

Referrals to the Hospice Service in Ireland

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Abstract: The impact of demographic changes, resource constraints and the increase in demand for palliative care services require a clear understanding of the aims of the hospice movement, an insight into the perceptions of the referring agencies and details of the service recipients.

A series of interviews and a postal survey of a sample of general practitioners were undertaken to establish the reasons underlying the referral of patients to the hospice service. The main reason for referral was palliation, although it was apparent that a number of factors, and their interrelationships, contributed to the decision-making process. The predominant view was that the hospice service provided an excellent service, although some concern was voiced at the emphasis given to cancer patients.

I INTRODUCTION

The modern hospice movement is not merely a physical facility but rather a philosophy of care that can be developed and applied in a variety of settings and circumstances (Saunders, 1978). These include purpose built in-patient units, specific units within the acute sector, night nursing services, home care services, which offers back-up and advice to patients and their carers, counselling and an information service (Clark, 1991a). Since the movement is committed to a tri-partite approach to death and dying which combines research, teaching and practice (Clark, 1991b), the objective of care therefore, is to give patients an opportunity to live to their fullest in physical ease and the assurance of personal relationships until death rather than having the curing function as the major focus (Saunders and Baines, 1989).

The hospice movement has grown out of a sense of dissatisfaction with a system of health care that was relatively poor in providing effective pain and symptom control and which ignored the emotional, social and spiritual needs of the dying person (Clark, 1993) and it has sought to demonstrate that a deterioration in the quality of life is neither an inevitable nor a necessary consequence of becoming terminally ill (Field and James, 1993), and in so doing, has restored the caring art of medicine in its approach to the care of the dying and their families (Dunlop and Hockley, 1990).

The aim of this study was to analyse referral patterns to the hospice services in Ireland. It is widely accepted that demand for palliative care services in Ireland is likely to increase in the future and, if services are to meet patient needs, organisation and planning for such services has to take place now. In order to organise and plan these services a clear understanding of the aims and objectives of the hospice movement and a knowledge of the population to be served is required (Calman and Hanks, 1993).

However resources available for the care of the terminally ill are finite and service development must take place against a background of resource constraint. Therefore, work is also needed to develop outcome measures for palliative care in order that both the effectiveness and efficiency of different patterns of care for the terminally ill can be assessed (Goddard, 1993; Griffin, 1991, and Higginson, 1993a).

II THE IRISH HEALTH SERVICE

The Irish Health Service is a mixture of public and private provision and funding of care. Publicly funded health care accounts for almost 20 per cent of government expenditure which represents approximately 7 per cent of GNP. Under the 1970 Health Act eight regional health boards were established to be responsible for the services within their own region, with their work being divided into three programme areas: the General Hospital Programme, which covers treatment in hospitals and out-patient clinics attached to hospitals; the Special Hospital Programme, with responsibility for psychiatric and mental handicap services; and the Community Care Programme, which aims to provide health and welfare services in an integrated way at local level.

The Community Care Programme has a significant role to play in the care of the dying as it employs and co-ordinates the activities of a number of professionals involved in the field, including General Practitioners (GPs) and Public Health Nurses (PHNs). There are, in addition, a number of voluntary organisations involved in the care of the terminally ill and dying. Two such organisations are the Irish Cancer Society (ICS) and the Irish Hospice Foundation (IHF).

The ICS was founded in 1968 in order to assist in the prevention, diagnosis, treatment and relief of cancer. Since 1985 the ICS has provided a domiciliary care service to those terminally ill patients who wish to remain at home. For patients who cannot be nursed at home and for whom admission to a general hospital is difficult the society endows beds in two Dublin private hospitals. In 1986 a group of independent people came together to identify needs in the field of hospice care and formed the IHF, which is committed to the practice of hospice care in all its aspects, conducting research into hospice care and the dissemination of information. The foundation has raised a considerable amount of money for the development of services since its inception and has identified two major factors which are likely to place pressure on the need for hospice facilities and services, that is the structure of the population and the need for hospice care for AIDS sufferers (IHF, 1993).

