anzspm
Australia New Zealand Society of Palliative Medicine

8 October 2021

For the Attention Of:
Healthcare Management Advisors
2/2 Bromham Place
Richmond VIC 3121

Dear HMA and Department of Health,

ANZSPM Submission re: Rural Procedural Grants Program (RPGP) and the Practice Incentives Program (PIP) Procedural GP payments

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) appreciates the opportunity to contribute to the streamlining and expansion of the Rural Procedural Grants Program (RPGP) and the Practice Incentives Program (PIP) Procedural General Practitioner (GP) payments. We strongly support the inclusion of palliative care as an additional advanced skill in these programs. The majority of palliative care in Australia, especially in rural and remote areas, is provided in the primary care setting with GPs playing a central role. Providing support and financial incentives for palliative medicine training would encourage the uptake of further training and additionally, support those rural GPs who currently provide palliative care services to address the unmet need in their communities.

We offer our specific feedback to the supplied consultation questions below.

(1) The underlying objective of the RPGP is to remove a cost barrier to skills maintenance for procedural disciplines. Is this barrier relevant to undertaking continuing professional development for non-procedural advanced skills?

The RPGP aims to 'improve rural and remote healthcare service delivery and workforce retainment by supporting GPs to undertake CPD to maintain or enhance skills'. This is also relevant to non-procedural palliative care, as there is a significant cost burden for rural GPs to obtain and maintain these skills. The high travel and registrations costs associated with conferences and other training opportunities create significant access issues for rural GPs. There is also a need to arrange locum services to allow GPs to undertake continuing professional development.

A rural grant program that covers non-procedural palliative care would help to ensure GPs maintain skills and are up to date with current and new clinical practice. The outcome supported by such a program would maintain service delivery capacity in rural communities and ensure safe and high-quality palliative care services.

The consultation paper notes that with the expansion of the program into non-procedural advanced skills, one needs to consider which additional skills should be supported, and if they require incentivisation for ongoing practice in that skilled area. ANZSPM offers the following suggestions regarding non-procedural palliative care skills:

- **Communication:** This is a core skill in palliative care. We strongly suggest that funds cover the cost of attending communication workshops, which can be prohibitively expensive for rural GPs. For example, both the Australasian Chapter of Palliative Medicine/Royal Australasian College of Physicians (AChPM/RACP) in Sydney and Barwon Health in Victoria run palliative care communication workshops.

- **Professional development (CPD):** Covering the cost of attendance at palliative care conferences would incentivise rural GPs to keep up to date with the latest updates in palliative care. Attendance at these conferences would also help rural GPs foster professional connections with both urban and rural medical practitioners. Funding should cover the cost of travel, registration, and necessary locum services. Funding for international conference attendance would further enhance access to professional development for rural GPs.

- **Clinical placements:** These are valuable opportunities to maintain palliative medicine skills. Funding should cover travel, accommodation, and locum cover to participate in 3-to-5-day placements.

- **Bereavement care:** This is an important part of end-of-life care. Funding rural GPs to attend bereavement care workshops would increase essential skills to support family members after the death of a loved one.

- **Spiritual care:** Attention to spiritual care is essential for quality holistic palliative care. Funding rural GPs to increase their understanding and skills would greatly improve palliative care provision in rural communities.

Due to the significant costs, these additional skills do require incentivisation. A rural grant program that covers non-procedural palliative care would therefore allow more GPs to obtain and maintain these skills.

(2) The underlying objective of the PIP Procedural GP payments is to encourage general practitioners in rural and remote areas to maintain local access to surgical, anaesthetics and obstetrics services in rural and remote settings (such as hospital theatres, maternity care settings and other appropriately equipped facilities). What should be the objectives relevant to other advanced skills e.g. seeking to promote access to a broader range of advanced skills within a locality?

Program objectives should reflect the need for GPs to provide palliative care services in various settings, including in practices/clinic rooms, homes (town and farm), residential aged care facilities, and hospitals.

The underlying objective of the Practice Incentives Program (PIP) is to encourage 'general practice to continue to provide quality care, enhance capacity and improve access and health outcomes for patients'. This is also relevant to non-procedural palliative care. A non-procedural GP payment aligns with the rural support stream of the PIP and would specifically encourage GPs in rural and remote areas to provide services that maintain local access to palliative care. This would importantly assist rural and remote residents to die in their preferred place, including at home on their farm. As a practice-based incentive, the PIP payment may encourage practices to recruit at least one GP to provide advanced palliative care skills.

The consultation paper notes there is a potential challenge regarding credentialing if the program expands into non-hospital settings. Further consideration is required to explore appropriate mechanisms for assessing ongoing involvement in service delivery. A formal collaboration with a specialist palliative care service is one suggestion.

Minimum numbers of activities required for payments may be difficult to achieve in palliative care. ANZSPM makes the following comments and suggestions relating to possible activity requirements:

- **Tier 1:** possible eligible activities – complex family meetings, management of complicated grief/bereavement, joint consultations with community nurses (home, RACF, rooms, and hospital visits), multidisciplinary team (MDT) meetings, backup for GPs, facilitation of dying at home for those living >5km from GP's rooms, achievement of preferred place of death, completion of advance care plans including prescribing of anticipatory end-of-life medications, and telehealth.

