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Submitted to Primary Health Reform Steering Group Draft Recommendations - Discussion Paper
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Organisation:
Australian and New Zealand Society of Palliative Medicine

Recommendation 1 (One system focus):
Reshape Australia's health care system to enable one integrated system, including reorientation of secondary and tertiary systems to support primary health care to keep people well and out of hospital

1.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM supports the view of the Royal Australasian College of Physicians (RACP) that the working relationships between general practitioners (GPs), specialists, and consultant physicians need to be recognised, mapped, fully understood, and strengthened in the 10 Year Plan. Palliative Medicine specialists are currently delivering palliative services across all healthcare settings and the specialist workforce is not able to meet demand alone. It is therefore important that the generalist palliative care workforce is urgently upskilled in a coordinated manner to meet future demands.

There is a need to articulate where palliative care services should feature primary health providers as part of the multidisciplinary team approach. These providers should be enabled, trained and reimbursed to provide generalist palliative care with the support of specialist services as required. This will require a flexible model which is responsive to changes in the current and future demands for palliative care services, including in-home service provision by primary care providers.

A one system focus should support more person-centred teams that bring together GPs, medical specialists, nurses, pharmacists, and allied health professionals to coordinate the care of a patient across healthcare settings. It should allow for telemedicine delivery of services and support, and it should have an appropriate reimbursement model which recognises the contributions of all palliative care professionals in integrated, multidisciplinary service delivery.

1.2 What do you see as the challenges in implementing this recommendation?

Do you agree with the intent of this recommendation and what changes would you suggest?:

The key barriers in implementing a one system focus for palliative medicine are:
· Lack of a funding and delivery model for a multidisciplinary, one system approach to consistently care for patients and their families throughout the lifetrajectory.
· The need to actively consider and then implement an approach that places general practitioners as the stewards for quality generalist palliative care delivery, supported by specialists including via remote mentoring of general practitioners where appropriate.
· Limited training opportunities in palliative medicine for general practitioners.

· Multiple GP providers (from different GP surgeries) for a patient, which limits the notion of a single medical primary care lead for the care of the patientas a “single source of truth”.
· End-of-life care (defined as the last year of life) should be a mandatory service provided by GPs to their patients. Support networks for GPs can include GPs with a specialist interest in palliative medicine, community specialist palliative care services, and palliative medicine specialists.

· Specialist workforce limitations to support the population needs, particularly in paediatric palliative care; non-malignant diagnoses; regional and remotecommunities; Aboriginal and Torres Strait Islander; and culturally and linguistically diverse populations.

Recommendation 2 (Single primary health care destination):
Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice

2.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM supports the notion of a single primary health care destination that allows individuals, families and carers to work with their chosen primaryhealth care provider and practice over the palliative care trajectory.

2.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

A key challenge will be the variability in access to primary care across Australia, not only in regional and remote contexts but also in the cities and across vulnerable populations. The links between palliative medicine specialists and the primary care system vary across localities and across different population groups. Barriers to access and weak connections between general practice and the specialty will need to be addressed in an already workforce resource-poor health discipline.

2.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

Please provide any examples of best practice for implementation of this recommendation (from Australia or

overseas):

We refer you to the systematic review:

Johnson CV, McVey P, Rhee JJ, Senior H and Monteross L. "General practice palliative care: Patient and carer expectations, advance care plans and place ofdeath - a systematic review" ResearchOnline@ND The University of Notre Dame Australia 2018.
Available at:
http://dx.doi.org/10.1136/bmjspcare-2018-001549

While not providing particular examples, it provides sound insights into patient and carer expectations of quality palliative care.

Recommendation 3 (Funding reform):
Deliver funding reform to support integration and a one system focus

3.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM supports this recommendation and draws to the Government's attention the need to ensure that the supportive role of both generalist and specialist palliative care services is recognised and appropriately remunerated, as part of a complex funding model that has quality integrated care for all Australians as its core focus.