The population of Ireland increased from 3 million in 1971 to 3.5 million in 1991. There has been a decline in the younger population due to the fall in the birth rate while the number of people between 25-44 years has increased by 50 per cent. The number of people between 45-64 has only marginally changed while there has been a steady increase in the elderly population with a decline in the proportion of the population who would look after them (CSO, 1993). This change in population structure is particularly noticeable in some of the western counties, which in general have a relatively high proportion of older people compared to the rest of the country. The percentage of people aged 65 and over in the Western Health Board (WHB) and North Western Health Board (NWHB) is 14.3 per cent compared to 11 per cent for Ireland as a whole. The implications of these demographic structures are compounded by the distribution of Irish Health Services. For example, while respondents indicated that 42 per cent of their patients died at home and 35 per cent died in hospital, there is evidence to suggest, that a significant number of patients from the west of Ireland have died in Dublin hospitals because there was no one to look after them in their "home locations". Furthermore, the impact of demographic changes on dependency levels has been exacerbated by for example the "breakdown" of the extended family which together with the increase in life expectancy, is likely to place a severe strain on future services, which emphasises the need for forward planning of services (IHF, 1993).

The IHF also highlighted the impact of AIDS on the demand for hospice care. The first cases of AIDS in Ireland presented in 1982 and to date 90 people have died of the disease. The IHF states that in order to adequately provide for the needs of these patients, adequate training of appropriate care teams and sufficient funding is essential (IHF, 1993). Nevertheless, the Commission on Health Funding (1989) concluded that the solution to the

problems facing the Irish Health Service did not primarily lie in the system of funding but rather in the manner in which services were planned, organised and delivered. This has obvious implications for the future development of palliative care services in Ireland. Given increasing demand and limited resources the most practical response to the issue maybe to redirect resources from the acute to palliative sector. However, to achieve this considerable changes will have to take place involving community education programmes, political and professional mobilisation and economic appraisal.

The expansion of primary health care and the management of health problems at the lowest level of complexity have been the focus of recent Irish debate. For example, in 1986 the Irish College of General Practitioners highlighted the need to create a climate in which GP and home care would be fostered rather than placing the emphasis on more specialist aspects of the health care system (McGee and Fitzgerald, 1991). This has particular relevance in the field of palliative care since it has been argued that the diagnosis of a terminal disease will propel patients and their families into an unfamiliar environment, in which they may find themselves having to contend with somewhat frightening and often physically distressing tests and treatments as well as having to deal with a diversity of professionals and make numerous decisions (Degner and Beaton, 1987).

Any decision made concerning the treatment and care of the terminally ill will obviously depend on the availability and accessibility of services. Factors influencing where, when and how a patient will receive care will depend on the referral process. In the case of hospice services referrals may come from a variety of agencies including GPs, hospitals, public health services, families and informal carers. However most studies suggest that the majority of referrals are made by GPs (Hull and Taylor, 1990, and Nash, 1992). GPs will have a primary function in assessing patients' problems and will either treat them themselves or, where appropriate, refer them to a specialist agency. Their perception of hospices and their role in allowing a patient to die with dignity will thus be an important factor in their decision whether or not to refer (Hyman and Bulkin, 1990). The sequence of events usually commences with the patient visiting the GP, who following the initial assessment, may refer to a specialist service. This service may treat the disease and continue to do so until the patient dies or may decide to refer to a hospice service or back to the care of the GP who, it has been suggested, is ideally suited to meet the demands of providing continuing care (Morrell, 1991).

It has been suggested that the main reasons for referring patients to hospice services include symptom control, respite care, support for carers and counselling, with poor social conditions and inadequacy or exhaustion of home carers being cited as the main reasons for admission to an in-patient

unit (Hull and Taylor, 1990; Hyman and Bulkin, 1990; Crane *et al.*, 1990; Nash, 1992). However, it has also been argued that professionals may use the service inappropriately, accessing it without a full understanding of the skills and resources that are available (Nash, 1992) and therefore, hospices should provide detailed service specifications so as to allow for an assessment of their effectiveness and efficiency (Goddard, 1990).