- **Tier 2:** provision of after-hours service on a regular basis (15hrs/week) – this may be difficult for palliative care due to inconsistent after-hours availability or the high risk of burnout if only one palliative care GP is available.

- **Tier 3:** more work is required to determine the minimum number of services in a 6-month period. For small locations, it might be difficult to set a quota.

- **Tier 4:** minimum number of procedures *or* meeting of the palliative care needs of the community.

(3) If the programs are expanded to include additional advanced skills, which of the following are most relevant at a national level for promoting community-delivered care in rural and remote areas?

(c) Palliative care services

As defined by the World Health Assembly (WHA), palliative care is "an approach that improves the quality of life of patients (adults and children) and their families who are facing the problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual."[1]

The WHA recognised that there is an "urgent need to include palliation across the continuum of care, especially at the primary care level, recognising that inadequate integration of palliative care into health and social care systems is a major contributing factor to the lack of equitable access to such care."[2]

The Australian National Palliative Care Strategy represents the commitment of the Commonwealth, state, and territory governments to ensure that evidence-based, quality palliative care is available to everyone who requires it.[3] The Strategy identifies people living in rural and remote areas as an under-served population in this

[1] World Health Assembly 2014. Strengthening of palliative care as a component of comprehensive care throughout the life course. Geneva: WHA. Viewed 30 September 2021, https://apps.who.int/iris/handle/10665/162863, p. 1.
[2] Ibid.
[3] Department of Health 2018. National Palliative Care Strategy 2018. Canberra, Australia. Viewed 30 September 2021, https://www.health.gov.au/resources/publications/the-national-palliative-care-strategy-2018.

respect. The Rural Procedural Grants Program and the Practice Incentives Program (PIP) Procedural GP payments represent crucial opportunities for the Australian Government to work towards several goals outlined in the Strategy, including:

- **Goal 2: Capability – Knowledge and practice of palliative care is embedded in all care settings**
  "Not everyone will have complex needs requiring specialist palliative care and there is significant potential to increase the capacity to deliver palliative care in all care settings, including the home"[4]

- **Goal 3: Access and choice – People affected by life-limiting illnesses receive care that matches their needs and preferences**
  "Underserved groups… experience various barriers in accessing and choosing the care they wish to receive, including geographical, cultural, language, and other barriers. Addressing these barriers and facilitating access can help overcome health disparities, particularly for Aboriginal and Torres Strait Islander people requiring palliative care."[5]

- **Goal 5: Investment** – **A skilled workforce and systems are in place to deliver palliative care in any setting**
  "Research and experience have identified the benefits for individuals and families in remaining at home as much as possible. Investment is needed into community-based models that are flexible to accommodate increased demand and public expectations."[6]

Whilst palliative care specialists are completing Fellowship training in greater numbers than in previous years, there is a significant attrition of 'established' specialists due to age and retirement from full-time practice. Additionally, increasing demands on existing specialist palliative care services have resulted in increased positions opening in these services. This means that many newly trained specialists are augmenting urban palliative care services, rather than moving into rural areas to augment or build new services for rural populations.

As a result, non-FAChPM trained doctors in rural areas (i.e., without palliative medicine advanced training) are more heavily engaged in the provision of complex palliative care and end-of-life care than their urban counterparts would be. This work tends to be labour-intensive, and often requires more time than can be adequately remunerated through current long-consultation arrangements. Currently there is no additional remuneration available to rural GPs who have obtained the Clinical Diploma in Palliative Medicine, or who have achieved an Advanced Specialised Training (AST) in palliative medicine with either the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). Incentivising and renumerating this advanced skills training would serve to acknowledge the increased demands on their practice occasioned by their work in palliative medicine.

[4] Department of Health 2018. National Palliative Care Strategy 2018. Canberra, Australia. Viewed 30 September 2021, https://www.health.gov.au/resources/publications/the-national-palliative-care-strategy-2018, p. 14.
[5] Ibid, p. 16.
[6] Ibid, p. 20.

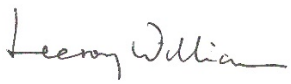
(4) Is there any other relevant feedback that should be considered in developing options for streamlining and expanding the RPGP and the PIP Procedural GP payments?

GP Procedural Training Support Program (GPPTSP): ANZSPM strongly recommends that this program be expanded to cover advanced palliative care training. Specifically, we recommend that this program provide funding for rural GPs to complete the RACP Clinical Diploma in Palliative Care (6-month training post). This funding should cover locum costs and living away from home expenses. This expansion would provide access to skills development, networking, and training in palliative care that might be otherwise inaccessible for rural GPs.

Voluntary assisted dying: As many states and territories legislate to open the availability of voluntary assisted dying, there must be a concomitant increase in the availability of well-trained and well-resourced palliative care practitioners. This is to ensure that all Australians have access to as broad a range as possible of high-quality, evidence-based end-of-life care treatments and services. The inclusion of palliative care in these programs would help to increase rural access to a higher standard of palliative and end-of-life care medicine.

Thank you for the opportunity to provide this feedback. We look forward to working with you regarding this important initiative in rural and remote health. The ANZSPM members that contributed to this response include rural general practitioners with palliative care training and rural palliative care specialists. Please contact us if you would like to discuss any points raised in further detail.

Yours sincerely,



Professor Leeroy William

President ANZSPM