



The Royal Australasian  
College of Physicians

**RACP Submission July 2017:**  
Productivity Commission Draft Report  
– Reforms to Human Services

## Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to comment on the Productivity Commission Draft Report on Reforms to Human Services. The RACP is the largest specialist medical college in Australasia and trains, educates and advocates on behalf of more than 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand. Thus we have a unique perspective to comment based on the experience of our members.

The submission addresses the recommendations of the Commission in the following areas:

- Referral choice reforms
- Public performance reporting of hospitals and specialists
- Human services in remote Indigenous communities and
- End of life care.

Our key positions on these areas of policy can be summarised as follows:

- Qualified support for some of the Commission's proposals on referral choice reforms and public performance reporting.
  - o We do not agree with the proposal to 'direct' public outpatient clinics to accept any patient with a referral letter for a condition that it covers, if this comes at the expense of clinician discretion to redirect referrals where appropriate.
  - o Only well-validated and rigorously measured hospital performance indicators should be publicly released. We have some concerns regarding the possible unintended consequences of public reporting of individual clinician performance (as outlined in Section 2).
- Qualified support for some of the Commission's proposals on human services in remote Indigenous communities. However, Aboriginal community controlled health services (ACCHSs) should be designated as preferred providers.
- Support for the Commission's proposals on end of life care.

## 1. Referral choice reforms

**Draft recommendation 9.1** of the Draft Report proposes that the *Health Insurance Regulations 1975* be amended to clarify that patients referred to a specialist can choose the public outpatient clinic or private specialist they attend for their initial consultation. Under this amendment, the *Regulations* would specify that when making a referral to a specialist, general practitioners (GPs) must explain to patients that they can attend a specialist or public outpatient clinic other than the one named in the referral, and patients can choose independently after receiving support and advice from their GP at the time of referral.

The Commission notes the Department of Health's advice that the intent of the *Health Insurance Regulations 1975* is that:

- referrals do not need to name a particular clinic or specialist
- any specialist can accept a referral to a specialist of their type, irrespective of whether another person is named as the specialist in the referral.

Insofar as this advice is correct, we support **draft recommendation 9.1** which would clarify the interpretation of the relevant provisions of the *Health Insurance Regulations 1975* governing specialist referrals.

**Draft recommendation 9.2** which proposes that the Commonwealth develop with GPs best-practice guidelines on how to support patient choice should ensure that over the long term the result would be better informed decision making by both parties. It is important to ensure that in this process of change, the engagement of referrers (e.g. GPs) in the referral process is maintained as in the majority of cases they will have a key role in the care post-referral. We recognise that there is a case for some greater flexibility with respect to patient referrals, and that it is not necessarily appropriate to restrict referrals to specialists within a patient's residential catchment. For instance some patients may find it more appropriate to have access to care close to their workplace rather than close to their home to reduce travel time to appointments which are within working hours – this would apply to patients requiring frequent visits to hospital such as those undertaking radiotherapy. Clarifying this regulation would open up more opportunities for doctor-patient dialogue and increase patient convenience and access to appropriate care, including earlier specialist appointments.

The Draft Report notes the likelihood that this project would be part of a broader strategy co-designed with relevant professional bodies to assist health professionals, including specialists, to implement the proposed amendments to the *Health Insurance Regulations 1975*. The RACP welcomes this and looks forward to further consultation to ensure that specialist input is appropriately represented in the implementation strategy for **draft recommendation 9.1**. In particular, it is worth noting that a share of specialist referrals come from non-GP medical practitioners, including but not limited to other specialists, so there may be specific considerations relevant to these specialist to specialist referrals which would need to be taken into account in designing a patient choice framework. This can only be feasibly achieved through appropriate consultation with specialist colleges.

**Draft recommendation 9.3** proposes that State /Territory governments should direct their public outpatient clinics to accept any patient with a referral letter for a condition that the clinic covers, regardless of where the patient lives.

We have some reservations with this and seek further details on how it would operate. In particular, we seek clarification on whether the 'direction' to public outpatient clinics to accept any patient with a referral letter for a covered condition would override any discretion that the consultant triaging the referral is afforded. Currently the consultant who triages a referral to a public outpatient clinic can redirect the referral to another hospital or even a specialty clinic if he or she thinks it is not an appropriate referral.

