

Chapter 12

Other matters

12.1 This chapter looks briefly at other important issues that arose throughout the committee's inquiry yet which did not fall specifically within the terms of reference.

International comparisons

12.2 Throughout the inquiry the committee received evidence suggesting that palliative care service provision could indeed be improved if Australia were to consider implementing approaches to palliative care that had proven effective in international jurisdictions.

Gold Standards Framework

12.3 One approach to care that was raised throughout the inquiry by numerous stakeholders was the Gold Standards Framework (GSF) developed and used in the United Kingdom.

12.4 Palliative Care New South Wales informed the committee that the GSF, which was designed to support advanced cancer patients in the community, focuses on community care rather than hospital based care. PCNSW however suggested that its translation to the Australian context may be difficult as the relationship between the government and general practitioners (GPs) in the UK is different to that in Australia. PCNSW told the committee however that in their opinion the 'GSF has some good tools and processes.'¹

12.5 Palliative Care Australia (PCA) informed the committee that they too advocated for the adoption of the GSF by GPs:

We were certainly part of their consultation process around setting up the Medicare Locals and we are certainly advocating with them at the moment for a national program for GPs that is modelled after the Gold Standards Framework in Britain.²

12.6 However, the committee heard that some care providers in Australia are in fact already applying the framework. Alzheimer's Australia informed the committee of a pilot being trialled by Tasmania's Cradle Coast Council.³ Representatives from Tasmania further explained the pilot to the committee:

The project is really based on the United Kingdom Gold Standards Framework, which has been adapted to Australian conditions. It is used in the UK in over 1,000 care homes, and has been since 2004. There is a lot of

1 Mr Peter Cleasby, President, Palliative Care New South Wales, *Committee Hansard*, 2 July 2012, pp. 55–56.

2 Dr Yvonne Luxford, Chief Executive Officer, Palliative Care Australia, *Committee Hansard*, 24 April 2012, p. 20.

3 Alzheimer's Australia, *Submission 44*, p. 19.

evidence showing that it gives better end-of-life care and better assessment and management of symptoms. There is more attention to those parts outside of physical medicine, such as the psycho-social, cultural and spiritual aspects. One of the important things is that it reduces avoidable hospitalisation. In fact, it promotes communication. We get better communication between the residents, all of the staff members within the institutions and the carers outside of the institutions.⁴

12.7 As well as Cradle Coast Council in Tasmania, Amaranth Foundation informed the committee that they too use the GSF in the provision of care:

We actually use the gold standards. The NHS in the UK use that prognostication question—just the basic one, that no-surprise question: 'Would you be surprised if this person were to die sometime in the next 12 months?'

We applied that basic question across all the people with advanced chronic illnesses who attended a GP practice. We then identified those people and, within that 12-month period, we brought them in for their usual chronic disease screening process. The nurse would take their blood pressure or do their diabetes, spirometry or whatever check they were doing and I would sit down and have a chat with them. I would ask: 'How do you feel about what is happening to you? What are some of the issues in your life?'⁵

Nursing Home Doctors

12.8 Another model that was suggested be looked into for adoption in the Australian context was that of the Nursing Home Doctor model used in the Netherlands. BlueCare suggested that the committee:

...look at the model used in the Netherlands, which is a nursing home doctor model [and] ...think about a feasibility study of the introduction of a medical specialty in aged-care medicine in residential aged-care, which is different to our current geriatricians. These specialists would be specifically trained and employed in residential aged care. I recently had the privilege of visiting the Department of Nursing Home Medicine, at VU University in Amsterdam. There they use a teaching nursing home model and they provide two-year training, which has been offered in the Netherlands since 1990, when they realised that reliance on GPs for care of their elderly was not adequate. So whilst it is a more expensive model, compared to using GPs, they find that cost savings are realised, with an almost 95 per cent death rate, in the nursing home setting, as opposed to transferring people to acute care, which is what often happens in Australia.⁶

12.9 BlueCare explained that in addition to helping achieve the outcome of deaths in the community setting rather than hospital, the model used in the Netherlands is:

4 Dr Alan Rouse, Tasmanian Health Organisation, *Committee Hansard*, 5 July 2012, p. 1.

5 Mrs Julianne Whyte, Chief Executive Officer, Amaranth Foundation, *Committee Hansard*, 10 July 2012, p. 29.

6 Associate Professor Deborah Parker, Director, University of Queensland/Blue Care Research and Practice Development Centre, Blue Care, *Committee Hansard*, 2 July 2012, p. 2.