3.2 What do you see as the challenges in implementing this recommendation?

How would you suggest this is implemented?:

The key challenge in delivering funding reform to support integration and a one system focus for palliative medicine will be the diversity of current funding sources, and the service delivery of palliative care that crosses all healthcare settings, e.g, from community care to residential aged care, acute care, subacute care, and outpatient services. These significant transitions between settings need to be well managed, with this further complicated by a funding pipeline that involves the federal and state governments, the private sector, and 'user-pays'. The funding is sometimes point-of-service and sometimes via funding to institutions. The services needed by a palliative care patient can often involve multiple disciplines, specialties and care supports.The funding model will need to be rethought and be the subject of consultation with all stakeholders, so as to ensure integrated service delivery is incentivised.

Recommendation 4 (Aboriginal and Torres Strait Islander health):
Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care systems

4.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM strongly supports this recommendation. The current structures for primary health system delivery to Aboriginal and Torres Strait Islander peoples are producing much poorer outcomes for these population groups than for the Australian population as a whole. As part of the structural reform process it will be important to take into account the need for support to families in bereavement. The primary health system needs capacity to be proactive in reaching out to families and communities to ensure grief and bereavement are supported. Lack of support during the bereavement phase has been shown to bring lasting negative health and community outcomes.

4.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

The key challenges in implementing a one system focus for Aboriginal and Torres Strait Islander Australians in need of palliative care mirror those barriers experienced in delivering palliative care across the health care system, and are made more complex by cultural and other barriers:

· Patient-led approaches and the need to build the Aboriginal & Torres Strait Islander specialist palliative care workforce
· The need for the primary health system to provide culturally safe care, including recognition of the importance of dying on country
· The importance of community in the care pathway, leading to the need for approaches beyond the immediate family. Some Aboriginal and Torres StraitIslander people are living in isolation from community connections but never-the-less will benefit from establishment of those links
· Diversity across Aboriginal and Torres Strait Islander populations – urban, regional, rural and remote
· The greater likelihood that care teams will be dealing with multiple comorbidities when putting together a one-system approach to care.

4.3 Please provide any examples of best practice for implementation of this recommendation.

Please provide any examples of best practice for implementation of this recommendation.:

See: Journey into
Sorry Business
https://www.swsphn.c
om.au/aboriginal-
palliative-care

Palliative Care Australia has an excellent example, in the
Purple House, which can be found at:
https://palliativecare.org.au/palliative-matters/living-and-
dying-in-the-place-that-matters-most

Recommendation 5 (Local approaches to deliver coordinated care): Prioritise structural reform in rural and remote communities

5.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM supports this recommendation. ANZSPM supports the RACP advice to:

· Incorporate incentives to provide telehealth services to under-serviced populations. The Government should consider an equity loading, or retaining the regional and remote loading, for example – this could be provided through MBS or non-MBS means of funding.
· Introduce complementary measures such as funding videoconferencing technology packages to facilitate high quality telehealth in other priority populations such as those in rural and regional areas.
· Improve patient travel assistance schemes to ensure appropriate equity and real benefit to patients.
· Consider the impact of COVID-19 on rural communities. For example, we understand there are shortages of nurses also in rural and remote regions because they have left to work in COVID-19 vaccination and quarantine facilities.

· Consider establishing centres of excellence in rural areas to attract and retain clinicians who might otherwise be drawn to opportunities.

5.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM is concerned that telemedicine approaches may come to be considered as a 'first option' for rural primary care/palliative care service development.

· Telemedicine item numbers should remain as a central feature of primary care provision in the rural sector into the future (regardless of the wax and ane of COVID). The question is how to ensure they are used appropriately going forward; and what is the ideal mix? We don't yet know that.

· Those complex consultations which must (by circumstance and geography) occur by telehealth must be remunerated appropriately. People entering palliative care will often need long consultations. One of ANZSPM's members provides an example of a discussion with a 39 year old and his family about his trajectory with MND. Discussion of the physical symptoms took 20 minutes, the broader discussion about "where to from here", and "what do we expect /what does my dying look like" and "when is enough, enough? And how will I know?" took over an hour, with him communicating using his iPAD and the community health nurse reading out what he had typed. These are important conversations which establish the care pathway for individuals and need tobe dealt with both authoritatively and sympathetically. They need to be preceded by multidisciplinary discussions at the PHN level that ensure an optimized and coordinated approach to care.

5.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas). :

A good example of a helpful scheme is the earlier Commonwealth Isolated Patients Travel Accommodation Assistance Scheme (IPTAAS) some thirty yearago. While states run other schemes, IPTAAS represented a very significant advance in the late 1970s and 1980s. A range of schemes are run by most States but these variable in their impact. The benefits of a national approach should be considered here.

