PalliativeCare VICTORIA
Living, dying & grieving well

# Palliative Care and End of Life Care

## Relevant Data and References

### Victorian Population[1]

**Total** Victorian Population as at June 2016 was 6.1 million (6,179,249)

Victorian **60 plus** population as at June 2016 was 1.25 million (1,253,534)

Victorian **75+** population as at June 2016 was 412,571.

Victorian Population Increases

| | Total Vic Pop | 75 plus Vic Pop | 60 Plus Vic Pop |
|---|---|---|---|
| 2011-2016 Annual increase | 2.3% | 2.7% | 3.3% |
| 2014-2016 Annual increase | 2.3% | 2.6% | 3.1% |

### Deaths in Victoria

In 2016, 40,015 people died in Victoria. [2] (1.5% increase on previous year).

2015 Crude death rate for Australia was 6.7 deaths per 1,000 population.[3]

### Place of Death

Only around 20% of Australians died outside of hospital or residential aged care in the first decade of the 21st century – one of the lowest rates in the developed world.[4]

Around half of deaths in Australia occur in hospitals.[5]

Silver Chain Hospice Care Service recipients were three times more likely to die out of hospital, compared with those who did not access the service.[6]

### Estimated Need for Palliative Care in Victoria

Population need indicators

In high-income countries, 69%–82% of those who die need palliative care.[7]

The percentage of potential palliative care candidates rises to …80.3 % in people aged 80 and over.[8]

Home and nursing home were the two places of deaths with the highest prevalence of palliative care needs.[9]

Need for palliative care in Victoria

| | # Deaths Victoria | Minimum Need for PC | Maximum Need For PC |
|---|---|---|---|
| Murtagh et al[10] | | 69% | 82% |
| 2016 (Actual) | 40,015 | 27,610 | 32,812 |
| 2020 (Estimate) | 43,491[11] | 30,009 | 35,663 |

Planning Guidelines for Palliative Care Service Provision in Australia

The planning guide for palliative care service provision in Australia recommends 1.5 FTE palliative medicine specialists per 100,000 population.[12] Based on the Victorian population in June 2016, this means that Victoria would require 92.7 FTE palliative medicine specialists. The actual FTE in 2016 was nearly 52% below this, at 41 EFT.

Increasing need for palliative care

The projected rise in deaths from chronic diseases, in addition to increasing overall deaths, and more deaths occurring at older ages, will drive growth in palliative care need that is much greater than previously expected. Our projection of mortality for major disease groups further indicates that the dominant illnesses accounting for the growth in palliative care need will be dementia and cancer.[13]

Multi-morbidity increases with age, which is particularly relevant because far more deaths are projected to occur at older ages by 2040…This means that the complexity of palliative care need is likely to grow due to the high symptom burden, complex healthcare needs, and high hospitalisation rates of patients with multi-morbidity.[14]

## Chronic Disease

In 2013 Chronic diseases were associated with 7 in 10 (73%) deaths.[15]

## Palliative Care Provision in Victoria in 2014-15[16]

Community - 16,084 people received specialist community palliative care at home in 2014-2015. Average duration of care per patient was 130 days at a cost of $2,574.

Inpatient – 6,702 separations from specialist palliative care inpatient services in 2014-15. Average duration per episode of care was 12 days at a cost of $8,893.

The latest available data from the Department of Health and Human Services data collections related to palliative care is from 2014-15.

## Admitted Palliative Care Services

Victoria

In 2014-15, Victoria had 25 public acute hospitals with hospice care units, down from 27 in 2010-11.[17]

In Victoria in 2014-15, there were 21,031 palliative care-related hospitalisations (of which 10% were in private hospitals) and there was an average annual increase in palliative care related hospitalisations of 4.3% in the period 2010-11 to 2014-15.[18]

In Victoria in 2014-15, the rate of palliative-care related hospitalisations was 35.7 per 10,000 population (compared with the national average of 27.5), and the rate had increased by 10% since 2010-11.[19]

In Victoria in 2014-15, the average length of stay for palliative care-related overnight hospitalisations was 11 days.[20]

