22 February 2019

Victorian State Pre-Budget Submission 2019 - 2020

To

The Hon. Tim Pallas, Treasurer
The Hon. Jenny Mikakos, Minister for Health
Mr. Anthony Carbines, Parliamentary Secretary for Health

“All Victorians and their families should receive the best possible end of life care and be able to genuinely make choices about the care they receive as they approach the end of their life.”
Ministerial Foreword, Victoria’s End of life and palliative care framework, 2016

Palliative Care Victoria Requests:

We call for additional recurrent investment of $65M a year in the May 2019 Budget to improve access to palliative care and end of life care for Victorians with a life limiting illness and their families so they are supported to live, die and grieve well.

Recognised priority

The need for improved access and funding for palliative care and end of life care has been recognised by Victoria’s Auditor General (2015), Victoria’s End of Life Choices Inquiry (2016) and the Productivity Commission (2017). Victoria’s End of life and palliative care framework (The Framework), released in July 2016, articulates important commitments, goals and priorities that require appropriate investment.

Palliative care service funding has declined in real terms over the past 5 years

Recurrent funding for community and inpatient palliative care services over the past 5 years has not kept pace with increases in wage and other costs, resulting in a 4% reduction in the purchasing value, placing pressures on the quality and scope of care able to be provided.

Growing unmet community need for palliative care

There has been no additional recurrent funding to respond to the 4% average annual increase in community need for palliative care [The Framework, p3.] At least 10,000 Victorians will die this year without needed palliative care, with negative impacts on the quality of life for them and their carers.

Economic value of investment in palliative care

Evidence shows that palliative care contributes to more effective and efficient use of health resources. This includes fewer emergency and hospital admissions, shorter lengths of stay, and the elimination of non-beneficial tests and treatments.

Recommendations and supporting data

Please refer to our detailed recommendations informed by extensive research and consultation, as well as supporting information on the economic value of palliative care, the trends in palliative care funding and unmet and growing community need for palliative care.

Thank you for considering this submission. We would welcome the opportunity to discuss this with you.

Dr Barbara Hayes, Board Chair and Odette Waanders, CEO
Introduction

This paper compares Victorian Government recurrent funding for inpatient and community palliative care services for 2014-15 and 2018-2019 respectively. Appendix 1 describes the methodology used.

4% Decline in Purchasing Value of All Recurrent Palliative Care Service Funding

In 2018-19, the total Department of Health and Human Services (DHHS) recurrent funding for inpatient and community palliative care services is $119.57 million, $18.24 million (18%) more than 2014-15. However, wage and other costs increased by 22% over the five-year period, reducing the purchasing value of the 2018-19 funding by 4% compared to 2014-15. The table below provides further details.

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2014-2015</th>
<th>Change</th>
<th>Change</th>
<th>Weighted Cost</th>
<th>Net change in real value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 000</td>
<td>$ 000</td>
<td>$ 000</td>
<td>%</td>
<td>Adjustment</td>
<td></td>
</tr>
<tr>
<td>Inpatient Palliative Care</td>
<td>$60,600</td>
<td>$59,420</td>
<td>$908</td>
<td>1.52%</td>
<td>20.87%</td>
<td>-19.35%</td>
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<tr>
<td>Community Palliative Care</td>
<td>$58,969</td>
<td>$41,165</td>
<td>$17,335</td>
<td>41.64%</td>
<td>23.53%</td>
<td>18.11%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$119,569</td>
<td>$100,585</td>
<td>$18,243</td>
<td>18.00%</td>
<td>22.18%</td>
<td>-4.18%</td>
</tr>
</tbody>
</table>

19% Decline in Purchasing Value of Recurrent Inpatient Palliative Care Funding

DHHS recurrent funding for 31 health services providing inpatient palliative care in 2018-19 is $60.6 million, just under $1 million (1.5%) more than in 2014-15. After adjusting for wage and cost increases over the 5-year period, the 2018-19 funding has declined by 19% compared to 2014-15.

18% Increase in Purchasing Value of Recurrent Community Palliative Care Funding

DHHS recurrent funding for 33 community palliative care services in 2018-19 is almost $59 million, an increase of $17.3 million (41.6%) compared to 2014-2015. Taking into account wage and cost increases over the 5-year period, the purchasing is 18% higher in 2018-19 compared to 2014-15.