There are numerous reasons why this individual clinician discretion to redirect a referral to a more appropriate service should be preserved:

- Notwithstanding that all public hospitals in Australia have a significant component of their funding based on activity, there is still a significant component of fixed funding for public hospitals i.e. funding which does not grow with demand for services or 'follow' the patient, particularly at the State/Territory level. This means that under a referral system which is more responsive to patient discretion, some hospitals could become victims of their own success if the consequent growth in demand for their services as reflected in referrals is not matched by proportionate increases in funding. If public outpatient clinics no longer have the discretion to redirect referrals, this could easily extend waiting lists for their patients which in turn can have other adverse consequences, including on health outcomes.
  - o There is also an additional question of equity of access. Frequently the patients who are least able to travel outside their residential catchment areas to seek care may be among the most socially disadvantaged or most incapacitated by their illness. This group tends to be comprised of those with high levels of disability, multisystem disease and unemployment for which centralised local services are required. If the hospitals serving these populations were to face additional demand from referrals from patients outside their catchment areas, this would add to the waiting list already faced by the more disadvantaged patients within the area.
- There are also special considerations that apply to some specialties which may limit the flexibility for referrals or make it inappropriate for patients to 'shop around' outside their residential catchment areas.
  - o The RACP-affiliated Endocrine Society of Australia points out that in the case of patients with some endocrine conditions referrals are better channeled to the relevant state-wide referral centre while other endocrine disorders require management by a multidisciplinary team, and these patients should be directed to those hospitals where such teams are located. Thus it needs to be recognised that there will be some constraints on patient choice in the public system even after taking account of outpatient clinic capacity.
  - o In palliative care, the medical service being provided is intimately tied to local community services. Palliative care physicians are encouraged to build relationships with their patients early in the course of their illness. One problem with seeking services outside the local catchment area is that when these patients become too frail to travel long distances in the later stages of their terminal disease, there is then often very limited time or opportunity to build the essential relationships with their local practitioners and local healthcare providers. A holistic approach, involving a multidisciplinary team, is essential to good end of life care. Having close and longstanding ties with the local medical, nursing and allied health team enhances the level and appropriateness of support that can be provided for the patients, their families and carers. Thus inadvertently encouraging patients to seek palliative care

outside their residential catchment area may potentially compromise the relationship with their local specialist and local community health service which may eventually play a significant role in their end of life care management. We note in particular that restricting clinician discretion to redirect referrals in this case may conflict with the intent, if not the letter, of the laudable **draft recommendation 4.1** on end of life care (which is discussed in greater detail in the relevant section of this submission).

These reservations do not mean that we would not support **draft recommendation 9.3** but this support is subject to some caveats. The first is that, though public outpatient clinics may be directed to accept a referral, they should retain the discretion to redirect it if they are capacity constrained or if there are appropriate clinical reasons to redirect it. The potential for this should be considered in the initial discussion and shared decision-making with the patient about the most appropriate referral. Secondly this recommendation should not be implemented without a proper audit of existing hospital capacity to ensure that hospitals will have sufficient resources to manage additional demand from outside their catchment areas and to ensure that there is sufficient flexibility within the State/Territory healthcare system to redirect funding to meet changes in demand in particular hospital sites as appropriate. Realistically it should be expected that introducing greater patient choice to seek referrals outside their residential catchment areas will make the flow of referrals less predictable, so State/Territory health departments will need to have adequate plans for this new challenge.

**Draft recommendation 9.4** proposes that State and Territory Governments should change patient travel assistance schemes so they are available to eligible patients regardless of which healthcare provider they attend. Under this recommendation, the level of assistance would still be based on the cost of getting to the nearest provider. Thus, what is being proposed is that patients should be able to use their existing travel allowance entitlements but would not get an additional 'top up' to cover the costs of additional distances they may have to travel if they choose to travel outside their catchment area. Any additional cost from travelling outside the residential catchment area would be borne by the patients themselves. We agree with this approach as it does not introduce an additional strain on travel subsidies for healthcare that would be borne by the States and Territory systems.

Finally, **draft recommendation 9.5** proposes that the Australian Government undertake an evaluation of the referral choice reforms five years after they commence operation. Such a measure should be an obvious accompaniment to any proposals for reform and we strongly support it. All reform should be subject to a rigorous evaluation process to understand whether it has had the desired impacts.