In Victoria in 2014-15, 52.6% of palliative-care related hospitalisations resulted in the person's death and 3.6% ended with the person being transferred to a residential aged care service (excluding those for whom this was the usual place of service).[21]

In Victoria in 2014-15, public patients comprised 78.3% of all palliative care-related hospitalisations in public hospitals.[22]

National

In 2014-2015, the national rate of palliative care hospitalisations per 10,000 population was 25.5 (a 4.5% increase from the previous year). Palliative care hospitalisations comprised 0.6% of all hospitalisations in Australia (4.7% increase on the previous year).[23]

Nationally in 2014-15, palliative care patients comprised 45.9% of people who died as an admitted patient.[24] (even though chronic disease accounts for 73% of deaths)

## Residential Aged Care Services and Palliative Care

Victoria

As at 30 June 2015, there were 46,086 Victorians living in 754 residential aged care facilities across Victoria.[25]

During 2014-15 in Victoria, there were 17,701 separations of permanent residents from residential aged care facilities[26] (almost 40% of all permanent residents). Assuming the national rate of separations due to death of 81.9% applied, death was the reason for the separation of 14,497 of these permanent residents.

In Victoria in 2014-15, there were 981.9 permanent residential aged care residents per 100,000 population and the rate of permanent residential aged care residents with palliative care status (assessed as needing palliative care using the aged care funding instrument (ACFI)) was 43.7 per 100,000 population.[27] This indicates that 4.5% of all permanent residential aged care residents were assessed as needing palliative care in that year.

In Victoria in 2014-15, there were 10,289 permanent aged care residents and 106 permanent aged care residents with palliative care status who took hospital leave during the year and 76% of these residents were in RACFs in major cities in Victoria.[28] This means that 23% of Victorian permanent RACF residents took hospital leave in 2014-15, and only 1% of them had palliative care status.

National

As at 30 June 2015, there were 176,967 people living in residential aged care services across Australia and of these 97% were permanent residents.[29]

Nationally, in 2014-15, death was the reason for 81.9% of separations of permanent residents from residential aged care facilities.[30]

Nationally, in 2014-15, around 12% of permanent RACF residents who died were accessing palliative care services in 2014–15.[31] This compares with 15% in 2013-14.[32]

Nationally, in 2014-15, death was the reason for separation for 97% of 6,900 permanent residents with palliative care status and death was the reason for separation for 83% of 58,620 residents (without palliative care status).[33]

In 2014-15 (nationally) 22% of permanent residents with palliative care status separated within 4 weeks and 35% within 8 weeks.[34] Table AC.14

Nationally, in 2014-15, aged care funding instrument (ACFI) appraisals had been completed for 231,500 permanent RACF residents and about 1 in 25 (4%) of these residents (9,144) had an ACFI appraisal indicating a need for palliative care. The population rate of palliative care among permanent residents was highest in Inner regional areas (69.0 per 100,000 population) followed by Outer regional (38.8) and Major cities (32.2).[35]

In Australia, as at 30 June 2015, 88,572 permanent aged care residents (50%) had dementia and of these 52% had been assessed as having complex / high care needs.[36]

Palliative care in aged care

Having a framework for the timing and processes involved with transfers from the palliative inpatient setting to RACF setting is an important initiative to work toward for improved patient outcomes.[37]

## MBS Subsidised Palliative Medicine Services in Victoria

In 2015-16, the rate of all MBS-subsidised palliative medicine specialist services in Victoria was 162.7 per 100,000 population, nearly 48% below the national average of 310.4 per 100,000 population. WA's rate per 100,000 population of MBS-subsidised palliative medicine specialist services was 183% higher than Victoria.[38]

In 2015-16, $332 was the average value medicare benefit paid per Victorian patients in respect of MBS-subsidised palliative medicine specialist services; this was15% below the national average and 21% below the average patient benefit paid in WA.[39]

If Victoria had, in 2015-16, had the same rate of patients per 100,000 population receiving MBS-subsidised palliative medicine services as occurred in WA (70.4, c.f. 38.3 for Victoria) and if the average medicare benefit paid per patient receiving these services had been the same as occurred in WA ($598, c.f. $332 for Victoria), the level of medicare benefits paid in respect of MBS-subsidised palliative medicine services in Victoria in 2015-16 would have been $2,522,918 (more than 3 times the actual payment of $763,242 in that period for this purpose).