In order to develop hospice services referral patterns will need to be closely monitored. This will provide invaluable information relating to which patients are referred and the factors surrounding the referral process, and thereby minimise inappropriate referrals (Calman and Hanks, 1993). In a similar vein, Griffin (1991) argues that, where possible, patients should have a choice also where they end their lives and, in order to avoid rushed decisions, alternative care models need to be planned. It has been stressed that good palliative care is about forward planning and anticipation rather than reactive or crisis intervention (Doyle, 1993). Accessibility and an understanding and knowledge of available services should make the referral process more efficient, hence enabling the patient to receive the most appropriate care. This may well require closer liaison and mutual education amongst professionals and carers.

III METHODOLOGY

In pursuit of a greater understanding of palliative care in Ireland three in-patient units were visited and a number of informal interviews with key people involved with the service were undertaken. These people included representatives from education, nursing, medicine and voluntary organisations. Information generated from the visits and interviews provided the impetus to undertake the study by identifying the contacts and the means of accessing service providers and referring agencies. As a result, a two stage survey was undertaken to identify the factors influencing the decision whether or not to refer to the hospice service and to analyse patterns and trends of referrals to the service from GPs.

Stage 1 consisted of a series of semi-structured interviews with representatives from referring agencies from six community care areas within the Eastern Health Board. The interview was considered the most appropriate option for stage 1 as potentially it would generate a more meaningful and in-depth analysis of the key issues. Extensive material was required in order to facilitate the compilation of a postal questionnaire to GPs throughout the country in stage 2. Interviewees represented urban, suburban and rural communities.

A pilot study of referring agencies was undertaken prior to stage 1. This

involved informal discussions with a GP, a PHN and a family. On the basis of these discussions some adjustments were made to the interview schedule.

Twenty-two interviews were conducted over a two week period with 6 families, 6 GPs, 6 PHNs, 2 hospital ward sisters, 1 palliative care nurse and 1 consultant geriatrician all of whom had been identified during the introductory visits and interviews.

The second stage of this survey consisted of a postal questionnaire to GPs throughout Ireland. The rationale for concentrating on GP referrals to the service was due to the significant role GPs play in the care of the terminally ill and as they are by far the largest referring agency to a hospice service (Nash,1992). There are currently just under 1,900 GPs registered with the Irish College of General Practitioners with approximately 1,600 participating in the General Medical Services (GMS).

A stratified random sample of GPs in each of the Health Boards was employed. A request to all Health Boards to provide GP listings was answered by 7 out of 8 and the telephone directory was used to obtain a sample of those GPs in the missing Health Board list and those GPs (approximately 5 per cent) who do not participate in the GMS. The sample constituted approximately 25 per cent of all GPs in Ireland.

The questionnaire was piloted with members of the medical profession who did not form part of the main study and after making adjustments on their advice 500 questionnaires were sent (see Table 1). The questionnaires were accompanied with a reply paid envelope and a covering letter. Two hundred and seventy eight replies were received, 3 of which were invalid which represents a 55 per cent response rate (see Table 1). This was considered to be a reasonable response for a postal questionnaire when factors such as a postal strike and the timing of the survey during the peak annual leave period are taken into consideration.

IV THE FINDINGS

Stage 1 was conducted in order to gain an understanding of perception surrounding the hospice service in Ireland and an insight into referral patterns and trends.

The 6 families questioned expressed the view that the hospice movement provided an excellent service. Their experiences of the in-patient units was exceptional and emphasised the comfortable and relaxed atmosphere. They believed that their relatives had a dignified death and although admission to the hospice was viewed as unwelcome and traumatic, once there patients and families were more than happy with the service they received.