## 2. Public performance reporting of hospitals and specialists

**Draft recommendation 10.1** proposes a number of measures to expand and strengthen Australian governments' commitment to public reporting in the National Health Reporting Agreement. We agree with some of these measures but have concerns with others. In particular:

- We agree that the information released by jurisdictions should be in a format that other organisations can readily incorporate into advisory services. Standardised reporting formats that are easily understood should be a prerequisite for any public reporting systems.
- We agree that assistance should be given to the Australian Institute of Health and Welfare (AIHW) to enable it to strengthen the MyHospitals website.
- However we have concerns regarding possible unintended consequences of the public release of data on individual hospitals and specialists.

On the latter point, while we support the development and public release of well-validated and rigorously measured **hospital performance indicators**, we are concerned with the implication that **'any'** data that a jurisdiction holds on either individual hospitals or individual specialists would potentially be fit for public release. While we support the proposed test that the release of data 'does not result in patient harm', this test would need to take into account consequential inadvertent adverse outcomes that might not initially be apparent by only considering the data item in isolation.

For example, simply reporting on outcomes without factoring in the complexity or risk profile of cases could potentially be misleading as to the quality of care provided. This could reduce patient confidence in what might well be highly functional and safe hospitals, adversely affect patients' involvement in the shared decision-making around their healthcare, and even inadvertently encourage hospitals or specialists to be more risk-averse when considering taking on complex and high-risk cases.

To reiterate comments provided in our previous submission, publicly released hospital performance indicators would need to be adjusted to take account of the case-mix and risk profile of each hospital and other factors beyond their control which may nonetheless influence their performance ratings. This would include the characterisation of their patient cohorts such as measures of relative socioeconomic disadvantage and patient demographics. One unintended consequence of poorly formulated performance indicators, as the evidence from the use of performance based indicators in the US indicates<sup>1</sup>, is that hospitals with a high share of socially disadvantaged patients may end up being unduly penalised for poor performance, perversely resulting in a further reduction in the capacity of these hospitals to serve their socially disadvantaged patients. .

It is vital that hospital performance reporting be undertaken in a way that fully addresses these risks; via well-formulated data that is clear on what it is aiming to report, using rigorously measured and well-validated hospital performance indicators that are provided in a consistent, standardised format. The design of this system could be informed by an audit on all the data that jurisdictions currently hold, and an audit of their performance and reporting mechanisms.

These concerns about the risk of errors in measuring or interpreting hospital performance data are magnified when applied to public reporting of the performance of individual clinicians. The unintended consequences noted above on clinicians who take on the care of more complex, higher-risk patients, could seriously compromise patients' equitable access to care, particularly given the greater difficulties associated with attributing performance to individual clinicians and publicising their performance data:

- It can be difficult to allocate individual responsibility for performance in what is frequently a team-based and multidisciplinary work environment where there may be multiple factors contributing to individual outcomes. These would also include systematic factors which may have adverse impacts on physician performance, for instance policies, systems or processes

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<sup>1</sup> See for example Joynt KE, De Lew N, Sheingold SH, et al. Should Medicare Value-Based Purchasing Take Social Risk into Account? *N Engl J Med.* 2017 Feb 9;376(6):510-513..

instituted at the hospital level. These measurement difficulties would be especially problematic for non-proceduralist physicians.

- Reporting on individual performance indicators can disrupt the team work environment by incentivising people to act in a 'tick the box' fashion to satisfy indicators even if this is at the expense of collaboration.
- There is also a question of procedural fairness. While some jurisdictions may already have data on individual clinicians, this data is currently generally not available to the individual clinicians themselves or reported to them as a matter of routine. So there is currently no opportunity for the individual clinician, or any colleague with whom they work, to identify or provide a rationale for any disparity, variation or poor outcome.

For the above reasons, we believe it is premature to introduce the public reporting of individual specialist performance data, and that further considerations are needed to ensure these concerns can be addressed.

