anzspm
Australia New Zealand Society of Palliative Medicine

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ANZSPM response: Consultation - Report on Rural Procedural Programs streamline and expansion

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) welcomes this opportunity to provide additional input into the design of RPGP and PIP program changes.

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 physicians and specialists as well as general practitioners and other medical practitioners who either practice or have an interest in Palliative Medicine.

We commend the Government for its actions in this regard and provide our comments on specific aspects of the call for input below.

Question 1: What is your preferred option from those presented in the report?

RPGP EXPANSION OPTIONS

Of the options presented, ANZSPM supports A1b, that is, a moderate expansion to include Aboriginal and Torres Strait Islander health, mental health, paediatrics and palliative care.

PIP PROCEDURAL GP PAYMENT EXPANSION OPTIONS

Of the options presented, ANZSPM supports B1b, that is, for GP payment expansion such that it provides an incentive payment for the delivery of non-procedural services in Aboriginal and Torres Strait Islander health, mental health, paediatrics and palliative care supported through an RCGP extension.

Noting that a mechanism will be needed such as MBS billing for delivery of incentive payments, ANZSPM urges this need is advanced in part by referral to the MBS Continuous Review Advisory Committee for its consideration and

prioritisation. The introduction of specific MBS items (reserved for eligible GPs) should be considered as a means to help track services.

STREAMLINING OPTIONS

ANZSPM considers that as streamlining of the program is an administrative matter, the decision on streamlining of arrangements needs to be made by ACRRM, RACGP and Services Australia. However our members have advised that the administration of funding by the College to individual practitioners is likely the optimal arrangement for the administration of financial support towards the advancement of non-procedural special skills. Decisions around administration should also take into account that most engagement with palliative care isn't necessarily through 'the practice', but through other vehicles / structures.

Question 2: What features are most important to you in the revised scheme (e.g. particular advanced skills, additional incentive mechanisms, flexibilities)?

ANZSPM firmly contests that palliative care needs to be included in the Program as GPs provide the bulk of palliative care in rural/remote settings and there is a lack of specialists in many rural areas.

In regards palliative care qualifications, we suggest ACRRM AST/FARGP ARST or equivalent qualification. ACRRM and RACGP (within input from relevant specialist colleges or organisations) should be well placed to determine what is considered 'equivalent'. RACP Clinical Diploma in Palliative Medicine is an acceptable equivalent. There needs to be flexibility to consider applicants with other recognised post graduate diploma/masters in Palliative Medicine e.g. from Flinders University and Melbourne, with written proof of a 6 month clinical placement/or accumulative experience (similar to the paediatric requirement).

Question 3: Are there any potential unintended consequences or barriers to implementation that the Department should address when considering changes to the scheme?

Where C4: Establishing a new Rural Generalist Support Program is concerned, care should be taken to ensure that not only current and new Rural Generalists (FACRRM or FARGP) are eligible for the program, but also FRACGPs who are working in rural/remote locations and practice non-procedural advanced skills. There are GPs (FRACGP) providing advanced clinical skills in rural areas who might not be considered 'Rural Generalists' (i.e. not FACRRM or FARGP). That is, the danger is that rural medical practitioners practicing with clinical diplomas in their chosen sub-specialty who may be interested in accessing the Program to broaden their non-procedural skills into other areas may not be considered 'Rural Generalists'.

ANZSPM contends that while there needs to be a threshold qualification to ensure only those with existing advanced skills are successful in gaining a grant, there also needs to be sufficient flexibility to ensure qualified outliers are not excluded. ANZSPM acknowledges that the RPGP currently includes threshold qualification as one trigger, with other triggers being:

- Hold vocational recognition as a general practitioner (VR GP) or be enrolled in a Fellowship pathway with

either ACRRM or RACGP;

- Principal clinical practice is physically located in a MM 3-7 region;
- Hold unsupervised clinical privileges in an eligible discipline (surgery, anaesthetics and/or obstetrics) at a hospital located in MM3-7; and
- Participate in a regular roster or general on-call roster.
- GP registrars must have pre-existing qualifications in one or more disciplines. Pre-existing qualifications may include a recognised qualification in the procedural components of Anaesthetics, Obstetrics, or Surgery (such as a DRANZCOG certificate)

Eligibility under the new arrangements should also take into account those who also hold unsupervised clinical privileges in palliative care, and who participate in a regular palliative care service roster or deliver services on-call, by extending the principles (above) into the non-procedural space. This would be consistent with Design Suggestion #6 & #7 later in the review document, which gives scope for involvement with a palliative care service 'out of hospital' / community-based palliative care service. Consideration should be given to expanding eligibility to any GP (regardless of qualification), who is demonstrated to be working MM3 – 7, with privileges to work 'unsupervised' in the non-procedural clinical area, and who is employed on a roster / on-call roster for that service. This could even be implemented as a 'grandfather' clause to give people time to sort out their eligibility and provide evidence of this with the assistance of the relevant local services; before reverting after some pre-set period [48 months perhaps] to a program that is solely around RG positions.

Question 4: Do you have any advice for the issues discussed around credentialling or threshold qualifications?

Anecdotally, ANZSPM has heard that LHD credentialling committees are often looking for guidance from state / federal documentation around eligibility for credentialing decisions, particularly in rural areas. Without clear guidance that takes into account the rural and regional context, decisions can be made that have unforeseen and harmful consequences. One particular issue in NSW some years back related to the state-wide discussions about the appropriateness of credentialling GPs in rural hospitals to admit children under the age of 12 years to their local facility. The restriction on credentialing to manage paediatric patients with minor illness in smaller centres resulted in a significant increase in long distance paediatric transfers for unclear benefit as a result, as GPs who had been credentialled to provide paediatric care lost their credentials in paediatrics.

For palliative medicine, our members advise on the importance of:

a) the credentialling decision being informed by the practitioner's threshold qualification

b) flexible assessment of 'RPL' and other relevant qualifications (for want of a better term), and

c) continuing to look at the role the person will undertake, including some formal engagement with existing palliative care services. Having this clearly spelt out in a revised RPGP would be very helpful.

Question 5: Any other related comments about the strengths and limitations of the RPGP

ANZSPM welcomes this review as one that can improve equity of access for rural general practitioners to the training support and remuneration incentives they need in order to develop their knowledge and skills in particular areas of interest or practice need across regional, rural and remote Australia. In order to ensure best use of finite resources, RPGP funding should only be available to GPs that cannot access any alternative funding. GPs employed by hospitals and state health services as CMOs or 'staff specialists' who have CPD funding available through the hospital should not have access to RPGP funding. However, if hospital funding is less that what is available through RPGP, then funding could be available pro rata to make up the difference.

Improving remuneration for non-procedural specialist practice in regional, rural and remote practice is also a high priority. In this respect, changes to the MBS should be considered as well as improving access to training via measures to draw palliative care service involvement into the PIP fold.

This advice has been prepared with input from our Rural and Remote Special Interest Group (Co-chairs Dr Suzanne Rainsford and Dr Rosemary Ramsay) and our General Practice Special Interest Group (Chair Dr Louis Christie). We trust our comments are of assistance as you consider and set in place the new arrangements and we would welcome the opportunity to contribute further, as needed. Please reach out to our Chief Executive Officer, Janice Besch (ceo@anzspm.org.au), if you have any questions or would like further information on any of the points we have raised.

Yours sincerely,

Dr Christine Mott
President ANZSPM