RACGP
Royal Australian College *of* General Practitioners

GP-led Palliative Care in Rural Australia

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Strategic objective

GPs play a central role in providing and coordinating multidisciplinary care for patients in palliative care across a range of settings in rural and remote communities throughout Australia. RACGP Rural is committed to ensuring GP-led community palliative care is prioritised in policy so that our members are well-placed and supported in meeting patient needs.

It is clear that palliative care services will become increasingly important as our population ages and demand for these services increase. Stage of illness, care setting and patient preferences deem this area a complex space and more policy attention is required. National planning must occur now to ensure there is a **supportive policy framework** to meet future need. RACGP Rural has sought to clarify, through an online survey of rural GPs, the key requirements in meeting a number of future challenges in addressing patient need in rural and remote Australia. This consultation forms the basis of this Position Statement.

Position summary

The provision of palliative care services remains one of our most significant health sector challenges. RACGP Rural advocates for stronger policy action to increase access to rural palliative care services which continue to be inadequately resourced in most rural areas.

Rural GPs deliver palliative care across a number of primary and secondary care settings and facilitate the broad range of services required to meet diverse patient need in rural areas. The current fragmentation of care and poor communication between service providers is impacting on the ability of the GP to coordinate and continue care for rural palliative care patients. More emphasis on those generalist skills and essential service links, which can see the patient through their end-of-life experience and at home in their community, is required. Solutions to improve access to palliative care for patients and their families rely on a commitment by both state and federal levels of Government.

Ensuring this care can be provided in the patient's community requires specific targeted and holistic supports, facilitated through a multidisciplinary team approach, which brings a diversity of specialised skills and expertise across a range of functions. Enabling quality end-of-life care in a rural community – whether that is care provided in the home, small hospital or aged care facility – requires particular service planning in the absence of a specialised palliative care centre. In this context there is stronger reliance on funding and programs to support service integration at the local level, in order to address complexities within a reduced service environment.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[1]

Palliative care in rural and remote communities

Recent RACGP Rural research shows that rural GPs are working across all service settings, with the majority providing community based care, and many also working within a residential aged facility or hospice. Whilst these are positive results in terms of patient access, and demonstrative of the breadth of role rural GPs provide, there were clear indications from those surveyed that more support is needed to assist them in providing palliative care in their community across each of the service settings.

Our research provides useful detail for policy makers and health service planners around the particular requirements to enable optimal care and well integrated rural palliative care services. Important insights from our general practitioner membership were analysed to inform this paper with a number of **key principles** developed. The following policy shifts are considered vital by our rural membership in addressing current need and future demand and will work to strengthen access for rural patients.

1. Service provision

Palliative care involves patients, their families and healthcare providers across a variety of service settings. A key objective and usual preference to keep the patient as close to home as possible underpins many service decisions which adds to the complexity of palliative care in rural areas. Access to palliative care services in these communities, where limitations such as service deficits and distance factor strongly, requires particular service planning, making the early identification of those who would benefit from advanced care planning important.

To facilitate greater access to GP-led palliative care services and to meet future demand in rural communities some key policy changes are required. These relate both to adequacy in the level of funding and the limitations within program parameters to enable flexibility to facilitate integration of funding streams. These policy requirements rely on significant new investment in order to build local capacity particularly in meeting future demand. The importance of establishing resilience to support service continuity in rural areas cannot be underestimated.

1.1 Key changes to support the coordination of comprehensive team-based planning and care in rural communities

It is essential that both state and federal level policy can respond to the broad number of service requirements, including the complexity and non-clinical time required to provide high quality palliative care in rural areas. Incentivised supports to facilitate the coordination of care for the entire palliative care team, must be included in future policy at both the state and federal levels.

Further, refinement of the payment system to ensure MBS item numbers adequately capture service complexity is important. The MBS only provides for specific items for palliative medicine specialist services (delivered by palliative medicine specialists). Therefore services provided by GPs can only be captured through other MBS items, such as those for chronic disease management, which results in national data deficiencies providing an unreliable data record which impacts on policy planning.[ii]

The service interface between primary and acute health care settings or various stages of illness must also be considered. Flexible service solutions to support clear referral pathways are essential. These solutions should enable continuity of care for patients moving between primary and tertiary care settings. A high level of service integration relies on collaboration and partnership building across primary and tertiary healthcare settings, with strong networks and better use of clinical pathways.

