

We welcome the opportunity to meet with Minister Miles next Tuesday after many years of advocacy for

- An equitable sustainable model of funding for Little Haven Palliative Care's gold standard Community Based Palliative Care Service.
- Recognition of the benefits of this model of care for QHealth in providing end of life care options for all Queenslanders.

As mentioned in previous correspondences this is the culmination of multiple meetings with various levels of QHealth bureaucrats and Politicians over many years, including with then Health Minister Cameron Dick in September 2017, where we were told he recognised our need for a funding increase and that it was his job to "fix it".

Ahead of our meeting on Tuesday I further provide the following background information.

... too many people are dying in a way they wouldn't choose, and too many of their loved ones are left feeling bereaved, guilty, and uncertain. The care most Australians receive at the end of life often does not reflect their values, goals, or informed choices.

Australian Centre for Health Research

However, there is a solution which both increases people's welfare and decreases healthcare costs.

Let's begin with where the Productivity Commission ended:

Table 4.1 Overview of proposed reforms to end-of-life care

<i>Proposed reforms</i>	<i>Timeframe</i>	<i>Potential costs and benefits</i>
Community-based palliative care		
Recommendation 4.1 State and Territory Governments to increase the availability of community-based palliative care so that people with a preference to die at home can access support to do so.	Assess needs as soon as practicable. Implementation timeframe depends on assessed needs.	Community-based palliative care could cost less than its hospital equivalent. Patients would be able to access community-based palliative care that supports them to die at home if they choose.

Needs for Community based palliative care in Queensland

- There has been a 22% increase in the numbers of deaths in Queensland in the last 10 years
- In 2017 31,555 deaths in Queensland- 5,754 more deaths than 2007.
- An incredible growth in the number of deaths in 2017 of 6.3% - three and a half times the rate of population growth in the same period
- That is 1,865 more deaths between 2016 and 2017 – an additional 5 people dying every day in Queensland in just a single year.
- The ABS says the number of deaths will double over the next 40 years.

In its report the Productivity Commission actually quoted our submission: "end-of-life care providers will face a 'tsunami of palliative care admissions ... as our baby boomers move through the system' (Little Haven Palliative Care, sub. 458, p. 2).

We know this puts a huge strain on the Queensland healthcare system and will continue to grow as Queensland's population ages

And people are living longer with life expectancy increasing by almost a year in that same period.

I think we can offer a model for the state government – a proven model which improves patient welfare and decreases costs

The Productivity Report notes:

Up to 70 per cent of Australians would prefer to die at home (PCA, sub. PFR329), but most end up dying in hospital instead (box 3.1). But only around 10% die at home.

Around 50-90% of people who die could benefit from end-of-life care – that is around 16,000 to 28,000 Queenslanders

Again, the Productivity Commission pulled out our service as an example of good practise:

“In some locations, hospices and community-based palliative care services largely succeed in supporting those who wish to die at home to die at home or in home-like environments. For example, Little Haven Palliative Care said that it supports 60 per cent of its patients to remain at home to die, and a further 24 per cent die with less than five days in hospital”

PC report: “This leads to a situation where ‘almost two-thirds of terminally ill people for whom home or hospice palliative care would be appropriate die in hospital, often receiving heroic interventions”

Few Australians make plans for their end-of-life care in advance

The welfare imperative

Little Haven has a long history in Qld of enabling people in our community to

- Receive health and social care that supports their wellbeing, irrespective of their diagnosis, sex, gender, age, socio-economic background or proximity to death.
- People have opportunities to discuss and plan for future possible decline in health, preferably before a crisis occurs, and are supported to retain independence for as long as possible.
- People know how to help and support each other at times of increased health need and in bereavement, recognising the importance of families and communities working alongside formal services.