Overall 4% Decline in the Value of Recurrent Palliative Care Service Funding for these Services

The capacity of Victorian inpatient and community palliative care services declined overall by 4% between 2014-15 and 2018-19 as funding did not keep pace with increasing wage and other costs.

$47 Million Shortfall in Funding to Meet Annual Growth in Need for Palliative Care

The Victorian Government estimates a 4% increase each year in the need for palliative care. To meet this growing community need, the 2018-19 recurrent funding would need to have increased to $148.3 million (inclusive of wage and cost increases to maintain purchasing value. This means there is a $47 million shortfall in the funding recurrent funding for inpatient and community palliative care services in 2018-2019. Victoria has gone backwards in meeting the community need for palliative care.
Methodology

Data source
The palliative care funding data presented in this report is from the DHHS Statement of Priorities Service Agreements with Victorian health services and the relevant DHHS policy and funding guidelines.

Data scope
The data presented relates to 31 health services funded to provide inpatient palliative care and 33 services funded to provide community palliative care in 2018-19 and 2014-15 respectively.

This analysis excludes:
- 8 district /community health services in regional Victoria that provide some community palliative care but for which specific funding data is unavailable.
- $16.9 million (2017-18)\(^1\) for state-wide and regional consultancy services to provide specialist palliative care advice and support to services.
- $23.4 million new palliative care funding for 2018-19 announced by the Minister of Health on 30 October 2018. As this is non-recurrent funding, it does not support ongoing palliative care service delivery to meet community need and has therefore been excluded from this analysis.
- Other DHHS funding for palliative care - research, education, projects, and capital funding.

Indexation
To assess the purchasing value of the palliative care funding over time, the Consumer Price Index (CPI) for December 2013 and December 2018 has been used. Wage costs increases have been assessed using the average wage rates for March/April 2014 and 2019 in The Nurses and Midwives (Victorian Public Health Sector Single Interest Employers) Enterprise Agreements for 2012-2020.

The composite index reflects a higher ratio of wage to other costs for community palliative care compared with inpatient palliative care. The proportions of inpatient and community funding are used to give the composite index for the total recurrent funding both service types.

<table>
<thead>
<tr>
<th>Palliative care service type</th>
<th>Proportion of Wage &amp; Other Costs</th>
<th>Movement in Costs Over 5 Year Period</th>
<th>Composite Index for Each PC Service Type</th>
<th>Overall Index Adjusted for PC Service Type as % Total Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CPI(^1) Wages(^2) CPI Wages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>33% 66% 9% 27.9% 20.87%</td>
<td>22.18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>20% 80% 9% 27.9% 23.53%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Growing Population Need and Unmet Need for Palliative Care
The Victorian Government estimates an average 4% annual increase in the need for palliative care.\(^2\) Palliative Care Victoria estimates that at least 10,000 Victorians die each year without required palliative care; international benchmarks and data used for this estimate are outlined in the document cited.\(^3\)

\(^1\) Department of Health & Human Services, Palliative Care Funding Model Review, 2018,p12
\(^2\) Department of Health & Human Services, Victoria’s end of life and palliative care framework, 2016, Melbourne, P3
\(^3\) Palliative Care Victoria, Estimated Need and Unmet Need for Palliative Care in Victoria, October 2017, http://bit.ly/PCV-VicNeed17
Giving everyone the choice of palliative care

In 2016, 40,015 people died in Victoria. Population growth, ageing and chronic disease will drive increases in the need for palliative care and end of life care.

Palliative care and end of life care teams support Victorians with a life-limiting illness and their families to live, die and grieve well. High quality care is available at the right time, is responsive to a person’s individual needs, preferences and situation, and where possible is delivered at their home or other preferred place. Currently not everyone in Victoria can access palliative care when they need it.

The need for additional investment

A commitment from the Victorian Government to provide an additional $65 million per year is needed to support implementation of Victoria’s End of life and palliative care framework and fund a range of measures to improve timely, local access to end of life and palliative care services to people across Victoria.

This document outlines three objectives and our recommended actions to respond to current and future need in Victoria.
SNAPSHOT: PALLIATIVE CARE IN VICTORIA

Home and nursing homes are the places where demand for palliative care is highest. Most people wish to receive care and, if possible, to die at home.

Evidence suggests that about 70 per cent of people who receive good quality community palliative care can die at home rather than in hospital or residential care.

**Community palliative care** – 16,084 people received specialist community palliative care at home in 2014/15. Average duration of care per patient was 130 days at a cost of $2,574.