## Palliative Care in General Practice

There is no nationally consistent, routinely collected primary healthcare data collection that enables reporting on the provision of palliative care by GPs. There are no palliative care-specific MBS items that can be used by GPs. Consequently, palliative care-related services delivered by GPs cannot be established from existing Medicare data.[40]

Nationally in 2014-15, approximately 5 GP encounters per 1,000 population were related to palliative care. (Palliative care-related GP encounters are difficult to define as palliative care is not a medical diagnosis in its own right but a process related to a stage in managing an illness. As such, GPs may record the problem(s) they manage as part of the palliative care process (for example, lung cancer) but not the palliative care process itself. The numbers of palliative care-related encounters are therefore likely to be an underestimate.[41]

## Workforce and Workforce Implications

In Victoria in 2016, there were 45 specialist palliative medicine physicians employed and the FTE rate was 0.7 per 100,000 population - 28.5% below the national average of 0.9 FTE.[42]

In Victoria in 2016, there were 970 palliative care nurses employed and the FTE rate was 13.6 per 100,000 population (compared with the national FTE rate of 12 per 100,000 population).[43]

A greater focus on non-specialist health professional education is needed. In particular, we must prepare for the growth in dementia and cancer if we are to provide appropriate care to people dying in the future.[44]

## Early Access to Palliative Care

Patients benefit from early access to palliative care.[45]

Early access to palliative care reduces costs.[46]

Earlier palliative care consultation for hospitalized patients with advanced cancer resulted in more cost reduction than did later consultation.[47]

### Service Model Implications

Future plans for end-of-life care must account for the rising healthcare use of older adults with comorbidity, and health services must adapt from the current tendency to focus care on single organ disease, to more co-ordinated, person-focused care. Appropriate integrated models of care, including integrated short-term specialist palliative care services, may help to improve care co-ordination and allow care delivery in line with individual preferences.[48]

### Impact of Palliative Care on Health Use and Costs

There is increasing evidence of the economic benefits associated with improved provision of palliative care and end of life care services, with these services costing a third to a quarter of the cost of standard care.[49]

Palliative care consultation yielded a 32% reduction in hospital costs when initiated within 2 days of admission for patients with cancer and multiple comorbidities.[50]

Use of community-based palliative care in the last year of life was associated with an average 50% reduced rate of ED visits.[51] (WA Study)

Four well-designed randomized interventions as well as a growing body of nonrandomized studies indicate that outpatient palliative care services can: 1) improve patient satisfaction, 2) improve symptom control and quality of life, 3) reduce health care utilization, and 4) lengthen survival in a population of lung cancer patients.[52]

Silver Chain … provides evidence that a well-coordinated community-based palliative care program has the potential to reduce emergency department presentations and hospital use in the last year of life, and increase the rate of dying out of hospital, thereby reducing the cost of hospital-based care and therefore overall palliative care costs.[53]

Silver Chain Hospice Care Service recipients had, on average, 8.0% fewer emergency department presentations and spent 5 days less in hospital over the last year of life, compared with those who did not access the service… HCS recipients were three times more likely to die out of hospital than those who did not access the service.[54]

### Lack of Access to Palliative Care

#### WA Study

One area that remains a concern is the number of people with life limiting non-cancer conditions who do not access specialist palliative care.[55]

Less than 20 % of decedents with the more common life limiting conditions of heart failure, renal failure and chronic pulmonary respiratory disease accessed specialist palliative care in the last year of life - and this care was accessed in the final few weeks.[56]

#### Eastern Health Study – patients with advanced lung cancer

Over 20% of non-referred patients to Box Hill hospital and over 42% of non-referred patients to Maroondah hospital died either during admission, or within 3 months of admission.[57]

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