The political imperative

- The families of people who use our service become strong advocates for the service
- They often donate money or their time as volunteers for the continuation of the service
- Little Haven Palliative Care is the poorest funded of any palliative care service in Qld.
(Please refer to attached Graphs showing historical funding restraints)
Consistent advocacy over many years to address our funding and seek recognition of the benefits of our model of care has elicited statements from the Health Bureaucracy and the SCHHS to “rationalise our admission policy in line with finite funding”. Does the HHS have a more cost effective / efficient solution to manage palliative patients delivering the outcomes that people facing end-of-life choices want should we take that advice?
- Any government who made this issue their own would benefit from a high degree of good will

The health system imperative

Spending on the last year of life are increasing but the spending is not delivering the outcomes that people facing end-of-life choices want

Giving patients the choice of home end-of-life care represents value for money for end-of-life care and is preferred by patients and would allow health spending to be directed to other areas (like prevention)

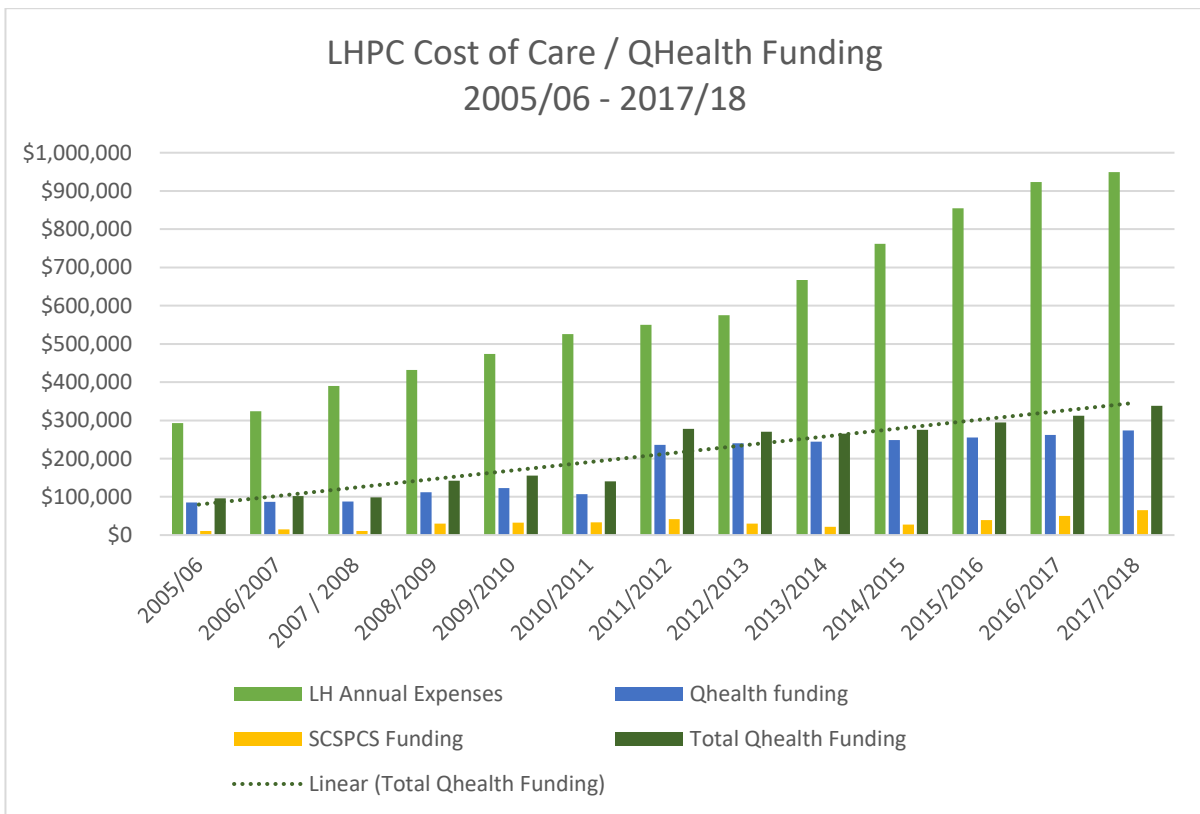
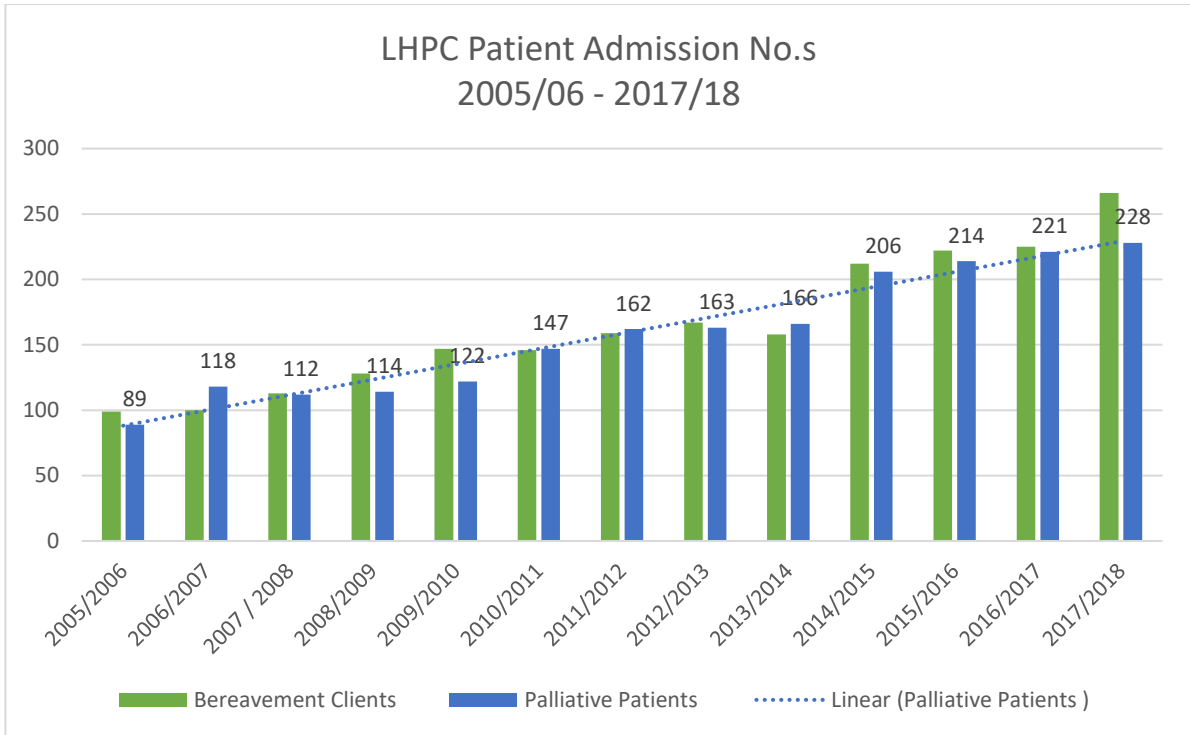
- studies show that at least 13% of healthcare spending is spent in the last year of life
 - that is equivalent to \$2.4 billion in 2017-18 in Queensland
- 30 to 40 per cent of costs incurred in the last year incurred in the last month of life
 - that is equivalent to \$720m to \$960m in 2017-18 in Queensland
- Hospitals account for 70% of these costs
- Number of deaths in Queensland rose over 6% in 2017 (over triple the population rate) and will double in next 40 years
- Most importantly this spending is giving outcomes that do not reflect individual preferences for dying at home