The GPs and PHNs both expressed the view that PHNs had a considerable

Table 1: *Population Size of Health Boards and Numbers of GPs*

<i>Health Board</i>	<i>Population</i>	<i>No. of GPs</i>	<i>Sample</i>	<i>Replies</i>		
				<i>n</i>	<i>% of Sample</i>	<i>% of GPs</i>
Eastern Health Board (EHB)	1,244,238	600	150	86	57.3	14.3
Western Health Board (WHB)	342,876	136	34	17	50.0	12.5
Southern Health Board (SHB)	531,533	428	107	57	53.3	13.3
Midland Health Board (MHB)	202,948	140	35	17	48.6	12.1
North Western Health Board (NWHB)	208,027	152	38	16	42.1	10.5
Mid-Western Health Board (MWHB)	310,511	172	43	25	58.2	14.5
North Eastern Health Board (NEHB)	300,265	164	41	28	68.3	17.1
South Eastern Health Board (SEHB)	383,003	208	52	29	13.9	55.8

amount to offer palliative care, emphasising the role they had in training families and carers in the skills of caring for the terminally ill patient. The PHNs however felt they needed more time to provide care and support for patients and their families, but acknowledged that the resources were not available at present. This view was endorsed by the families who indicated that while the patients were at home they would have appreciated more visits from the PHNs in the early stages and extra nursing support throughout the illness. The families mentioned that occasionally, it was difficult to assess the support that was needed and obtain what they viewed as the most appropriate placement for their relative. Concern was also expressed about the lack of information available in order to enable them to make choices.

All the GPs were committed to the 24 hour care of their patients with a terminal disease. However, some of them indicated that they had not received any specific training in palliative care and therefore the approaches adopted in providing care for their patients depended on their particular philosophy towards terminal disease. One respondent stated that:

There is no drama in terminal illness. ... doctors don't like telling people they have failed.

What was evident from the interviews with the GPs was that changes were occurring. For example, there was evidence of education programmes in palliative care for GPs being developed. However, there was still scope for improvement as, for example, one GP felt that hospitals were still "not good" in their use of drugs and palliation.

The hospital doctors and nurses interviewed also stated that acute hospitals had problems in dealing with terminal illness. Some stated that these hospitals did not want to feel that they had "failed" and that for this reason doctors would not refer to a hospice service. Although it was emphasised that this situation was changing, the need for further training in symptom control and discharge planning was clearly highlighted.

While there was evidence to suggest that communication between agencies was improving, further developments were also needed since, for example, communication between the acute hospitals and community teams was said to be non-existent. One interviewee stated that communication between the hospitals and hospice also had its difficulties. Acute hospitals tended to refer a patient at the very early stages of terminal illness and sometimes there was a lack of information passed on about treatment.

GPs, PHNs and hospital nurses made the point that the needs of patients suffering from diseases other than cancer were not given as high a profile by the hospice movement. Examples of such views were:

A lot of people don't come under the umbrella of palliative care ... it's tough luck if you don't have cancer.

Cancer is priority, what about other diseases?

A few of the GPs and PHNs felt that palliative care was restricted to symptom control, which possibly restricted its development. It was argued that by placing the emphasis on symptom control barriers were being erected and some patients were consequently excluded from the service.

As was highlighted earlier the structure and the geographical distribution of the population will inevitably have a bearing on developments in palliative care. For example, the respondents referred to difficulties which have arisen in rural areas when families wanted relatives to return home from a Dublin City hospital to die. Requests from family members to have their relative returned to their locality tended to come during the later stages of illness and as a result some patients had only lived a few hours following arrival at home. This had caused great distress to both the family and staff dealing with the patient. Within the inner city such occurrences are rare since the tradition is for the eldest child to care for their dying relative with close support from families and neighbours.

While the predominant feeling amongst the interviewees was that the hospice movement provided an exceptional service, there was strong feelings that there was not sufficient commitment from the government towards palliative care as compared to acute care. One interviewee stated that:

If the government had sense more funding would be given to palliative care.

