

# THE NATIONAL PALLIATIVE CARE PROGRAM



## Working towards improved access to and quality use of PALLIATIVE MEDICINES in the community

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### The policy context

Not all palliative care medicines are available or affordable to people who want to stay in the community or at home – this is a major barrier to providing choice of setting of care.

A key aim under the National Palliative Care Strategy and National Palliative Care Program is to increase options and support for people to receive care at home.

### The problem

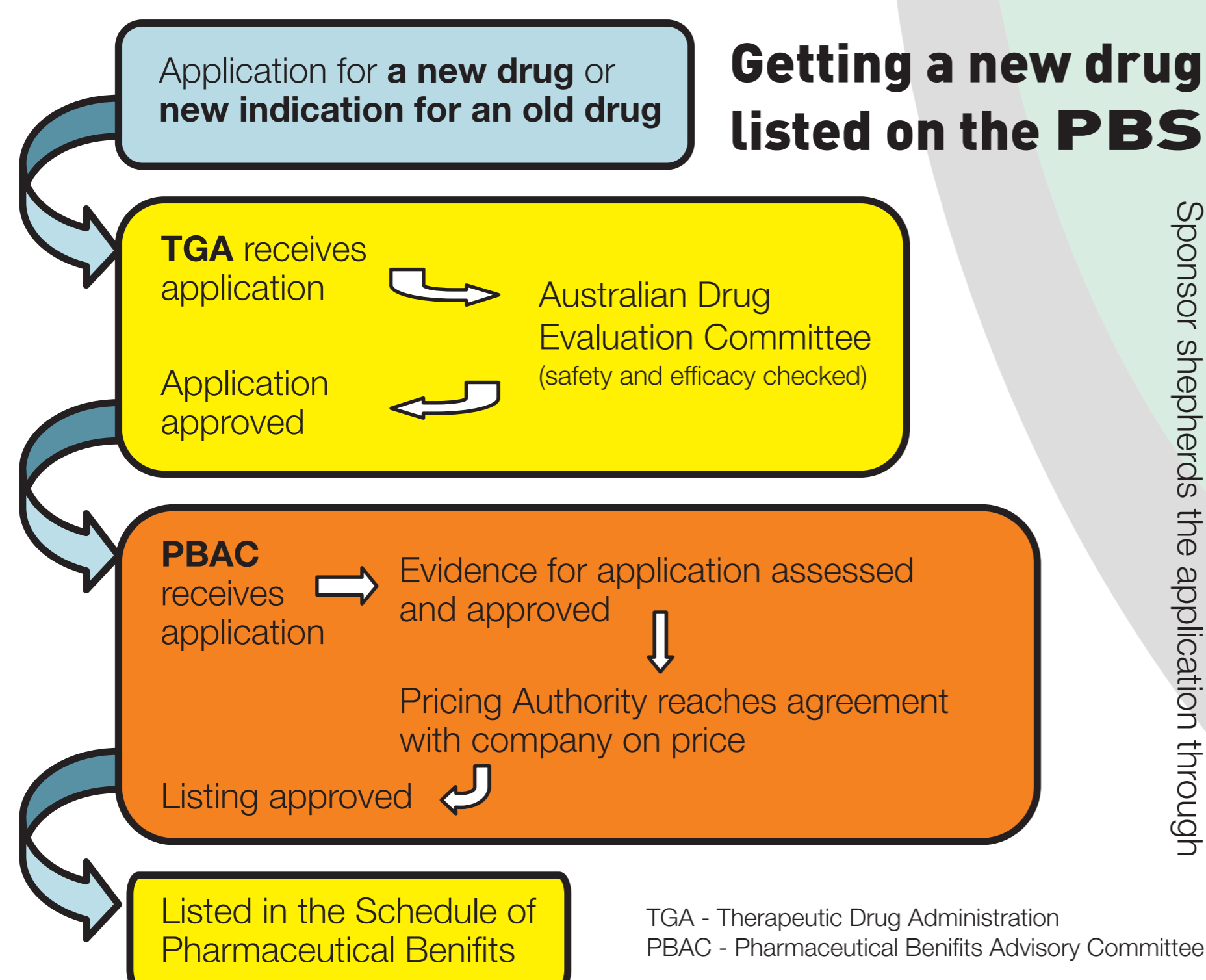
Many medicines used in palliative care are not registered for a palliative care indication on the Australian Register of Therapeutic Goods (ARTGs) and therefore cannot be listed on the Pharmaceutical Benefits Scheme (PBS).

This can result in the necessity for some patients to have to travel to state hospital OPDs, or to become hospital inpatients.

### Method

The Australian Government has provided funding under the National Palliative Care Program to:

- Establish the Palliative Care Medicines Working Group
- Identify priority medicines used in palliative care not currently available through the Pharmaceutical Benefits Scheme (PBS);
- Develop a framework for consideration of these medicines by the Pharmaceutical Benefits Advisory Committee (PBAC) which takes account of the Australian drug regulatory processes
- Foster a clinical research agenda to further the evidence base for the use of medicines within the community for people with life-limiting illness
- Develop a strategy to enhance communication and awareness of palliative care medicines among key stakeholder groups including the pharmaceutical industry



### Palliative Care Medicines Working Group and communication subgroup

Comprises representatives of key clinical, professional and government stakeholders including the Therapeutic Goods Administration (TGA) and PBAC.

### Terms of reference include:

Improving access to palliative care medicines;  
 Improving the quality use of palliative care medicines; and  
 Improving awareness of both the medicines that are available through the PBS and the need for additional research to be done to support the registration of palliative care medicines by TGA

### Results

- A new section was introduced into the Schedule of Pharmaceutical Benefits dedicated to palliative care medicines on the PBS on 1 February 2004. All authority only.
- A communication network established to enhance communication and raise awareness
- A Palliative Care Clinical Studies Collaborative established to gather required evidence

### Medicines in PBS Palliative care list. (April 2006)

Carmellose sodium	Hyoscine butylbromide
Promethazine	Paracetamol Suppositories
Clonazepam	Laxatives
Bisacodyl	Docusate with bisacodyl
Sterculia with Frangula bark	Bisacodyl enemas
Microlax enemas	Glycerol suppositories
Diazepam	Oxazepam
Nitrazepam	Temazepam
Diclofenac	Ibuprofen
Indomethacin	Naproxen
Sulindac	Naproxen sodium

### To be listed August 2006

Morphine Sulfate tablet (10 mg and 20 mg)	Morphine sulphate SR 200 mg
Benzylamine Hydrochloride	Lactulose
Macrogol	Paracetamol Tablet 665 mg (SR 4 months supply)
Naproxen (oral suspension)	

Initial supply 4 months

Mandated review by a palliative care service.  
 Can be by phone, can be specialist Dr or Nurse

Subsequent supply

### The next steps:

Palliative Care Clinical studies collaborative to be established with clinical trials commencing early next year.

### The role of the Nurse

- To advocate for their patients
- Keep well informed of emerging evidence in palliative care (see the CareSearch website [www.caresearch.com.au](http://www.caresearch.com.au))
- Raise the awareness amongst GPs of the availability of medicines in the palliative care section of the PBS
- To ensure that medical officers discharge patients home correctly and where possible prescribe medicines that are listed on the PBS

### Conclusion

The strategy has enabled clinicians to prescribe a broader range of medications outside of hospitals, and to provide greater patient choice about place of care.