The *RACGP's Vision for general practice and a sustainable healthcare system*[iii] sets out a framework to better support the delivery of quality, sustainable and effective patient health care, designed to meet the needs of the patients, GPs and governments. Reorienting funding for primary healthcare to a medical home model will support a sustainable health system and help to address disparities. Implementing a patient centred approach (whilst maintaining fee for service), will better support practices and GPs to provide a broad range of services, so they can meet the needs of the communities they serve. A service complexity loading and comprehensiveness payment would help to address rural inequities in particular including in the provision of GP-led palliative care services.

Funding must support GP-led coordination of palliative care services. This includes team-based planning and care, with adequate funding for rural practices for after-hours care, home visits, nursing care and Telehealth services to support access to broader specialist care. Improved access to specialists through e-health initiatives for rural patients is an important investment as these service help connect to specialists as well as streamline care delivery in rural areas. These services must fully factor the cost impost for rural practices to enable and support innovative models in Telehealth. The RACGP continues to play a leading role in the design and implementation of e-health initiatives in the Australian primary health care setting and has developed Standards in this area.

Service integration

The degree of integration largely depends on available service infrastructure to allow movement of the patient between the primary and acute care settings such as access to general practice, inpatient teams, outpatient clinic and hospice care. Facilitating integration of care requires supportive funding or program sources such as after-hours care, home visits, nursing care and Telehealth services. These together can provide for the required integration across broad patient need including symptom control and pain management, psychological support as well as transition of care arrangements.

In the interest of creating a culturally safe palliative care service system, specific measures are needed to ensure access for Aboriginal and Torres Strait Islander patients to palliative services. This includes a specific focus which acknowledges the distance constraints and complexities of end-of life decision making for Aboriginal and Torres Strait Islander patients living in remote communities.[iv]

Recommendations

RACGP Rural recommends prioritised increased investment for GP-led palliative care in rural communities and calls for targeted action in the follow areas:

National planning measures

(i) Prospective study of GP-led palliative care in rural communities to define need (populations under 50,000) to identify the unmet care needs of patients and how they can be addressed.

(ii) Develop more equitable ways of allocating new funding to rural community palliative care services based on a population health planning approach to help manage increasing service demand.

Coordination of care

(iii) Develop new expanded funding measures to enable rural service integration and team-based planning to occur including:

- Expand the case conference items, as provided for in the current multidisciplinary case conference items, to target palliative care including the facilitation of bereavement care.
- Implement a travel allowance to address costs in providing care in the community.
- New practice viability measures to enable rural practices to provide palliative services including after-hours care, home visits and nursing care.

(iv) Implement specified palliative care MBS items for GPs to improve needs based planning and to ensure community based care and services are financially feasible and sustainable.

Access measures

(v) Investment in innovative Telehealth models to support palliative care delivery in rural and remote Australia

(vi) Invest in strategies to ensure Aboriginal and Torres Strait Islander patients have access to culturally appropriate palliative care services in the setting of their preference.

2. Workforce factors

Non-procedural rural advanced skills are seen by our general practice membership as essential in addressing service need in rural Australia.[v] However there is little recognition of these skills at the local, state or federal level. Increasing recognition (right to practice) and credentialing of advanced skills are important requirements to enable both the utilisation of skill sets and funding of sustainable service solutions in rural areas. Broader workforce factors include the need to develop benchmarks against what defines an optimal service mix (including the need for greater nursing support), which will be a key factor for developing rural palliative care models.

Rural Palliative Care Survey

Expanding GP role

A majority of palliative care survey participants (63%) indicated a need for greater involvement in GP-led services in the local community.

Facilitating GP-led palliative care

For rural GPs providing community based palliative care the key barrier identified was time/workload (64%), after hours and home visit restrictions (50%) followed by inadequate palliative care education (49%).[vi]

2.1 Addressing the key workforce barriers for GPs working across all service settings

The undefined role of the rural GP in the palliative care team requires further policy attention. Skill recognition is essential in federal and state-level policy planning and in finding service solutions and efficiencies across settings. Many residential aged care, hospice and hospital facilities receive a mix of service provision from palliative care specialists and GPs, as determined by local need and available resources.

The recognition of palliative care skills is important in ensuring GPs have access to these facilities and can provide care to their patients. It is also key to clarifying the role of the GP within the multidisciplinary palliative care teams of these institutions and facilitating clear referral pathways which promote continuity of care for patients moving in and out of primary and tertiary care. The provision of GP specific palliative care MBS item numbers, as outlined in section 1, would ensure GP-led services are more accurately captured and this would in turn support stronger national planning and investment.

Skill-specific solutions for the full multidisciplinary team that address service gaps and enable patients to be treated locally should be prioritised and supported. An important rural and remote consideration is the inclusion of Aboriginal Health Workers in palliative care teams. Key evidence-based palliative care resources to inform practice and policy can be found on the Australian Indigenous HealthInfoNet.