The solution

- Community based home palliative care offers:
 - Great outcomes
 - Value for money
- Little Haven Palliative Care is recognised nationally as a best-practise provider
- Little Haven Palliative Care is facing severe funding constraints
- Providing Quality care has promoted a virtuous circle where patients families and local medical practitioners recommend our services
- QH funding has not kept up with demand
- Short-term solution is additional money preferable over a multiyear period to ensure stability
- Little Haven Palliative Care is keen to be a pilot for a model integrating community based palliative care and the QH system
- Better outcomes and lower cost

In Conclusion, whilst we are aware there is a current Palliative Care Policy Review in progress Little Haven

- Require a response from the Minister regarding our funding review – as promised by Minister Dick and Nick Steele in previous meetings
- Why is Little Haven the poorest funded of the NGO's receiving less than ½ the funding of our Sunshine Coast equivalent and ½ again of our Brisbane equivalent, when the number of patients on our books at any given time equals or exceeds both these services?
- Wish to discuss our concerns this policy review will hand control of funding for Palliative Care solely to the HHS (as indicated in conversations with David Harmer and Belinda Lewis). This would be devastating for our community based model as the SCHHS continue to send us all their referrals while steadfastly refusing to provide the necessary funding attached to that referral. (Clearly demonstrated on attached graphs)



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