4.33 HammondCare suggested that the bundling of COAG funds for palliative care into the subacute care category was resulting in less funds being allocated to palliative care:

In NSW, COAG funding intended for sub-acute services is distributed varyingly through local health districts (LHDs), limiting the scope of

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32 New South Wales Health, *Submission 71*, p. 1.

33 HammondCare, *Submission 41*, p. 3.

34 HammondCare, *Submission 41*, p. 3.

services that specialist affiliated health organisations (AHOs) are able to deliver to people living in their own homes or in residential aged care.<sup>35</sup>

4.34 Like HammondCare, the Bega Valley Community Health Service (BVCHS), located in the Bega Valley Shire with a population of 30,060 and covering 6,052 square kilometres,<sup>36</sup> were also concerned that state government funding for palliative care was inadequate. They explained that primary level palliative care funding is provided through a mixture of general funding mechanisms including general practice rebates, public hospital and community health budgets, residential care subsidies and community services funding. They were concerned that funding received for enhanced primary palliative care services under the Commonwealth's NPCP:

...is inadequate and is unable to meet the present and future palliative care demand. Currently, this funding is used locally to fund the part time Palliative Care Registered Nurse position and provide a weekend generalist community nursing service for people requiring palliative care.<sup>37</sup>

4.35 The BVCHS explained that it provides services through two general district hospitals as well as through a variety of nursing and allied health professionals.<sup>38</sup> As the majority of its staff are employed on a part time basis, including the specialist palliative care registered nurse, the BVCHS informed the committee that any future additional funding would:

... best be directed towards service support aimed at meeting the often complex psychosocial needs of people requiring palliative care [and a] suitably qualified professional such as a Social Worker, Counsellor or Psychologist could be employed to fulfil this role.<sup>39</sup>

4.36 The Hunter New England Local Health District Palliative Care Clinical Stream informed the committee in its submission that due to the fragmented approach to data collection and inconsistencies in reporting palliative care services, it is difficult for service providers to make a case for additional palliative care funding.<sup>40</sup>

### ***Tasmania***

4.37 The Tasmanian Department of Health and Human Services (TDHHS) in their submission to the inquiry informed the committee that following a 2004 state government commissioned review of the provision of palliative care, they had been working on implementing the recommendations which the review made. The Model for Palliative Care service delivery was developed as a result of the review and is now

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35 HammondCare, *Submission 41*, p. 3.

36 Bega Valley Community Health Service, *Submission 120*, p. 1.

37 Bega Valley Community Health Service, *Submission 120*, pp. 4–5.

38 Bega Valley Community Health Service, *Submission 120*, pp. 4–5.

39 Bega Valley Community Health Service, *Submission 120*, pp. 4–5.

40 Hunter New England Local Health District Palliative Care Clinical Stream, *Submission 6*, p. 3.

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in use in the three Tasmanian Area Health Services.<sup>41</sup> The TDHHS explained that although the three Area Health Services operate independent palliative care services they have a consistent approach and meet monthly to 'facilitate good networking and problem solving between services.'<sup>42</sup>

4.38 In its submission to the inquiry, the Tasmanian Association for Hospice and Palliative Care Inc. informed the committee that of the areas requiring additional funding identified in the 2004 Review, although progress has been made, more needs to be done in terms of 'designated palliative care beds across the State' and the palliative care workforce which is still experiencing a shortfall.<sup>43</sup>

### **Committee comment**

4.39 The evidence received by the committee on state and territory funding was limited. However, there were recurring themes in the evidence. First and foremost was concern about the lack of data about palliative care service provision and expenditure, particularly as a component of sub-acute care in hospitals. This makes it difficult to determine whether services are being appropriately provided.

4.40 Other themes included whether funding was for services at the appropriate level and for round-the-clock care; whether funding growth was matching service demand; and the consistent message, noted in other chapters of this report, that the funding and delivery of palliative care as part of sub-acute health care was not efficient, whether considered from a funding or a service delivery perspective.

4.41 The committee is concerned by the level of variation in the standard of care being provided. Given the differences in service models and demographics between jurisdictions, a one-size fits all approach to funding and the provision of care may not be appropriate. Nevertheless, the current variability appears undesirable. The committee acknowledges the work going on at COAG, and in individual states such as Western Australia (which took a new approach in 2008), in South Australia, and the current review in Queensland. These are positive signs that palliative care funding and delivery is getting attention from policy-makers. The challenge will be to translate this attention into adequate resourcing, effective team-based care, and sufficient support outside hospital care, both to ensure efficient use of funds, and effective support of people's wishes to 'die well' and, often, to die at home or in an appropriate non-hospital setting.

4.42 In later chapters, the committee looks at some of the problems – and solutions – that will help address these issues, such as workforce planning, service delivery models and case management. However, the committee first considers the role of the largest workforce in palliative care: carers.

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41 Tasmanian Department of Health and Human Services, *Submission 22*, p. 3.

42 Tasmanian Department of Health and Human Services, *Submission 22*, p. 8.

43 Tasmanian Association for Hospice and Palliative Care Inc., *Submission 116*, pp. 2–3.