Whilst many GPs feel confident in their palliative care skills, and this is a core component of general practice training, members indicated through the survey that the opportunity to upskill or refresh is important. The RACGP's Silver Book[vii] (Medical care of older persons in residential aged care facilities – 4th edition) provides best practice guidelines encompassing multidisciplinary carepath for palliative care, advance care planning and new models for end of life care.

A further key priority identified through the survey related to enabling admitting rights and visiting rights to hospitals for rural GPs to support continuity of care across settings. Greater recognition and standardised credentialing arrangements for GP palliative care skills are needed.

Rural Palliative Care Survey

Skill recognition

A significant portion of rural GP members surveyed reported that their palliative care skills were not recognised at a local (72%) or state level (92%).

Recommendations

RACGP Rural calls for more supportive policies which enable increased participation of rural GPs across all services settings:

Skill recognition

(i) Address the barriers that impact upon the ability of GPs to provide palliative care services across the full health system (community, hospital, residential aged care and hospice facility) including:

- Stronger local area planning supported at the state level to increase participation of rural GPs overall but particularly within the hospital setting.
- Prioritising credentialing arrangements to enable stronger service continuity for rural GP-led palliative care.

(ii) Address remuneration issues including through the provision of specific GP palliative care items.

3. Skills focus

Enabling more training and upskilling opportunities across the full multidisciplinary palliative care team are key factors in ensuring the rural workforce is equipped to meet current and future need. Training barriers persist for rural GPs in terms of access to, and availability of, upskilling opportunities in palliative care. Lack of time and the cost of being away from the practice are major barriers to training, and can be addressed through more flexible training options which utilise both technology and locally available clinical expertise.

3.1 Support to upskill to meet patient need

Training opportunities need to be delivered in a supportive framework which enables service continuity and practice viability, particularly in rural Australia. This includes ensuring rural GPs have access and time to undertake training in the areas they identify, in order to address patient need or service gaps in their community.

It is acknowledged that the Australian Government provides a number of existing initiatives, such as the Decision Assist Project and the Program of Experience in the Palliative Approach (PEPA), which provide education, training and placement programs. More incentivised supports are, however, required to enable training to be undertaken by rural GPs which includes facilitating more upskilling opportunities in the local setting to reduce service impacts and time away from their patients.

Recommendations

RACGP Rural calls for stronger investments in palliative care skills through accessible and flexible training options for rural GPs and across the full multidisciplinary team:

(i) Support the development of rurally accessible training or rurally accessible modules in the key identified skill areas relating to palliative care and chronic disease management.

(ii) Provide increased incentives for rural GPs to undertake advanced skills training in palliative care.

(iii) Support the development of specific training to enable palliative care services to provide culturally appropriate palliative care to Aboriginal and Torres Strait Islander patients.

Rural Palliative Care Survey

Skills focus

The palliative care skill areas which rural GPs identified as training they would like to undertake included pain and symptom management (67%), palliative care medications (63%) and disease specific processes applicable to palliative care (60%). Many indicated that they would also undertake training in providing culturally appropriate palliative care to Aboriginal and Torres Strait Islanders patients.

[I.] World Health Organisation. nd. Definition of Palliative Care. Available at: www.who.int/cancer/palliative/definition/en/

[II.] Australian Institute of Health and Welfare 2014. Palliative care services in Australia 2014. Cat. no. HWI 128. Canberra: AIHW.

[III.] The Royal Australian College of general Practitioners. Full version RACGP Vision for general practice and a sustainable healthcare system. East Melbourne, VIC: RACGP; 2015. Available at: www.racgp.org.au/support/advocacy/vision/

[IV.] Maddocks I, Rayner RG. 2003. Supplement. Issues in Palliative Care for Indigenous Communities. Med J Aust 2003; 179 (6): 17. Available at: www.mja.com.au/journal/2003/179/6/issues-palliative-care-indigenous-communities

[V.] The Royal Australian College of General Practitioners. New approaches to integrated rural training for medical practitioners – final report. Melbourne: RACGP; 2014. Available at: www.racgp.org.au/yourracgp/faculties/rural/projects/doh/

[VI.] The Royal Australian College of General Practitioners. Preliminary results: RACGP National Rural Faculty – Palliative care survey. Melbourne: RACGP; 2015.

[VII.] The Royal Australian College of General Practitioners. Medical care of older persons in residential aged care facilities (silver book). 4th edn. East Melbourne: RACGP; 2006. Available at: www.racgp.org.au/your-practice/guidelines/silverbook/