**Draft recommendation 10.2** proposes that the Australian Institute for Health and Welfare (AIHW) be directed by Australian governments to take a lead role in transforming the MyHospitals website into a vehicle that better supports patient choice. There are some measures specified under **draft recommendation 10.2** which we support and others that we have significant reservations about:

- For the reasons already cited previously, we have significant concerns regarding the public reporting of performance of individual specialists on the MyHospitals website; and also concerns on the Commission's proposal to report user ratings and reviews, (as discussed below).
- We support the proposal to look at lessons from overseas examples of information provision, including the National Health Service website used to inform patients in England. It is essential that we learn from the experience of other countries in enhancing patient information websites and avoid known mistakes and 'reinventing the wheel' where possible.
- We agree that rigorous market research is needed to improve the design of MyHospitals and enhance its role as a site for promoting patient choice and information. Market research can help us better understand patient expectations and what kind of support patients are looking for to help them make more informed choices.
- We support the proposal to put greater emphasis on reporting outcomes, as excessive reliance on process based indicators can incentivise clinician activity towards satisfying the process measures while deflecting attention away from the clinical improvements being sought. However our support is subject to the caveat that the outcome indicators ultimately selected for public reporting should be rigorously measured and well-validated in the academic literature. For this reason, while we believe that while well-established patient reported outcome measures (PROMs) and clinical outcomes (subject to proper risk adjustment) could be appropriate outcome indicators for adoption, we do not support the adoption of user ratings and reviews into the MyHospitals website. User ratings and reviews have the potential to be highly unreliable as performance indicators, insofar as they create opportunities for the reporting of vexatious or vindictive feedback. This can be a significant risk in two specialties in particular:
  - o The management of chronic pain and addiction
  - o Paediatric cases where harm done to the child by adult carers and actions taken to protect the child by the practitioner may prejudice the relationship with the adult carers who are the ones likely to provide the user ratings.

Finally while we agree that the AIHW has an important process to play in the redesign and enhancement of the MyHospitals website, the recommendation in its current form gives too much emphasis and authority to the AIHW. We support improvements to MyHospitals but believe that the development process should be a collaborative one. The development of appropriate performance indicators, data analysis, processing, interpretation and other ongoing work that will be required should be jointly led by consumers and health care professionals, including specialist colleges such as the RACP. We look forward to further engagement in this process.

### 3. Human services in remote Indigenous communities

This section of the submission addresses **draft recommendations 8.1 to 8.5** in the Draft Report.

**Draft recommendation 8.1** proposes that the length of human services contracts in remote Indigenous communities needs to take account of the additional challenges of service delivery in remote communities and therefore proposes increasing the default contract length to ten years, subject to appropriate exceptions such as program trials. The RACP welcomes the Commission's recognition that the process of tendering for human services in Indigenous communities needs to take into account special circumstances such as the additional time that providers need to establish their operations and capacity on a stable footing in this setting. As long as there are safeguards in place to ensure that communities do not get 'locked in' to contracts with poor performers – and this appears to be acknowledged in the draft recommendation – we can offer our qualified support for this draft recommendation. We suggest that one of the safeguards that would need to be established is a clear process of timely evaluation with defined parameters of success and progress.

**Draft recommendation 8.2** sets out guiding principles for service provider selection processes in remote Indigenous communities. While we do not disagree with the principles proposed, we note that the Commission's approach still starts from the premise of competitive neutrality between service providers. We fundamentally disagree with this premise and reiterate the argument made in our previous submission that Aboriginal community controlled health services (ACCHSs) should be designated as preferred providers. This point is explained further in our comments on **draft recommendation 8.4**.

The previous RACP submission to this inquiry also recommended that the employment of Aboriginal and Torres Strait Islander people in service delivery and a commitment to upskilling an Indigenous workforce for long term service delivery should be among the performance indicators used for selecting human services providers in Indigenous communities. We applaud the recognition of these considerations in:

- **Draft recommendation 8.3** which proposes that the Australian, State and Territory Governments should ensure that commissioning processes for human services in remote Indigenous communities have a strong focus on transferring skills and capacity to people and organisations in those communities.
- **Draft recommendation 8.4** which proposes that when selecting providers of human services in remote Indigenous communities, governments should take into account attributes such as culturally appropriate service provision, community engagement and governance, and employment and training of local and/or Indigenous staff.