Recommendation 6 (Empowering individuals, families, carers and communities):
Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them

6.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM agrees with this recommendation and proposes that Palliative Care Australia could play a valuable role in supporting people and communities inthis respect.

6.2 What do you see as the challenges in implementing this recommendation?:

What do you see as the challenges in implementing this recommendation?:

· The growing needs of the ageing population are likely to increase the demands on hospital beds, especially during winter and COVID surges. The pivot to greater care in the community will require a partnership between community assets, non-professional carers and healthcare professionals across settings. A public health approach to palliative care requires greater engagement from the healthcare system, including primary care.
· The level of health and death literacy within the Australian community remains poor for several reasons. Furthermore, the knowledge of palliative care in our communities and healthcare systems prevents informed end-of-life shared decision-making processes. Subsequently, less advance care planning discussions occur. There is also the question of who the lead clinician undertaking advance care planning discussions should be – the specialist who has most of the information or the GP who may have a richer relationship with the patient and their family?
· Voluntary assisted dying legislation may change the nature of end-of-life discussions, raising concerns regarding prognostication; communication in general, but especially the exclusion of coercion and clarification of capacity and processes; and effects on the therapeutic relationships between patients, their families, and clinicians.
· GPs have an integral role in social prescribing and supporting communities to develop local solutions to their own problems. Patient self-monitoring and the development of compassionate communities have been areas of increasing research to facilitate more timely interventions and avoid crises. More research and exploration of this area is required.
· From a palliative care perspective, opportunities exist to consider the holistic needs to our communities utilising all the resources at our disposal. Primary health networks are ideally placed to coordinate the services required in conjunction with community groups and providers. The aim should be to ensure that all people who need palliative care in the community have access to appropriate supports and services as needed. Currently, certain groups have had less access to palliative care, e.g., people who are homeless, prisoners, people with disabilities, and people in residential aged care.
· End-of-life care communication remains poor across healthcare settings, contributing to the health economics of futile investigations, treatments, and undesired admissions.

6.2 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas). :

6.3 Please provide any examples of successful digital solutions and devices.

Please provide any examples of successful digital solutions and devices.:

Recommendation 7 (Comprehensive preventive care):
Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support

7.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM is supportive of any measures that allow people to live well for longer. In the context of palliative care, the task is one of ensuring that peoplewith life-limiting illnesses can receive quality care that allows them to have the best possible quality of life.

7.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

Prevention in the context of palliative care is not well understood.

· Comprehensive preventative care should also be applied to the prevention of poor end-of-life care and bereavement. The last year of life should be supported holistically and via a multidisciplinary team. Members of the allied health team can provide support to maintain function, address psychosocial and existential concerns, and relieve carer stress.
· It should be recognised that the peri-death experience can impact on the bereavement of the carers and families. This issue is pertinent across the healthcare system and contributes to prolonged grief disorder that may develop without monitoring or recognition. There is a need to address this issue residential aged care where death is more prominent and supports may not be available to help people express their feelings of grief about friends in thefacility who have died.
· The "Mental Health Plan" to support bereavement care should be reviewed to reduce stigmatization and ensure the sessions are accessible andeffective.
· Healthy lifestyle education programs may be an opportunity to incorporate palliative care information but should be reviewed to ensure that they areevidence-based and effective.
· From a cancer perspective, another form of preventative palliative care can be the reduction in treatment breaks based on a holistic approach and a focus on cancer pain.

Recommendation 8 (Improved access for people with poor access or at risk of poorer health outcomes):
Support people to access equitable, sustainable and coordinated care that meets their needs

8.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM supports all Government measures to address issues of equity of access to high quality, coordinated palliative care in our community.

8.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM has already noted that the key challenge in delivering funding reform to support integration and a one system focus for palliative medicine will be the diversity of funding sources currently, and the wide range of sites in which palliative care is delivered, from home and community care, to primary care, residential aged care, and to acute care. The transitions between these settings are significant and must be well managed and the funding pipeline involves the federal and state governments, the private sector, and 'user-pays'. The funding is

sometimes point-of-service and sometimes via funding to institutions. The services needed by a palliative care patient can often involve multiple specialties and care supports. The funding model will need to be rethought, and be the subject of consultation with all stakeholders so as to ensure integrated service delivery is incentivised.