...also about quality of life and promoting residential aged-care facilities as homes where people can maintain quality of life and be well until they die—which is the palliative care philosophy. You need to have personnel who can not only do good assessments, order the right medications or stop the wrong medications, and look to the future to make sure the care people receive is the best that it can be but also support the family through that. So it is partly about stopping people inappropriately going to hospital. We also do not have any data comparing the outcomes for quality of life between that system and others. It is such a unique system that they do not tend to match it with that of other countries.⁷

12.10 BlueCare did however explain that at present the model used in the Netherlands could not be implemented in Australia given the Australian system's requirement that a patient choose their general practitioner:

At the moment, legislatively we cannot oppose somebody having a particular doctor. I have done research in organisations where I have had to write 40 letters to 40 GPs to tell them that we were doing some research in a particular facility and could they participate. If one or two registered nurses have to deal with 40 GPs, administratively that is a major challenge.⁸

Committee comment

12.11 The committee considers that the ongoing development of the provision of palliative care service and models of service delivery in Australia should be informed by international best practice. The committee however considers that this is occurring largely as a result of the dedicated practitioners and academics who work in this field to achieve these outcomes.

12.12 In view of the evidence the committee received concerning the effectiveness of service delivery models that focus on 'dying in place' (covered in Chapter 7), the committee would like to see further research on the appropriateness of introducing a Netherlands-style 'nursing home doctor' model in Australia.

Access to and use of schedule 8 drugs

12.13 Throughout its inquiry stakeholders discussed the importance of ensuring access to schedule 8 drugs for palliative care patients. Schedule 8 drugs are controlled drugs:

Schedule 8 (Controlled Drug) – Drugs of addiction. This category is for substances that should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.⁹

7 Associate Professor Deborah Parker, Blue Care, *Committee Hansard*, 2 July 2012, p. 7.

8 Professor Deborah Parker, Blue Care, *Committee Hansard*, 2 July 2012, p. 8.

9 Pharmacy Guild of Australia, Australia's unique medication scheduling system http://www.guild.org.au/iwov-resources/documents/The_Guild/PDFs/News%20and%20Events/Publications/Fact%20Sheets/scheduling_system.pdf (accessed 4 October 2012).

12.14 The committee heard that the use of schedule 8 drugs is common in palliative care:

The use of morphine and other opioid medications is common in palliative care, as well as in the management of pain more generally, for example for people with chronic pain of all types. These 'drugs of dependence' are listed on Schedule 8 of the Poisons Standard published by the National Drugs and Poisons Schedule Committee and are thus commonly known as Schedule 8 (or S8) drugs.¹⁰

12.15 Although the use of schedule 8 drugs is common and necessary for pain management in palliative care, the committee consistently heard that access to these drugs is at times problematic.

12.16 The South Australia Advanced Practice Palliative Care Pharmacists (SAAPPCP) stated in their submission that although the addition of pharmaceutical benefits for palliative care had improved access to a small number of listed medications for some patients:

...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.¹¹

12.17 The SAAPPCP went on to explain that:

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.¹²

12.18 They suggested to the committee that what was required was a 'full review of the medications available on pharmaceutical benefits for palliative care' given that 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.'¹³

12.19 In addition to these concerns, Aged and Community Services of Western Australia spoke of the jurisdictional inconsistencies that also led to access issues:

10 Aged Care Association of Australia, *Submission 93*, p. 5.

11 South Australia Advanced Practice Palliative Care Pharmacists, *Submission 13*, pp. 2–3.

12 South Australia Advanced Practice Palliative Care Pharmacists, *Submission 13*, pp. 2–3.

13 South Australia Advanced Practice Palliative Care Pharmacists, *Submission 13*, pp. 2–3.

Legislative jurisdictions also impact on a nationally consistent approach to providing health care because of differences in regulations relating to who is able to administer medicines (such as Schedule 8 drugs) and the use of syringe drivers to manage pain, and indeed, access to certain drugs that are funded under the Pharmaceutical Benefits Scheme and public hospital system.¹⁴