However, we again note that a common shortcoming of each of the **draft recommendations 8.2, 8.3 and 8.4** is that they still begin from the premise that competitive neutrality should be adopted in selecting providers. We contend that ACCHSs should be designated as preferred providers unless it can be demonstrated that some other arrangement can produce better results in terms of both access to, and quality and outcomes of services. There is a case for expanding ACCHs into new areas, as a range of primary health care data indicates ACCHSs are doing better than mainstream services in delivering best practice care for Indigenous people.<sup>1</sup> We therefore propose that an

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<sup>1</sup> Panaretto KS, Wenitong M, Button S, Ring I. Aboriginal community controlled health services: leading the way in primary care. *Med J Aust* 2014; 200 (11): 649-652.



amendment be made to **draft recommendation 8.4** that, when selecting providers of human services in remote Indigenous communities, governments take into account the presence of existing Aboriginal community controlled health services given their pre-existing strengths in such areas as capacity building and cultural appropriateness which have already been recognised as potential success factors in the other draft recommendations on this sector. To facilitate this, we also propose that the Commission should consider the role of Primary Health Networks and how they could better work with these communities to transition health services towards greater Aboriginal community control through better collaborations and capacity building of existing ACCHs.<sup>2</sup>

**Draft recommendation 8.5** proposes that governments should collaborate by, among other things, conducting and publish ongoing assessments of the characteristics and needs of Indigenous Australians living in remote communities and establishing systems to identify and share information on ‘what works’ in human services in remote Indigenous communities. We support this draft recommendation, as evidence based approaches supported by regular evaluation should be a prerequisite of the design of human services in all communities, including Indigenous ones. However, we note that there is significant diversity among remote Indigenous communities and what works for one will not necessarily work for others. It is important that local adaptability and Indigenous community-led solutions be key factors.

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<sup>2</sup> Couzos S, Delaney-Thiele D, Page P. Primary Health Networks and Aboriginal and Torres Strait Islander health. *Med J Aust* 2016; 204 (6): 234-237.

## 4. End-of-life care

**Draft Recommendation 4.1** proposes that people with a preference to die at home should be able to access support from community-based palliative care services to enable them to do so. The draft recommendation proposes that State and Territory governments have a role through:

- assessing the need for additional community-based palliative care services
- designing services to address identified gaps in service provision
- using competitive processes to select providers (or a single provider) to deliver additional community-based palliative care services
- monitoring and evaluating the performance of community-based palliative care services; and
- ensuring that consumer safeguards are in place.

We support measures to allow a patient to die in their home environment and can support all the above proposals with one caveat. We caution that the care requirements to facilitate this outcome may extend beyond provision of palliative care interventions and may also require access to home nursing and GP support for those with complex end of life care needs.

**Draft Recommendation 4.2** proposes that the Commonwealth can improve the provision of end of life care in aged care facilities by:

- removing current restrictions on the duration and availability of palliative care funding in residential aged care so that palliative care is available to residents with pre-existing high health care needs, and for periods of time that align with those provided in the health care system; and
- providing sufficient additional funding to residential aged care facilities to ensure that people living in residential aged care receive end-of-life care that aligns with the quality of that available to other Australians.

We support these measures and would like to highlight some additional points that need consideration in any implementation of this recommendation:

- According to input from a Fellow practising in Western Australia, one problem with the current WA model of community palliative care service provision is that the focus on end-of-life care and symptom control in the latter terminal stages of disease is not matched by a similar level of service for patients in the early stages of terminal disease. Therefore there is a need for more proportionate targeting of end-of-life care at all stages of terminal disease.
- The physical frailty of people with terminal illness needs to be better managed in community hospice and palliative services through the provision of appropriate personal (i.e. non-medical) care. Where family members and formal or informal care supports are insufficient, physically frail patients in the terminal phase can end up being rapidly fast tracked to residential care which can be a traumatic experience, or end up requiring hospital admission. Even in residential care, the provision of palliative care may lack medical practitioner services other than registered nurses.

**Draft recommendation 4.4** proposes that the aged care Quality of Care Principles be amended to require that residential aged care facilities ensure that clinically trained staff holds conversations with residents about their future care needs. We support this recommendation. To be able to have appropriate conversations regarding a patient's end of life care wishes in the aged care setting is vital and all patients in an aged care facility should have documented end-of-life care plans commensurate with their wishes, in line with their medical condition and prognosis, and in accordance with relevant state or territory law. The resulting conversations should cover topics such as setting goals and limits of treatment, including whether to transfer to hospital and when, and discussions regarding access to early and prompt palliative care prior to an acute episode. The recommendation should include patients with dementia and Alzheimer's disease. Such conversations should be a mandatory part of the Aged Care Assessment of Admission to Residential Aged Care Process and be updated at regular intervals as appropriate.