Equity of access must be a consideration in such a comprehensive review of how primary care is currently provided.

Recommendation 9 (Leadership):
Foster cultural change by supporting ongoing leadership development in primary health care

9.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM agrees with this recommendation. As a specialty society, ANZSPM works with the RACP and Royal Australian College of General Practitioners (RACGP) to deliver education and training opportunities across the specialist and generalist medical workforce. These education and training programs also provide leadership opportunities for medical practitioners, connecting them with each other and with researchers working to build the evidence base for quality palliative care.

In implementing the 10 year plan, ANZSPM would welcome the opportunity to enhance and expand this leadership and education platform, which has been built over 20 years by its membership.

9.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM is committed to ensuring the translation of new evidence into practice, and relies on its membership to assist in the delivery of medical and surgical updates both within the membership body, and more broadly across the RACP and RACGP.

Those involved in developing leadership and change programs are generally contributing as volunteers, on top of a demanding workload. Ensuring the skills, education platforms and resourcing are available to support those involved in practice leadership will be important.

9.3 What do you see as the areas of opportunity for leadership and cultural change?

What do you see as the areas of opportunity for leadership and cultural change?:

ANZSPM's General Practice Special Interest Group has initiated discussions across key stakeholders with a view to achieving new and stronger pathwaysto palliative medicine education, training and leadership.

Recommendation 10 (Building workforce capability and sustainability):
Address Australia's population health needs with a well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce

10.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM agrees with this recommendation.

10.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM sees the main challenges to building palliative medicine workforce capability and sustainability as being:

- Lack of consistent and integrated medical, nursing, and allied health undergraduate education in palliative care
- Lack of consistent and integrated medical, nursing, and allied health postgraduate education in palliative care in healthcare organisations
- Lack of incentives to practice in particular regions and communities
- Lack of accredited training positions for trainees in general practice
- Lack of data to understand the primary care palliative care workforce needs as reported by the Australian Institute for Health & Welfare
- Lack of data on GPs and other specialists with a Clinical Diploma in Palliative Medicine (via the RACP) and their current utilisation of this qualification.

Recommendation 11 (Allied health workforce):
Support and expand the role of the allied health workforce in a well integrated and coordinated primary health care system underpinned by continuity of care

11.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM is supportive of the contribution that the allied health workforce can make to patients and their families in staying well in the community for aslong as possible across the palliative trajectory

11.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM considers that the training and workforce planning for allied health professionals in generalist and specialist palliative care requires review.Social workers are critical for psychosocial support for patients and their families when a life-limiting illness has been diagnosed.

Recommendation 12 (Nursing and midwifery workforce):
Support the role of nursing and midwifery in an integrated Australian primary health care system

12.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM strongly supports the role of the palliative care nursing workforce in delivering quality care to people living with a life-limiting illness and theirfamilies and carers.

12.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM is concerned that the palliative care nursing workforce is facing capacity constraints and that the level of training in palliative care in Australia today is insufficient to deliver quality palliative care, particularly for patients dealing with life-limiting illnesses beyond cancer. These capacity constraintswill need to be addressed if PHNs are to reach their full potential in delivering coordinated and supportive palliative care to patients and their families.

Recommendation 13 (Broader primary health care workforce):
Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system

13.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM considers this to be a very important recommendation.

13.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM is concerned that the level of training in palliative care for the healthcare workforce in Australia today is insufficient to deliver consistent quality palliative care. An example is access to, and quality use of, medicines for people with palliative care needs, where the treatment regime will be very different from usual approaches to treatment. Cancer pain is a good example of this difference. Specialist palliative medicine physicians, general practitioners, and their patients and families, rely on a multidisciplinary approach to deliver quality care; therefore, the care can be compromised without an appropriate baseline of knowledge.

Recommendation 14 (Medical primary care workforce):
Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce

14.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM agrees with this recommendation, and considers that the focus on GPs as at the centre of patient-led palliative care is an important one.