12.20 The Pharmacy Guild of Australia (the Guild) also raised these concerns:

...there are differences that apply across jurisdictions that can hinder the access of palliative care patients to medicines. This is particularly problematical in communities on the border or across territories where patients may travel across jurisdictions to access appropriate care ... If you are going to have a national monitoring scheme for opioids, you should have regulations in a standard format in place before you start. ... To have this legislation in common across jurisdictions would facilitate the care of patients.¹⁵

12.21 The Guild suggested that having a safe disposal system in place could assist in the control of schedule 8 medications:

The disposal of controlled drugs in a proper manner could be achieved by having a safe disposal system put in place. Safe disposal is essential to avoid accidental poisoning of household members, particularly children, medicine abuse and toxic release into the environment. As such, the guild would recommend that a return system be considered. That would assist in removing high-risk medicine such as schedule 8 medicines and cytotoxic medicines from households where they are no longer required.¹⁶

12.22 When asked who they consider should address this problem, the Guild explained that action was required at the federal level as the federal government could ask the states to introduce 'uniform regulation for the supply of schedule 8s:'

It is a common-sense approach and a lot of other things under COAG have been established to deliver a uniform set of rules. Providing the Commonwealth were putting a strong case that this was needed for a universal control system as well as for other more humane and medically based conditions, that argument should certainly win the day. I think the Commonwealth would need to take the lead role.¹⁷

12.23 The Guild went on to explain that in their opinion there should be no arguments against such a reform although the states may resist any such changes:

There is no argument against it, except the states like to control what goes on. The argument the states could run is that, even though there would be a centrally based scheme of approval, if something went wrong they would

14 Aged and Community Services WA, *Submission 66*, p. 5.

15 Mr Denis Leahy, Committee Member, New South Wales Branch, Pharmacy Guild of Australia, *Committee Hansard*, 10 July 2012, pp. 1–2.

16 Mr Denis Leahy, Pharmacy Guild of Australia, *Committee Hansard*, 10 July 2012, pp. 1–2.

17 Mr Denis Leahy, Pharmacy Guild of Australia, *Committee Hansard*, 10 July 2012, pp. 7–8.

have to clean it up. They would like to have control within their own states to make sure nothing goes wrong that would be adverse to the patient. So you have an issue there of the cost to the state if there is a misadventure, as opposed to an argument about the universality of availability. You would probably need to address those questions about what the funding mechanisms are to monitor at a state level, as opposed to having regulations that are all-encompassing across state borders.¹⁸

12.24 They informed the committee however that steps were being taken to improve standardisation and national consistency:

...the first step in the process has been put into place. We now have national registration of health professionals. We all have a number, whether we like it or not, and that is already in place. There are linkages in our dispensing systems and our recording in Tasmania and narcotics are recorded live to the state health department. It is a model that is going to be rolled out around the rest of the country as a government initiative.¹⁹

12.25 The Pharmacy Guild explained their 'hope for global palliative care funding being made available to include such things as wound care, compound medicine and nutritional assistance:'

We believe that this could be achieved by the expansion of the palliative care schedule that already exists. Any controlled drug monitoring system should take into account that there will be high use of opioids by this particular group of people during the palliative care phase.²⁰

12.26 The committee also heard that difficulty accessing medication is an issue in rural areas, particularly where medical practitioners are few and nurses do not have access to the necessary drugs:

...where populations tend to be fairly small...the local doctor, the GP, is usually the first port of call. There are towns that do not have a GP and where specialist nursing staff may be of assistance. A lot of palliative care problems can be relatively quickly sorted out by nurses who are properly trained, but they still need access to prescribers. You basically cannot run a non-prescribing service in palliative care and you also need pharmacy back-up... your little kit of drugs, for instance, that you might need to manage someone dying at home is mostly tightly regulated as schedule 8 drugs. So they are not the sorts of things that your community pharmacy is going to be happy to supply without appropriate authority and in the kinds of amounts and volumes that might be needed. Specialist nursing staff can do a lot but they cannot do that without prescribers. We think that some of the newer technologies might be able to assist.²¹

18 Mr Denis Leahy, Pharmacy Guild of Australia, *Committee Hansard*, 10 July 2012, pp. 7–8.

19 Mr Harvey Cuthill, National Councillor, Pharmacy Guild of Australia, *Committee Hansard*, 10 July 2012, pp. 7–8.

20 Mr Denis Leahy, Pharmacy Guild of Australia, *Committee Hansard*, 10 July 2012, pp. 1–2.

21 Associate Professor Frances Boyle AM, Former Executive, Medical Oncology Group of Australia, *Committee Hansard*, 2 July 2012, pp.41–42