V THE SECOND STAGE

The postal questionnaire received 275 (55 per cent) responses from GPs throughout Ireland, of whom 226 (82 per cent) stated that they had referred to a hospice service, which constitutes some 46 per cent of the overall sample group of GPs (Table 2). The overall number of GPs who had not referred was 41 (15 per cent) with the main reasons for not referring being that they preferred to manage their patient's conditions themselves or that a hospice service was unavailable locally (see Table 3). The nature of the catchment area did affect referral patterns however and a number of respondents indicated that the nearest hospice was 30-50 miles away from their practice and, although they would like to make use of the facility, it was not convenient to do so. A small number of the respondents had recently set up in practice or had very small practices and had not been in contact with terminal illness. One of the respondents refers all his patients to private nursing homes.

In terms of referrals to particular aspects of the hospice service some interesting differences emerged. In the case of in-patient units 78 per cent of GPs from the WHB and 54 per cent of GPs from the North Western Health Board (NWHB) indicated that they did not make referrals to this service,

Table 2: *GPs Who Made Referrals to Hospice Services by Health Board*

<i>Health Board</i>	<i>GPs Who Refer</i>	
	<i>n</i>	<i>(%)</i>
EHB	72	(84)
WHB	14	(82)
SHB	46	(81)
MHB	12	(71)
NWHB	14	(87)
MWHB	25	(100)
NEHB	16	(57)
SEHB	27	(93)
Ireland	226	(82)

Table 3: *GPs Who Made Referral to Hospice Services by Catchment Area*

<i>Area</i>		<i>Rural</i>	<i>Semi-Rural</i>	<i>Suburban</i>	<i>Urban</i>
GPs who refer:	n	52	57	45	71
	%	(81.0)	(81.0)	(91.8)	(93.4)

while 47 per cent of GPs from North Eastern Health Board (NEHB) stated that they did not refer patients to Hospice Home Care Teams (HHCTs).

The frequency of referrals to HHCTs varied amongst Health Board regions with 59 per cent of South Eastern Health Board (SEHB) GPs stating that referrals to the service were the norm compared to 39 per cent of GPs from Midland Health Board (MHB). Forty-seven per cent of GPs from Eastern Health Board (EHB) indicated that they would only make an occasional referral to an in-patient unit while 60 per cent of GPs from Mid-Western Health Board (MWHB) occasionally referred to this service. The MWHB and NEHB were the only areas where referrals to other facilities e.g., private nursing homes, were the normal mode of operation.

Until recently the hospice movement in Ireland has been confined to Dublin and Cork with virtually no hospice care provision outside these cities. This situation is changing and, although the hospice movement has extended to most parts of the country during recent years, there are still many areas without such provision. The perception amongst GPs regarding the availability of hospice services in their locality was variable across Health Boards ranging from SEHB, where 97 per cent of GPs stated that there was a hospice in-patient unit available locally to 54 per cent of GPs from the NEHB. The EHB had the highest proportion (77 per cent) of GPs indicating that HHCTs were available compared to just 3 (18 per cent) GPs from the WHB.

Currently there are 9 hospices and 28 HHCTs in Ireland (St Christopher's, 1992, Irish Cancer Society, 1993). The availability of hospice services have varied from just under a year in Co. Galway to over a hundred years in South Dublin and the extent of referrals may well reflect the length of time facilities have been available. While HHCTs are available in all Health Boards there was a noticeable lack of awareness of such facilities. Twenty-three per cent of GPs from EHB indicated that HHCTs were not available within their region and this percentage rose to 82 per cent of GPs in the Western Health Board (WHB).

