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Australia New Zealand Society of Palliative Medicine

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For the Attention Of:

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ANZSPM Submission re: Streamlining and expansion of the Rural Procedural Grants Program (RPGP) and Practice Incentives Program (PIP) Procedural General Practitioners (GP) payment – Consultation Paper #2

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) welcomes this opportunity to provide additional input into the Australian Government's deliberations in relation to design issues and additional issues arising.

ANZSPM is a specialty medical society that supports the professional needs of medical practitioners as they work to improve the health outcomes of every person with a life-limiting illness, and their family/whānau, in Australia and Aotearoa. Our focus is on palliative and end-of-life care (PEOLC), but our influence also affects the healthcare system via our advocacy for holistic care, improved communication skills, and education and resources to support professionals in shared decision making with patients. ANZSPM members are medical practitioners. Our members include Palliative Medicine specialists as well as general practitioners and other medical practitioners who either practice or have an interest in Palliative Medicine.

ANZSPM strongly supports the current work to design a streamlined and expanded program that will ensure better alignment of incentives with the objectives of the National Rural Generalist Pathway (the Pathway). We recognize the importance of attracting, developing and retaining students and trainees by strengthening rural medicine training pathways. We understand that in so doing, there is an increased opportunity of providing a wider range of medical services and improved health outcomes for rural and remote communities including for Aboriginal and Torres Strait Islander peoples.

We provide our comments on specific aspects of program redesign below.

THRESHOLD QUALIFICATIONS: (QA1.1 – 1.4)

ANZSPM supports the Australian College of Rural and Remote Medicine (ACRRM) Advanced Rural Skills Training /

Fellowship in Advanced Rural Skills Training (AST/ FARGP). ARST as a threshold qualification for access to the RPGP for individual non-procedural advanced skills Continuing Professional Development (CPD), and also recommends the inclusion of the following palliative medicine training in the threshold qualifications:

1. The RACGP extended skills post in palliative medicine

2. The RACP Chapter in Palliative Medicine training programs: Clinical Diploma in Palliative Medicine (a 6-month full-time term for doctors not specializing in Palliative Medicine) and the Palliative Medicine Specialist training pathway (3 years leading to FAChPM qualification).

Commentary:

The inclusion of additional qualifications in the eligibility criteria is considered appropriate given that non-FAChPM training could be described as in evolution presently, driven by the rural generalist process. The RACGP extended skills post requires someone to achieve the Clinical Diploma from the RACP Australasian Chapter of Palliative Medicine (AChPM) in their extended skills term, and the ACRRM AST in palliative medicine has been running for less than 12 months. Trainees are encouraged to obtain the Clinical Diploma in Palliative Medicine but that is not essential to complete the AST term. There are some GPs who have obtained the Clinical Diploma, but who did not do their AST in palliative medicine. A more inclusive approach will be more effective in meeting the aims of the program redesign.

Careful consideration of appropriate threshold qualifications is important – for example, an academic Diploma of Palliative Care (which may not involve practice placements) should not be confused with the RACP Clinical Diploma in Palliative Medicine which provides 6 months training in a clinical placement. ANZSPM defers to the Australian Medical Council (AMC), the Medical Board of Australia and the RACP for the purposes of determining equivalent training and experience for the program as a whole. In the non-procedural area of Palliative Medicine, ANZSPM works closely with the AChPM and could be consulted as appropriate in relation to the issues being addressed. Consideration could be given to establishing a multidisciplinary committee with representatives from ACRRM and RACGP (FARGP), rural GP/s with AST or RACP Diploma, AChPM, and a representative from ANZSPM.

ANZSPM does not support initial limitation to GPs with recognized AST/ARST. There is a current and urgent need to include GPs with a RACP Clinical Diploma in Palliative Medicine or FAChPM. Under current funding arrangements, unless a GP with FAChPM is employed as a staff specialist, there is no funding available for CPD or to maintain advanced skills. The broader qualifications we propose for eligibility purposes will address this lack of funding by providing comprehensive advanced skills training in an accredited training post.

We note that there are numerous postgraduate palliative care/medicine courses nationally and internationally; however, currently there are no data available on what postgraduate palliative medicine qualifications are held by GPs. A survey of GPs would be of benefit to determine what, if any, post graduate palliative care/medicine qualifications are held by GPs. It is important to determine the level of clinical training involved in each course.

DESIGN FEATURE 2: ADDITIONAL SKILLS (QA2.1 – 2.3)

ANZSPM is highly supportive of an expansion of the program to include indigenous health, mental health, palliative care and paediatric palliative medicine education.

Expansion of the program would be appropriate in circumstances where an individual practitioner can demonstrate that they are providing service, at a level not usually expected of a GP in the conduct of their regular consulting. The PIP already includes several guidelines around this for the procedural specialties which could be adapted to non-procedural services, as follows:

- The (currently only procedural service) must be done by a GP who participates in an appropriate skills maintenance program in the relevant procedural areas
- Operate within an area classified MM3 – 7
- use facilities and resources which are centralized
- involve a team of health professionals.

The first steps taken should include all four identified non-procedural priority areas. A stepwise approach could be taken in order to bring in new non-procedural services, such as women's health.