12.27 Professor Boyle went on to explain that new technologies may assist in the delivery of palliative care, including pain management, to rural and remote areas. He cited a possible role for the national broadband network:

We have a project with the National Broadband Network, for instance, which has called for research projects to look at delivery of care using telemedicine, and things like managing people's pain using the broadband network in rural areas might well be feasible. We do not know whether that will get funding, of course.²²

12.28 Although these problems of access are greater in rural areas, the committee heard that they also extend to residential aged care facilities where problems accessing medication often arise as a result of a limited workforce:

Where we have difficulty is if that aged-care facility does not have a registered nurse and we are requiring morphine or some schedule 8 medications. If there are untrained staff—and I am talking about PCAs—then we will not train them on that.

What we will often do is train a family member, just like in the home. Just like when you are in your own home, we will train a family member. We find that facilities will not allow a family member to give medications because that confuses their regulations, but we will actually educate a family.²³

12.29 Professor Jane Phillips spoke of this problem and suggested that the concept of nurse practitioners who can dispense controlled drugs could assist in both rural and regional areas and residential aged care facilities:

...it is really important to make sure that we do not make regional differences with nurse practitioners being in only rural communities and not necessarily in metropolitan communities. It should be based on where their skills would be best utilised. Yes, some of the issues around prescribing items are really quite important because you do not actually want to penalise patients by not being able to access their medication because they are seeing a nurse practitioner.²⁴

12.30 Palliative Care Australia went further and suggested that registered nurses be authorised to provide the 'full range of symptom and end-of life support including:'

...symptom assessment, the ordering and administration of medications, particularly schedule 8's and to be able to provide p.r.n. medication administration.²⁵

22 Associate Professor Frances Boyle AM, Medical Oncology Group of Australia, *Committee Hansard*, 2 July 2012, pp.41–42.

23 Ms Jeanette Moody, Chief Executive Officer, Eastern Palliative Care Association Inc., *Committee Hansard*, 4 July 2012, p. 4.

24 Professor Jane Phillips, Professor of Palliative Nursing, University of Notre Dame and St Vincent's Sacred Heart, *Committee Hansard*, 2 July 2012, pp. 60–61.

25 Palliative Care Australia, *Submission 98*, p. 9.

12.31 PCA suggested that this may assist with limiting the:

...many occasions staffing shortages lead to unrelieved pain and admission into an acute care facility, often through Emergency Departments with unnecessary trauma for both the patient and family. Rural RACFs can only manage patients with complex palliative care needs if they are able to access support, consultation and medications from specialist palliative care teams. This requires more staffing of specialist palliative care teams.²⁶

12.32 When these matters were raised with the department, DoHA explained that:

Each state and territory has its own legislative requirements on the matters that must be included on a valid prescription for a Controlled Drug (Schedule 8) medicine which differ between states and territories. The Therapeutic Goods Administration (TGA) does not regulate prescriptions. Note that the technical requirements for prescription validity is a small aspect of regulation of Schedule 8 medicines by states and territories, which have differing approaches to the public health management of Schedule 8 medicines in drugs and alcohol treatment programs, attention deficit hyperactivity disorder, and longer-term use.

The TGA is aware that states and territories have given priority to assisting the delivering of the Electronic Recording and Reporting of Controlled Drugs (ERRCD) initiative. This initiative is funded by the Australian Government Department of Health and Ageing as part of the Fifth Community Pharmacy Agreement between the Commonwealth and The Pharmacy Guild of Australia. A move from manual to electronic recording and real-time reporting will improve the ability to efficiently monitor the prescribing and dispensing of Controlled Drugs to ensure appropriate access to these medicines. Real-time access to accurate dispensing information will improve the efficiency by which state and territory regulators, prescribers and pharmacists identify problems of forgery, abuse and doctor shopping and improve public health outcomes.²⁷

12.33 Another matter raised with the committee was the issue of 'off-label' use of drugs which stakeholders suggested occurs frequently in palliative care. According to the Pharmacy Guild of Australia, between 30 and 45 per cent of prescriptions are used 'off-label':

I would respectfully suggest you could be looking at between 30 and 45 per cent of prescriptions that are dispensed in this space could well be for off-label use. For example, the hypnotics and benzodiazepines that are used have often been approved for sleeplessness or anxiety but in fact in this space are used for delirium, tremors and something similar, and on and on it goes. Quite a substantive volume of the drugs that are used in this space are used for so-called off-label use.