GPs were asked to rank the factors which contributed to their decision to refer patients to the hospice service. The reasons for referral to the hospice services were ranked in the following order:

- 1 Pain control.
- 2 Family willing to care for the patient but need extra help.
- 3 Management of symptoms.
- 4 Back-up service.
- 5 Quality of life for the patient.
- 6 Inability of family to cope.
- 7 Patient on their own.
- 8 Counselling for the patient and family.
- 9 Nursing support.
- 10 Patient does not want to die at home.
- 11 Home has inadequate facilities.
- 12 Assessment.
- 13 Unwillingness of the family to cope.
- 14 Financial considerations.
- 15 Respite care.
- 16 Primary carer caring for others.
- 17 Problems at night.

Thirty GPs (11 per cent) indicated other reasons for referral to the hospice service, including the cost of drugs and the availability of opiates and morphine pumps, while 6 GPs (2 per cent) stated that they used the service for advice on symptom management and a second opinion, although they did not necessarily refer the patient to the service. Other GPs indicated that they used the service not only for back-up support for their patients but also for their own personal support and 12 GPs (4 per cent) indicated that pressure from patients was their main reason for referral. One GP went so far as to suggest that, as the service was available, people would want to know why he did not refer to the service.

Twenty nine GPs (10 per cent) indicated that their reasons for referral to a hospice service had changed since they first referred. Four GPs indicated that they now referred more frequently as a result of being more aware of the service and the expertise it provides. Three GPs highlighted that communication with the service had improved which had led them to refer more often. Three GPs stated that they were now less likely to refer due to the availability of morphine pumps and three other GPs stated that they had reservations about the service feeling that the service had taken over their role without any consultation with them. One GP highlighted the need for the movement to be careful in order not to disrupt the doctor/patient relationship, a relationship which may have taken years or generations to build up.

A recurrent theme was that the hospice movement was restricted to cancer patients. A large number of respondents indicated that they only referred

patients with cancer to these services while others voiced the opinion that the service needed to be more universal taking into account the needs of other terminal diseases. It was mentioned that the hospice services should be available to people suffering from HIV/AIDS and Motor Neurone diseases, amongst others.

While 89 GPs (32 per cent) indicated that they had received training in palliative care and all highlighted the importance of such training, there was limited evidence to suggest that training had made an impact on reasons for referral to the hospice service.

VI DISCUSSION

The hospice movement has been active in the development of an advanced and specialist service for cancer sufferers. Currently, evidence points to the hospice movement providing an excellent service for people with a terminal disease. However, there are claims that services are restricted. It has been suggested that the notion that palliative care is solely for cancer patients is an old one and Higginson (1993b) argues that palliative care can be extended to non-cancer sufferers. The predominant view of respondents from both stages of the survey was that palliative care services should be available to all those people with a terminal disease. Initiatives have already begun in the Irish palliative care services to care for those suffering with HIV/AIDS, much of which is based in the patient's own home. If the movement is to continue to develop it will need to take account of the increasing demand stemming from a probable increased awareness amongst GPs of the service, an increasing ageing population and the growing numbers of people with terminal illness other than cancer sufferers.

The primary reason given for referral to the hospice service was pain control, although there was some difference in opinion between the Health Board regions, which may be due to the availability of morphine pumps in some areas. Other explanations may be based around individual GP's training and experience. Although there was no significant difference between the GPs who had been trained in palliative care and those who had not, a number of GPs stated that they were less inclined to refer to the hospice service for pain control purposes since receiving training and having gained more experience in caring for terminally ill patients.

Pressure from patients to refer to a hospice service was another factor in the reasons for referral, a feature which was noted by Pritchard (1978). If consumer involvement and choice is to be fostered, this is a very positive aspect of general practice. However, if the sole reason for a GP referring to the service is based on actual or perceived pressure to do so from the patient

or family it may lead to inappropriate referral and inefficient use of resources. If palliative care is to be effective and efficient then appropriate referral is essential. Some hospices recognise this and the importance of the doctor-patient relationship, hence they view prioritising cases as one of their initial functions, which goes some way to ensuring that the GPs relationship with their clients is not broken and patients receive the most appropriate care.