**Draft recommendation 4.5** proposes that Australian, State and Territory governments work together to ensure that there are sufficient data to enable governments to fulfil their stewardship functions by monitoring how well end-of-life care services are meeting users' needs across all settings of care. There is little point in changing services if we have no idea whether the changes – often made at professional, personal and economic expense – have resulted in improvement in people's end-of-life experiences. Accordingly we strongly support this recommendation, as the development and implementation of a data strategy will enable better informed decisions to be made about the effectiveness and efficiency of current end-of-life care service models.

## Summary and recommendations

The RACP welcomes this opportunity to comment on the Productivity Commission Draft Report on Reforms to Human Services, and have summarised below our key comments and recommendations on the following four areas:

- Referral choice reforms
- Public performance reporting of hospitals and specialists
- Human services in remote Indigenous communities and
- End of life care.

### Referral choice reforms:

- It is not necessarily appropriate in all cases to restrict referrals to specialists within a patient's residential catchment and there is a case for clarifying the intent of the *Health Insurance Regulations 1975* to encourage more shared decision making between GPs and patients on specialist referrals.
- We look forward to further consultation to ensure that specialist input is appropriately represented in the implementation strategy for practitioner co-development (with the Commonwealth) of best practice guidelines on supporting patient choice.
- Flexibility should be a two way street and there are still numerous circumstances why it may be either clinically justified or justified as a means of managing capacity to redirect referrals that come from patients outside the residential catchment area. Thus we do not agree with the proposal to 'direct' public outpatient clinics to accept any patient with a referral letter for a condition that it covers, if this comes at the expense of clinician discretion to redirect referrals where appropriate.

### Public performance reporting of hospitals and specialists:

- Only well-validated and rigorously measured hospital performance indicators should be publicly released.
- The public release of specialist performance data collected by the jurisdictions may have unintended consequences in terms of
  - o unduly penalising individual practitioners who take on the care of complex, higher risk patients ultimately compromising these patients' access to care, and
  - o erroneously attributing to individual practitioners outcomes which are systems-based
- Until these concerns can be addressed, it may be more prudent to consider trialling the public release of hospital performance data first.
- There should be greater emphasis on reporting outcomes for hospital performance data as long as these are well-validated. This would, for instance, entail support for the greater use of well-established patient reported outcome measures (PROMs), and clinical outcomes (subject to proper risk adjustment) but not the reporting of user ratings and reviews
- The AIHW has an important process to play in the redesign and enhancement of the MyHospitals website but ultimately the development process should be a collaborative one jointly led by the profession and consumers

### Human services in remote Indigenous communities

- Extending the default contact length for provision of human services in remote Indigenous communities is justified to take into account special circumstances such as the additional time needed for providers to establish their operations and capacity on a stable footing, as long as there are safeguards in place to ensure that communities do not get 'locked in' to contacts with poor performers.

- Aboriginal community controlled health services (ACCHSs) should be designated as preferred providers unless it can be demonstrated that some other arrangement can produce better results in terms of both access to, and quality and outcomes of services. In fact there is a case for expanding ACCHs into new areas. To facilitate this, the Commission should investigate the use of Primary Health Networks in these communities to transition health services towards greater Aboriginal community control through greater collaborations and capacity building of existing ACCHs.

### **End of life care**

- Measures to allow a patient to die in their home environment should be supported but facilitating this outcome may go beyond palliative care interventions and extend to access to home nursing and GP support for those with complex end of life care needs.
- The physical frailty of people with terminal illness needs to be better managed in community hospice and palliative services through the provision of appropriate personal care. There is also a need for more proportionate targeting of end of life care at all stages of terminal disease so that services are available to those in the early stages of terminal disease as well as to those in the later stages of terminal disease.
- To be able to have the appropriate conversations regarding a patient's end of life care wishes in the aged care setting is vital (including whether and if so when a transfer to hospital is appropriate) and all patients in an aged care facility should have documented end of life care plans commensurate with their wishes and in line with their medical problems. These discussions should where possible encompass those with dementia and Alzheimer's disease.
- Commonwealth, State and Territory governments need to work together to ensure that there are sufficient data to enable governments to fulfil their stewardship functions by monitoring how well end-of-life care services are meeting users' needs across all settings of care