Commentary:

These are all areas of need for rural and remote areas. Greater provision of services in these areas at an advanced level would not only fill a gap in access to specialist services, but also enable enhanced management of patients in local settings, providing benefits for the patients as well as cost savings to the health system.

From the community standpoint, the delivery of end-of-life care is being rapidly altered by the emergence of voluntary assisted dying/ euthanasia legislation in every state in the country. There is, therefore, a pressing need to bolster and further develop/ incentivize high-quality palliative care in rural and regional areas. The majority of these services are nurse-led and have limited specialist palliative medical input, and are therefore much more reliant upon involvement of locally-available rural generalists to provide the medical component of care on a day-to-day basis. This includes not just the prescribing/ pharmacological oversight of patients, but often providing direction in advance planning and end-of-life care discussions, being centrally involved in case-conference and multi-disciplinary team (MDT) discussions, and in the provision of counselling, psychological and spiritual support.

ENGAGEMENT WITH HOSPITALS AND COMMUNITY SERVICES QA3.1 – 3.5)

ANZSPM supports connection with a specialist team as best practice. ANZSPM cautions against an overly prescriptive approach being taken to the geographical range of general practitioners when determining access to the program. Overall time commitment would be a suitable alternative, given the geographic range of practice is determined by the characteristics of the care services setting. For example, not all GPs would provide services across all settings in their geographical area – they may not have access to a hospital, they may or may not be involved in telehealth delivery, and/or they may not be connected with residential aged care.

Commentary:

We note that many rural areas do not have a local palliative medicine specialist/ physician, but they do have a

community-based nursing service. To provide comprehensive palliative care, we would expect community palliative care nurses to form part of the team. Eligible rural generalists could be reasonably expected to be engaged with their local palliative care service (palliative care is an interprofessional approach to holistic care). So, they should be able to demonstrate some fractional engagement/ appointment with the service (either formally through an appointment, or via consulting load). Some of these services may be heavily weighted to hospital-based services, but others will be largely (or exclusively) community-based palliative care services. The most important element is being able to demonstrate an integral involvement in the palliative care service, at a greater level than would be expected of any general practitioner who is providing care to people in the last year of life through their regular consulting work in their own private practice.

Quote from rural general practitioner: In relation to the question of 'on-call' – "There may not be a formal 'on call roster'. I am currently the only doctor employed by our regional (LHD) palliative care service. My 'on call roster' is when I answer the phone after hours".

ADDITIONAL ISSUE 1: RURAL LOADING (QB1.1 – 1.2)

ANZSPM considers that the approach proposed, based on the Monash Model (MM) rankings and favouring more remote practitioners, would seem appropriate. ANZSPM agrees that the funding should be additional to that already in the system, and not a reallocation of current resources.

ADDITIONAL ISSUE 2: BANKING OR BORROWING RPGP FOR EXTENDED CPD (QB2.1 – 2.2)

Feedback from the ANZSPM membership suggests that GPs who are paid incentives under the program should be able to budget their time/ funds to cover the CPD required over three years without it being held centrally in a 'reserve' and paid out *en bloc*. On face value, 'banking' entitlements would seem to be an additional, cumbersome piece of accounting which may only serve to hinder access to payments under the scheme.

Members also raised the issue of locum cover and family responsibilities as very real barriers to being away from their practices for training purposes for long periods of time.

ADDITIONAL ISSUE 3: INEQUITY OF ACCESS TO CPD SUPPORT (QB3.1 – 3.2)

ANZSPM notes that where funding exists to access CPD via appointments with state health departments, the need for federally funded CPD support is not as great, and probably should not be required. This would focus ongoing CPD support to people who have limited access to alternative sources of funds to support ongoing education/ training and who will have additional costs associated with remoteness of location.

OTHER GENERAL COMMENTS

The existing PIP program contains a number of clear tables around tiers of support, depending upon level of activity. These could be easily adapted to palliative medicine, by including specific requirements in the tiers that address

specialist palliative care services. Palliative 'procedures' that could be considered include items like MDTs, home visits to facilitate home-dying, and management of a complex medication regime (syringe driver + PRN S/C medications) in the community.

ANZSPM also draws your attention to the specific needs of regional, rural and remote Australians who are in need of quality paediatric palliative care. Paediatric palliative care requires specialist communication skills and an appreciation of the differences in the paediatric approach and context. Ensuring specialised training amongst the rural generalist cohort and incentivizing participation in the program, should be regarded as priorities.

Thank you for the opportunity to provide these Stage Two comments, and for taking forward a number of key ANZSPM's recommendations from our first stage submission. ANZSPM welcomes the opportunity to continue to assist in your work towards addressing the skills shortages currently impacting on quality of end-of-life care, and the availability of quality care more generally, in the regions.

I thank members of the ANZSPM Rural & Remote Special Interest Group and the ANZSPM General Practice Special Interest Group for their contributions to this advice. I note and declare that in seeking comment from these groups there is potential conflict of interest. Some who contributed to this submission may in due course benefit from receiving funding to maintain and enhance their skills given they are GPs with either FACP Clinical Diploma in Palliative Medicine or full FAChPM. All speak from experience and in the interests of improving palliative care provision.

Yours sincerely

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