14.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

ANZSPM notes that the provision and funding of palliative medicine training should be a priority within this recommendation. There are courses available for GPs currently, such as the RACP's Clinical Diploma in Palliative Medicine and Advanced Training in Palliative Medicine Program. However, most GPs, and especially those in rural areas, do not have the capacity to undertake such extensive training. While there are some educational resources available for self-learning, there remains a lack of training opportunities that require a medium level of commitment. ANZSPM recommends that quality short courses in rural palliative care, similar to the short courses that exist for rural emergencies, rural obstetrics, and paediatric advanced life support be developed and rolled out. The ability to attend a 2- day or 4-day workshop with an intensive focus on palliative care and complex palliation in the rural setting is needed. There should be a coordination between the RACP, RACGP and Australian College of Rural and Remote Medicine (ACRRM) at a federal level to develop a suite of appropriate training workshops specifically targeting rural GPs without ready access to specialist physicians. However, every effort should be made to ensure specialist advice is readily available and utilised as required.

ANZSPM asserts that training for GPs in palliative medicine needs to be prioritised and funded. Currently, the options for frontline GPs are the Clinical Diploma in Palliative Medicine or the Advanced Training in Palliative Medicine Program (conferring a FAChPM post-nominal). Postgraduate courses exist via many universities but require more time to complete and absence from frontline work. Other educational resources are available through PCC4U, CareSearch and other platforms but these are aimed at undergraduate and interprofessional audiences, that may not be appropriate for working GPs.

ANZSPM recommends the consideration of palliative medicine rotations in GP training that support GPs to network between rural and metropolitan

areas, as well as contribute to the one system integration between healthcare settings, i.e., community, acute and subacute care. ANZSPM will be workingwith the RACP, RACGP and ACRRM to explore these training opportunities. More flexible working arrangements and inter-organisational appointments may also bolster the experiential learning for established GPs in specialist palliative medicine.

Recommendation 15 (Digital infrastructure):
Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care

15.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM agrees with this recommendation, and considers that digital infrastructure must be comprehensive of the patient journey, practitioner needsand which has the capacity for interrogation for research and quality monitoring.

15.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

This complicated area requires an understanding of the required reporting data, the best system/s to collect such information, and the requisite data and privacy management protocols. A review of both private sector developers and public sector data management options should be undertaken, ensuring that palliative care will specifically benefit from the data.

15.3 Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).

Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas). :

Recommendation 16 (Care innovation):
Enable a culture of innovation to improve care at the individual / population level, build 'systems' thinking and ensure application of cutting-edge knowledge and evidence

ANZSPM supports this recommendation and recognises the wealth of information in primary care that could inform future service delivery and quality improvements. Collaborative research is vital to ensure our services are meeting the demands of the community. Individual and population-based data provides an opportunity for translational research and promotes evidence-based practice. In order to develop such innovation, however, service delivery gaps will need to be improved to allow dedicated time to undertake this research.

Recommendation 17 (Data):
Support a culture of continuous quality improvement with primary health care data collection, use and linkage

17.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM supports the development of a palliative care dataset that will inform many areas detailed above.

17.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

An understanding of the current palliative care landscape and gaps is essential if we are to develop the necessary workforce to meet the future demands of the population. Evidence from all healthcare settings should be collected and reviewed to inform change. The Palliative Care Outcomes Collaboration (PCOC) provides an ideal approach to review non-specialist palliative care services in the future, as it has done with the specialist palliative care sector.

17.3 Please provide any examples of utilising primary health care data collection and linkages to support continuous quality improvement(from Australia or overseas).

Please provide any examples of utilising primary health care data collection and linkages to support continuous quality improvement (from Australia oroverseas). :

ANZSPM supports the work in this area by Palliative Care Australia (PCA) and both organisations contribute to the federally sponsored Palliative Care andEnd-of-Life Data Development Working Group.

Recommendation 18 (Research):
Empower and enable contextually relevant, translational and rapid research and evaluation in primary health care, addressing questions directly relevant to service delivery in localised context

18.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM is strongly supportive of this recommendation and considers that a priority for this to occur will be tapping into the wealth of primary care datathat can inform future service delivery improvements.

18.2 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

Key challenges are well known and include:
- ensuring collaborative research approaches involving multiple disciplines across research and clinical practice
- data stewardship and permissioning
- addressing the service delivery gaps that keep specialists, general practitioners and other health professionals constantly 'on the back foot' when itcomes to providing quality palliative care.