The essential feature of good communication (Baines and Kearney, 1993) was highlighted by nearly 30 per cent of the respondents. However, it was stated that some tensions existed between the different referring agencies and professionals, while, on occasions, there was a lack of understanding and clarification about the role of different professionals. For example, some GPs felt ignored by the hospice movement, while PHNs, because they were unable to refer directly to the service themselves, felt that they were undermined by the medical profession. This has obvious implications for service planners and questions need to be asked about how best to develop the role of the PHN in the care of the terminally ill and what is the most effective and efficient way of utilising this resource. Families also stated that they were dissatisfied with the communication between themselves and the medical profession, particularly at the time of diagnosis, a problem documented by other investigations (Blyth, 1990 and Higginson *et al.*, 1990).

Although, assessment and respite care were ranked relatively low by the GPs who responded, it is these factors which may drive future developments. Hospice in-patient units are increasingly likely to provide shorter lengths of stay for the patient with a terminal illness, acting as locations where needs can be assessed and the most appropriate form of treatment package decided (Griffin, 1991). Respite care could provide the break for the primary carer enabling them to care for the patient for longer periods at home. The two Dublin hospices are currently being used for these very purposes.

Problems at night also varied amongst Health Boards as a reason for referral. A contributory factor to this could be the lack of back-up support for the primary carer and GP. A night support service was suggested by some respondents as a way of alleviating some of the problems experienced by primary carers, enabling them to care for patients at home for longer periods of time. Given that levels of carer-support may be critical in the decision to refer patients to in-patient care (Field and James, 1993, and Hull and Taylor, 1990), the service would be of particular value for older patients and those people, who although suffering from a terminal disease, were not going to die in the immediate future.

The predominant feeling amongst the respondents to both stages was that training in palliative care was an essential part of vocational training for

GPs. Although a significant proportion of the respondents have had no formal training in palliative care, a number of them have read extensively in the area and attended seminars and lectures on the subject.

Some GPs were highly critical of the government because they felt that the whole area of primary health care, including palliative care, was neglected when it came to funding. One respondent indicated that palliative care at the primary health care level was considerably cheaper and the most appropriate form of care.

Thus, any evaluation of palliative care services must establish if patients are being appropriately referred to in-patient units. If there is evidence of inappropriate referrals, measures will need to be taken in order to redress the balance and ensure appropriate utilisation of resources. In addition, if service planners are committed to the provision of palliative care services, disease and population trends will have to be monitored by, for example, the adoption of patient registers.

However, the predominant feeling amongst respondents was that the hospice movement was an excellent service, making a major contribution to the Irish health services. However, its development is being curtailed by inadequate government policy and a lack of public and professional education.

VII CONCLUSIONS

Palliative care in Ireland is still in its infancy. However, if it is to develop, appropriate measures need to be taken now. Central to its development is the issue of funding. To date, much of the funding for Irish hospice services has come from voluntary contributions and grants from the National Lottery. However, fund raising can be difficult, particularly during periods of protracted economic recession and given the predominance of funds to the acute sector there has been severe pressure on hospice services. The services are therefore keen to ensure some redistribution of funds from the acute sector, with its concentration on high-technology and life prolonging procedures, to the palliative sector, thereby providing improved support to dying patients and their families.

One possible solution to some of the issues in palliative care would be to develop a centralised initiative as recommended by the World Health Organisation (1990). This could involve the establishment of a common focus for education, training and research in palliative care and provide a means of developing, evaluating and analysing a nationwide service, with the Health Boards playing a role in ensuring that the quality and quantity of provision will fulfil as many needs as possible within their regions.

GPs were identified as the main referrers to the hospice service. However, It is acknowledged that an analysis of referrals from other groups, for example, consultant geriatricians, would provide an interesting comparison with the findings of this study. The major reason for referral to the service identified by respondents was pain control, however, the existence of other factors suggests that it is not the sole reason for referral and that decisions surrounding referral are often *ad hoc* and complex.

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