26 Palliative Care Australia, *Submission 98*, p. 9.

27 Department of Health and Ageing, answers to questions taken on notice, question 4, received 23 August 2012.

12.34 The Guild explained that although the use of drugs 'off-label' is not illegal it requires additional work for prescribers:

It is quite a legitimate use. There are some connotations out there that it is illegal. It requires extra work on behalf of the prescribers to provide adequate patient information and that is that you need, as I understand the law, to have an informed patient in this instance. In the case of palliation, that is sometimes quite a difficult space to go into—to have a patient who is informed, if you are using an end-of-life drug for something like delirium, is an extraordinarily challenging circumstance; good luck.²⁸

12.35 When questioned about these matters the department explained:

...there is a project that we are funding that is looking at a number of different off-label drugs for use in palliative care. I think at present there are 26 drugs on the PBS in 50 different forms that are available for palliative care services. They are under the PBS, but obviously the decision to place a drug on the PBS requires a recommendation by PBAC before the government takes action.²⁹

12.36 The department further explained that:

The practice of prescribing registered drugs outside of their approved indications is not regulated or controlled by the Therapeutic Goods Administration (TGA), as it is at the discretion of the prescribing physician. In these circumstances, the TGA is unable to vouch for the safety and efficacy of this use for an unapproved indication and its use is therefore regarded as experimental. It should also be realised that the Australian Government, the Secretary or a delegate of the Secretary cannot be rendered liable to a person in respect of loss, damage or injury suffered by the person as a result of, or arising out of the use of a therapeutic good for a non-approved indication.³⁰

Committee comment

12.37 The committee was concerned by the evidence it received suggesting that palliative care practitioners often encounter barriers when trying to prescribe medications for their patients. The committee considers that these barriers to access are the result of a number of factors and therefore to overcome the problems a multifaceted response is required.

12.38 The committee acknowledges the importance of controlling the use and disposal of schedule 8 drugs, however considers that the need to control these drugs must be balanced with recognition of the important role they play in providing relief to both patients and families, where a loved one is passing through the latter stages of life. The committee takes the view that this cohort of patients has unique needs that

28 Mr Harvey Cuthill, Pharmacy Guild of Australia, *Committee Hansard*, 10 July 2012, p. 8.

29 Mr Nathan Smyth, First Assistant Secretary, Population Health Division, Department of Health and Ageing, *Committee Hansard*, 10 July 2012, pp. 42–43.

30 Department of Health and Ageing, answer to questions on notice, question 5, received 23 August 2012

require flexibility. Impeding access in these cases may in fact cause more pain for both the patient and their family.

12.39 The committee also takes the view that the current mechanisms in place to control schedule 8 drugs is resulting in greater off-label use of medications. The committee considers that as off-label use is not regulated by the TGA, steps should be taken to look at improving access to schedule 8 drugs so that off-label use is minimised.

Recommendation 31

12.40 The committee recommends that the federal government initiate a full review of the medications available on the pharmaceutical benefits scheme for palliative care, particularly schedule 8 drugs.

Recommendation 32

12.41 The committee recommends that through the Council of Australian Governments the federal government expedite the introduction of uniform regulations for the supply of schedule 8 drugs.

Recommendation 33

12.42 The committee recommends that the federal government review the role of nurse practitioners and registered allied health professionals in prescribing palliative care medications to remove barriers to accessing such medications in settings of care where these professionals have a central role in care.