Recommendation 19 (Primary health care in national and local emergency preparedness):
Deliver nationally coordinated emergency preparedness and response, defining Commonwealth, State and Territory roles and boosting capacity in the primary health care sector

19.1 Do you agree with this recommendation?

Do you agree with this recommendation?:

ANZSPM supports this recommendation, especially in light of the recent COVID-19 pandemic.

19.1 What do you see as the challenges in implementing this recommendation?

What do you see as the challenges in implementing this recommendation?:

The ability for the healthcare system to care for people who are dying in a pandemic, is directly related to the ability of that same system to care for this population despite a pandemic. Vulnerable members of our population are more at risk than usual during a pandemic for many reasons. Hence, a focuson developing services that meet the needs of these people is critical if we are to avoid unnecessary deaths in a pandemic.

19.2 What has worked best for you during disasters such as the COVID-19 pandemic, bushfires and other disasters?

What has worked best for you during disasters such as the COVID-19 pandemic, bushfires and other disasters?:

In 2020, ANZSPM rapidly assembled a special interest group of palliative medicine specialists and general practitioners who were dedicated to thedelivery of palliative medicine guidelines at the COVID-19 coalface.

The guidelines have informed broader national best practice guidelines and, importantly, were available very soon after the beginning of the pandemic.

The Group has agreed it will remain assembled while the current pandemic continues to challenge the delivery of quality palliative care in Australia andNew Zealand.

Recommendation 20 (Implementation)
Ensure there is an Implementation Action Plan developed over the short, medium and long-term horizons
Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of primary health care reform

20.1 Do you agree with this Implementation Action Plan approach?

Do you agree with this Implementation Action Plan approach?:

ANZSPM congratulates the Department of Health on its comprehensive approach in developing and implementing the 10 year plan.

20.2 Do you see any challenges in implementing primary health care reform?

Do you see any challenges in implementing primary health care reform?:

ANZSPM's understanding of the challenges have been outlined above and we welcome the approach taken, which is to ensure consumers, communities,service providers and peak organisations are engaged throughout implementation, evaluation and refinement of primary health care reform.

ANZSPM places people with a life-limiting illness and their families at the heart of its Mission and regards a person-centred approach to be essential to quality end-of-life care. ANZSPM is concerned that person-centred approaches and patient-led approaches can be different. For instance, a person mayseek the option of physician-assisted euthanasia due to a lack of understanding of, or access to, quality palliative care. In this instance and many others, ANZSPM advocates for the resources and public education to allow people to have access to quality palliative care as an essential firststep in delivering a patient-led approach.

Additional feedback

21 Please provide any additional comments you have on the Primary Health Reform Steering Group Draft Recommendations.

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Steering Group Draft Recommendations.:

The impact of Voluntary Assisted Dying Legislation

Unless there is urgent action to remedy the deficiencies in rural palliative care expertise in the primary care workforce, many communities will be in the ethical and moral situation where their access to assisted dying is a legislated right; but their access to high-quality, skilled palliative care is not.

Rural generalists

The development of 'rural generalism" as a sub-specialty of general practice is appreciated, but there is still a lack of clarity around what this means, andhow it will work into the future.

Incentivisation to work in regional areas

The incentives for junior doctors are not necessarily monetary. They need to have their undergraduate training within the regional area. This is now happening for about 20% of medical students. However, sufficiently funded and accredited JMO posts in the region are required, so that they can remainand work in the region. Training sites have sufficient staffing to prevent unduly onerous overtime rosters, and other workplace concerns, which may act as a disincentive to local training. The majority of vocational training should be possible in a rural or remote setting, but at present this is not possible in

Palliative medicine, due to the lack of accredited supervisors and sites in these regions. Finally, permanent employment positions should be available inthe region that are well-supported and attractive for long-term commitment and wellbeing of the practitioner.

The Fly In Fly Out Workforce

ANZSPM recommends that "Fly Inn Fly Out" (FiFo) be considered as a small part of a much larger push to ensure PHNs are viable throughout the country.The current FiFo model is unsustainable, with large salary packages being negotiated on the basis that the Local Health District will have little option but to sign off on large packages in order to deliver the service.

A final comment: Palliative care is important to community- based health services and with an ageing population, more Australians are using palliativecare services. This is not addressed in the Discussion Paper.