**Inpatient palliative care** – 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.

**Recognised need to improve access to palliative care**

- Victoria’s End of life and Palliative Care Framework requires substantial funding to support its implementation as a priority.
- In 2016, Victoria’s End of Life Choices Inquiry made 30 recommendations to improve palliative care funding and access.
- In 2015, the Victorian Auditor General recommended improvements to improve access to palliative care, noting difficulties in meeting demand.
- The Productivity Commission has recently recommended substantial increases in the availability of palliative care in the community and in aged care facilities.

**Objective 1**

**Increase community awareness and engagement**

Victoria’s End of life and Palliative Care Framework (the Framework) stresses the need to build community understanding in relation to advance care planning, palliative care and end of life care across metro, regional and rural Victoria.

**Recommended actions**

1. **Undertake a strategic community awareness campaign** in collaboration with relevant consumer, chronic disease and peak groups across Victoria. This would build and support their capacity to communicate and engage with consumers about palliative care and end of life care. Target: 20 participating organisations. **Investment:** $1.5M a year.

2. **Engage communities face to face** on these sensitive issues. Using a proven collaborative approach with community organisations, trained volunteers and staff, facilitate small group sessions in relevant languages using tailored resources. Target participation: 20,000 Victorians. **Investment:** $1.5M a year.

**A distressed daughter worried about her father’s future**

A distressed daughter called us about her 92-year-old father who has multiple health issues and 10 per cent remaining kidney function. After six weeks in a Victorian public hospital for an acute infection he was discharged to respite care for four weeks while permanent care was arranged. She was concerned about his future care. No one had discussed his prognosis or palliative care with her father or his family.

One of the many calls PCV recently received from the public.
Objective 2

Increase specialist palliative care availability and capacity

A strong specialist palliative care workforce is needed to address complex needs, to provide education and clinical support to the broader health care workforce, and to achieve the goals of the Framework.

Recommended actions

3. **Increase community palliative care services** to meet current and future need for care at home, including improved support for carers who provide most of the care. *Investment: $14M a year.*

4. **Supplement last-days-of-life at home with more palliative care.** Access to in-home overnight care for the dying person at home by appropriately trained and qualified staff will relieve carers and reduce avoidable hospital admissions. Target: More than 5,000 nights of care at home. *Investment: $5M a year.*

5. **Increase availability of consultancy palliative care.** Sixty per cent of these services cannot meet current demand. They facilitate the right care at the right place and at the right time in inpatient and community settings across Victoria. *Investment: $13M a year.*

6. **Increase inpatient palliative care services.** The rate of palliative care related hospitalisations in Victoria increased by 10 per cent between 2010–2015, and 78.3 per cent of these admissions were public patients. Increasing inpatient services will improve capacity to meet this growing need. *Investment: $7M a year.*

Objective 3

Develop workforce and service system capacity

The Framework highlights the need to build workforce and service system capacity across Victoria’s health and aged care service system, with the support of specialist palliative care where there are complex needs.

Recommended actions

7. **Increase access for residents in aged care services.** Specialist palliative care and end of life consultancy teams are needed to provide proactive and responsive specialist clinical support for aged care staff and GPs caring for residents with complex needs. Target: One team per 33 residential aged care facilities. *Investment: $13M a year.*

8. **Improve after-hours access** to GPs and pharmacists with palliative care and end of life care expertise by providing education and by establishing effective links and protocols to facilitate access to urgent after-hours support. This could be facilitated through collaboration with Primary Health Networks. *Investment: $4.5M a year.*

9. **Enhance workforce availability, education and models of care.** Education and workforce development programs are required to ensure staff with the requisite skills and expertise are available to meet the current and growing need for high quality palliative care and end of life care across Victoria’s health and care system. Further innovation and collaboration is necessary so that service models and practices deliver the best outcomes for people with a life limiting illness, their carers, and the health system. *Investment: $5.5M a year.*
A neighbour concerned about a woman struggling to care for her ailing husband

We were contacted by the neighbour of an 82-year-old man with advanced lung disease who is bed-bound and cared for at home by his 80-year-old wife. The man is determined to die at home. A former patient of the local public hospital, follow-up treatment has been through visits to his GP’s surgery but he can no longer manage this. His wife is struggling to care for him. Nobody had discussed community palliative care with them. The neighbour expects that the man will die before this can be put in place.