The role of private health insurers

12.43 Throughout its inquiry the committee heard that there are limited private health funds that cover the provision of palliative care in Australia. Palliative Care Australia (PCA) explained that this was the result of it (palliative care) being seen as a 'bottomless pit' rather than a 'prudent investment' not because of any legislative barriers:

There is no legislative barrier to the private sector providing palliative care and the patients claiming for these services through their health insurance. However, insurance funds do not see why they should place it on their schedules. It is seen as a 'bottomless pit' rather than a prudent investment where they could save on inpatient and drug costs.³¹

12.44 PCA went on to explain to the committee that although some private palliative care service providers had managed to receive funding from private health insurers, federal government leadership was necessary to encourage greater participation by private health funds in the funding of palliative care:

...the general lack of willingness of private health insurers to fund more cost-effective palliative care reduces the overall efficiency of the health system and inhibits equity of access. This is an area where national leadership by the Australian Government in relation to demonstrating the

31 Palliative Care Australia, *Submission 98*, pp. 86–87.

business case and negotiating greater participation by private health funds in the funding of palliative care, could be very helpful and productive.³²

12.45 PCA informed the committee that the National Hospital Morbidity Database (NHMD), which provides information about the main funding sources for health care in terms of admitted patients separations, identified that:

In 2008-2009, 77% of palliative care was for public patients; 16% of these cases were funded by private health insurance and 7% by the Department of Veterans' Affairs.

There are marked differences in funding sources for palliative care in public hospitals across jurisdictions ranging from 68% public funding in New South Wales to 96% public funding in the Northern Territory. The proportion funded by private health insurance ranges from less than 1% in the Northern Territory to 23% in New South Wales.

The main funding source for palliative care in private hospitals is significantly different from that in public hospitals. Private health insurance pays for 54% of palliative care in private hospitals of which 31% is for public patients, and the Department of Veterans' Affairs funds 12%. There are also clear differences in the main funding source by jurisdiction in private hospitals. For example, the proportion of palliative care which is designated for public patients and provided in private hospitals ranges from less than 1% in Victoria to 61% in Western Australia.³³

12.46 Cabrini Health,³⁴ the only 'specialist palliative care service in Australia delivering care to patients and families who have private health insurance' also noted the reluctance of private health insurers to participate in the provision of palliative care are:

...resulting in patients needing palliative care being transferred into the public sector at end of life, or the needs of patients and families not being met at this time.³⁵

12.47 They went on to explain that:

This gap in services means that the privately insured patient who receives active treatment for their cancer or other chronic illness from a private specialist and private hospital, is not able to readily access palliative care through the private sector. It is reasonable to assume that privately insured

32 Palliative Care Australia, *Submission 98*, pp. 86–87.

33 Palliative Care Australia, *Submission 98*, p. 42.

34 Cabrini Health is a large Catholic private sector health service providing acute, sub-acute, and aged care services both within the hospital sector and the community, to the people of Melbourne. Within its services portfolio, Cabrini is proud to provide a significant specialist palliative care service through a 22 bed specialist inpatient unit at Cabrini Prahran, a Community Home Care Program to some 160 patients and families, and a Consultative service to improve symptom management and end of life care in our acute hospitals at Malvern and Brighton. Source: Cabrini Health, *Submission 115*, p. 1.

35 Cabrini Health, *Submission 115*, p. 1.

patients generally have an expectation that their private insurance will cover them through all aspects of their illness journey, and not end when curative treatment is no longer appropriate. Some privately insured patients may be able to access private inpatient palliative care, but are missing out on opportunities for comprehensive palliative care in the home because the current funding arrangements favour in-hospital care.³⁶

12.48 As a result, Cabrini recommended that the role of the private health sector in providing comprehensive palliative care to privately insured patients and families be the subject of further inquiry.³⁷

12.49 In its submission PCA went on to explain that '[w]ith appropriate arrangements in place the private sector could play a useful role in providing more choice and access, as well as diversifying the funding sources' for palliative care. It suggested that the main impediments to the greater participation of private health insurers in the provision of palliative care are:

- A fear of cost shifting where the public purse may have funded these services.
- Defining end stage palliative care.
- Assessing patient functionality and the capacity of carers.
- Allocating a budget.
- Managing the private-public mix of services and subsequent funding.
- Locating the required services.³⁸

Committee comment

12.50 The committee acknowledges that in the future demand for palliative care services will increase as the population ages. As more Australians invest in private health insurance, the committee calls on the private health sector and private health insurers to contemplate the role they might play in helping meet the growing demand for comprehensive palliative care.

12.51 The committee considers that further research into the potential role of the private health care sector, including private health insurers, in providing palliative care services is required and suggests that the federal government initiate such a review.

36 Cabrini Palliative Care Service, *Submission 115*, pp. 1–2.

37 Cabrini Health, *Submission 115*, p. 1.

38 Palliative Care Australia, *Submission 98*, pp. 86–87.