One of the many calls PCV recently received from the public.

What is Palliative Care?

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (World Health Organisation)

Who Can Benefit from Palliative Care?

Palliative care is beneficial for people of all ages with a wide range of life limiting conditions, including cancer, end stage organ failure, dementia, other neurodegenerative conditions and genetic disorders. It is provided on a needs basis from diagnosis and including bereavement.

Palliative Care Victoria

Palliative Care Victoria is an independent not-for-profit peak body in Victoria. Established in 1981, we represent palliative care providers, consumers and their families, and those with an interest in palliative care in Victoria. We are a member of the national peak body, Palliative Care Australia.

Our desired outcomes: Caring communities that are supportive and resilient in responding to life limiting illness, death, grief and loss. Equity of access to quality palliative care when and where it is needed. High quality palliative care achieved through a capable and compassionate workforce and a strong, innovative and effective service system.

For more information contact:

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E owaanders@pallcarevic.asn.au
www.pallcarevic.asn.au
ABN 88 819 011 622
Incorporated Association No: A0022429M
WHAT IS PALLIATIVE CARE AND END-OF-LIFE CARE?
The WHO defines Palliative Care as "an approach that improves the quality of life of consumers and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".1 Palliative care is for people of any age who have a serious illness that cannot be cured. Dying is a normal process with palliative care offering a support system to help people to live their life as fully and as comfortably as possible until death and to help families cope during this illness and in their bereavement. People are approaching the ‘end of life’ when they are likely to die within the next 12-months.2

DYING IN AUSTRALIA AND USE OF PALLIATIVE CARE SERVICES
In Australia, palliative care services are provided in a range of healthcare settings including acute hospitals, neonatal units, paediatric services, general practice, residential aged care as well as in community settings such people’s homes. There were 159,052 deaths in Australia in 2015.3 Two-thirds of deaths occurred in people aged 75 years or older, with the most common underlying causes of death being coronary heart disease (12.4%), dementia (7.9%), cerebral vascular disease (6.8%), lung cancer and cancer of the trachea (5.3%), and chronic lower respiratory diseases (5%).3 Although 70% of Australians say they would prefer to die at home, only 15% do.4 Around half of all deaths occur in hospital and just over a third in residential aged care.5 Compared with other OECD countries such as New Zealand, South Korea, Ireland, France and the US, the rate of deaths at home in Australia is low.4

Many Australians reaching the end of life do not receive palliative care, even though when asked, they have clear preferences for the type of care they would like. In 2014-15, of the 76,856 people who died as a patient admitted to hospital, only 46% had received palliative care during their final hospitalisation; only 4% of residents in aged care had a formal appraisal indicating that they required palliative care; only 1 in 1,000 patient encounters with GPs was palliative care-related. Of all the services provided in 2015-16 by palliative medicine specialists and which were subsidised under Medicare, only 5.8% involved consultations in a patient’s home; and the majority of patients who received palliative care had advanced cancer.6 People with other chronic life-limiting conditions such as chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD) or dementia have symptoms as severe and distressing as those of cancer patients, but they do not have the same access to palliative care services as those with cancer.

ECONOMIC BENEFITS OF PALLIATIVE CARE
Research consistently shows that people who receive palliative care compared with those receiving usual care, have less hospitalisations, shorter lengths of hospital stay, reduced use of Intensive Care Units (ICUs) and fewer visits to Emergency Departments (EDs). Cost-savings from palliative care interventions occur across a number of settings including delivery at home, in hospital, in residential aged care, for cancer and non-cancer life-limiting illnesses and early versus late delivery of care.

Palliative care at home: Most people prefer to die at home or in a home-like environment surrounded by family and friends.7 The evidence shows that home-based palliative care saves costly resources while improving consumer quality of life and that person-centred palliative home care is cost-effective.8-10 When palliative care is provided at home, palliative care patients are 87.5% more likely to remain in the community until death.9 While there are increases in the costs of GPs and other health professionals providing palliative care relative to usual care, home palliative care programs are cost-effective with the reduced need for and decreased costs of hospital-based care more than off-setting the costs of the program.3,12-13

Palliative care in hospital: Inpatient specialist palliative care consultation teams are found consistently to be less costly than usual care practices.14 Cost-savings from palliative care are greatest among persons who die in hospital and increase the earlier palliative care is introduced.15,16 Both inpatient palliative care consultation services and specialised palliative care units in hospitals are associated with economic benefits. Cost-savings accrue through earlier hospital discharge, reduced intensity of care (use of resources including clinical services, ICUs, therapeutic procedures, diagnostic and imaging, pharmacy), or a combination of both.14,17,18 Inpatient palliative care has also been shown to reduce 30-day hospital re-admissions, an indicator of quality of healthcare. The provision of palliative care decreases costs of hospitalisation by better matching treatments to patients’ and families’ preferences and goals of care. This not only improves the quality of end-of-life care also the quality of dying.

Palliative care in residential aged care: Identifying the need for end-of-life care in aged care residents is difficult as residents often have multiple morbidities, symptoms are under-estimated, underlying illness trajectories vary and time to death may be unpredictable.19,22 Staffing levels also tend to be low, there are competing demands on nursing time, and medical care to residents is largely provided by GPs and is very time limited.19,20 These aspects of residential aged care lead to residents
receiving sub-optimal care. The economic evidence shows that an investment in palliative care in residential aged care significantly reduces costs in the hospital sector through reduced visits to EDs, decreased overnight hospital admissions and reduced days stayed while providing more symptom control, pain relief and comfort for both residents and their families. The percentage of residents dying in hospital also decreases.

**Non-cancer Life Limiting Conditions:** Traditionally palliative and end-of-life care is associated with advanced cancer. Palliative care improves symptom management, pain relief and quality of life but in many chronic life-limiting conditions, like CHF or COPD, palliative care is still significantly underutilised and referral delayed. There has been a small but appreciable increase over the past 10 years in access to palliative care services in Australia by patients dying from non-cancer conditions, but the majority of people with other life-limiting illnesses still die before they receive palliative care. The continuing high use of costly resources in the final months of life suggests models of care still focus on prolonging life and a tendency toward aggressive care. Palliative care saves resources and is cost-effective in delivering compassionate person-centred care to this group of Australians.

**Early Access to Palliative Care:** The strong association between early palliative care and decreased costs suggests that palliative care teams are effective in modifying the care and health trajectories of patients and improving quality outcomes. With respect to the hospital sector, cost-savings associated with early inpatient palliative care are more pronounced the earlier palliative care is integrated into patient care. The main reasons underlying the economic benefits of early palliative care are the reduction in clinically futile treatments and more patient-focussed and less aggressive care due to improved clinician-patient-family communication about treatment goals, preferences and transition planning. Early palliative care mediates the escalation of direct costs of care towards the end of life. Despite its cost-effectiveness and recommendations that early palliative care is offered to consumers, specialist palliative care services are still underutilised in Australia.

**CONCLUSION**

If the place of death and care preferences of people approaching end of life are to be realised then a much greater investment is needed in the provision of specialist palliative care services in Australia. There is clear evidence of the cost savings that accrue from palliative care and its cost-effectiveness. It is imperative to expand the scope of economic evaluations to more fully understand and recognise the role palliative care plays in enhancing value in healthcare and improving the quality of life of people with progressive life-limiting illness.
Estimated Need and Unmet Need for Palliative Care in Victoria

1. **Population need for palliative care**

   Current population needs for palliative care produce broadly similar results in terms of how many people are estimated to need palliative care.\(^1\)

   The estimated population need for palliative care at the end of life is 75% of all deaths.\(^2\)

   This population estimate of need is based on ten conditions that are recognised as benefiting from palliative care: cancer, heart failure, renal failure, chronic obstructive pulmonary disease (COPD), Alzheimer’s disease, liver failure, Parkinson’s disease, motor neurone disease, HIV/AIDS and Huntington’s disease.\(^3\)

2. **Estimated unmet need for palliative care in Victoria**

   At least 10,000 Victorians who die currently miss out on needed palliative care.

   This is a conservative estimate based on available data on palliative care service provision to Victorians compared with the estimated population need for palliative care.

   This includes specialist palliative care and palliative care integrated into usual care within primary, acute, and aged care settings.

   - **Palliative care provision as a proportion of deaths in 2014-2015**: available data on services provided prior to death indicates that up to 19,939 Victorians who died in that year may not have received palliative care at the time of their death. This represents a shortfall of two-thirds compared to estimated need. The data suggests that up to 80% of those who died in residential aged care and up to 63% of those who died in acute care may have missed out on needed palliative care.

   - **Victorians receiving specialist palliative care services in 2016-17**

     An estimated 20,000 Victorians received specialist palliative care services in 2016-2017; of these 8,288 died in that year. An estimated 21,712 Victorians would have benefited from palliative care prior to their deaths, and this would need to have been provided by non-specialist palliative care services. This level of palliative care provision by acute, aged care and primary care services is not reflected in available data. Greater expertise and capacity is needed to provide palliative care than is currently available in the non-specialist palliative care workforce.

   Section 3 below provides data available on palliative care provision as a proportion of Victorian deaths and in relation to specialist palliative care service provision.
3. Data on Palliative Care Provision Relative to Need

a) Provision of palliative care in relation to Victorian deaths:

The estimates of population need for palliative care are based on the number of deaths. The data below shows available data on palliative care provision in relation to people who died in Victoria. As the most recent available data for deaths in residential aged care is 2014-2015, this year has been used to compare need with provision. However, available data for 2015-16 for the other services shows little change.

<table>
<thead>
<tr>
<th>% Deaths</th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Deaths in Victoria</td>
<td>39,955</td>
<td>40,015</td>
</tr>
<tr>
<td>Population Need for PC</td>
<td>75%</td>
<td>29,966</td>
</tr>
</tbody>
</table>

Community Palliative Care Deaths (VINAH)

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community palliative care deaths</td>
<td>6,850</td>
<td>6,888</td>
</tr>
<tr>
<td>Less community palliative care clients who died as PC inpatients</td>
<td>3,973</td>
<td>3,958</td>
</tr>
<tr>
<td>Total community palliative care deaths (excluding those who died as inpatients)</td>
<td>2,877</td>
<td>2,930</td>
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</table>

Inpatient PC # deaths (VAED)

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,411</td>
<td>5,340</td>
</tr>
</tbody>
</table>

Deaths in Victorian residential aged care (AIHW)

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>14,497</td>
<td>not available</td>
</tr>
</tbody>
</table>

Percentage aged care residents who died receiving palliative care

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>1,740</td>
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</tbody>
</table>

Total number deaths where palliative care was provided the services listed above

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2015-16</th>
</tr>
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<tbody>
<tr>
<td>10,028</td>
<td>see note</td>
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</table>

Shortfall compared to minimum palliative care population need

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>-19,938</td>
<td></td>
</tr>
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</table>

Data on place of death

<table>
<thead>
<tr>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>19,978</td>
</tr>
<tr>
<td>35%</td>
<td>13,784</td>
</tr>
<tr>
<td>15%</td>
<td>5,993</td>
</tr>
</tbody>
</table>

[Note: Specialist palliative care was provided for 8,288 of these deaths.]
b) **Population need estimates compared with specialist community palliative care provision (not limited to deaths)**

In 2016, 40,016 Victorians died.\(^1\) This means that 30,011 Victorians who died in that year would have benefited from palliative care, using an estimated need for palliative care of 75%.

In 2016-17, specialist palliative care services providing care to around 20,000 Victorians (of whom 8288, 41%, died that year).

Data available on palliative care provision in aged care\(^1\) and General Practice\(^2\) indicate that this falls well short of the indicated population need, reinforcing the need for a greater focus on palliative care education of health professionals providing primary care and aged care to people with conditions that would benefit from palliative care.

As the disease trajectory of dementia is both prolonged and unpredictable, specialist palliative care services may need to care for individual patients for longer periods of time and potentially at several time points.\(^3\) Around 52% of over 46,000 Victorians resident in aged care facilities are likely to have dementia based on national data.\(^4\)

4. **References**

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4. Births Deaths and Marriages Victoria, Victoria
5. Murtagh, FE, at al, ibid
6. Department of Health and Human Services, Victorian Integrated Non-Admitted Health (VINAH) dataset for community palliative care – number of community palliative care clients who died during the relevant reporting period.
7. Ibid, number of community palliative clients who died as palliative care inpatients during the reporting period.
8. Australian Institute of Health & Welfare, 2016, Residential aged care and Home Care 2014-15,
   During 2014-15 in Victoria, there were 17,701 separations of permanent residents from residential aged care facilities (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.
9. Australian Institute of Health & Welfare, 2017, Palliative Care Services in Australia 2016, Palliative care in residential aged care, Table AC.14
10. Swerissen, H and Duckett, S., 2014, Dying Well, Grattan Institute, p 20
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