



**Australian Government**  
**Department of Health and Ageing**

# **EDUCATION, TRAINING AND SUPPORT FOR GENERAL PRACTITIONERS IN PALLIATIVE CARE**

**Australian Government Department of Health and Ageing:  
National Palliative Care Program  
Summary of policy context and progress against the findings of the  
Research Study into the Educational, Training and Support Needs of  
General Practitioners in Palliative Care**

**November 2004**

THE NATIONAL  
PALLIATIVE CARE  
PROGRAM

A small red tulip flower with a green stem and leaves, positioned between the words 'CARE' and 'PROGRAM'.

## 1. INTRODUCTION

This paper provides an outline of how the findings of the *Research Study into the Educational, Training and Support Needs of General Practitioners in Palliative Care* (the GP Research Study) are being progressed in relation to the National Palliative Care Program. It has been prepared by the Australian Government Department of Health and Ageing.

A copy of the final report of the GP Research Study is available from the National Palliative Care Program website at <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/Palliative+Care-1>.

## 2. CONTEXT

The Australian Government is committed to the concept of general practice as a central coordinating focus for the provision of primary health care services. Within the Department of Health and Ageing, Primary Care Division supports the broader primary health care agenda. Specific to palliative care, the Department recognises that many people prefer to die at home or within their local community. Care of these people is often provided by health workers who know the person and their family, particularly their general practitioner.

### **National Palliative Care Strategy**

The Australian Health Ministers' Advisory Council (AHMAC) endorsed the *National Palliative Care Strategy* in October 2000. The Strategy represents the commitment of the Australian Government, and the state and territory governments, to the development and implementation of palliative care policies, strategies and services that are consistent across Australia, and to the delivery of quality palliative care that is accessible to all people who are dying.

The *National Palliative Care Strategy* recognises that the needs of people who are dying and their families span the physical, psychological, emotional and spiritual domains and that palliative care therefore ideally involves a team approach with a blending and coordination of skills and disciplines. In addition, the Strategy identifies the need for developing opportunities for increasing the skills and knowledge of primary care practitioners, including general practitioners, in the care of people who are dying.

To support the National Strategy, the Australian Government has made available a total of \$201.2 million throughout the five years of the Australian Health Care Agreements (2003-2008) for palliative care. Of this, \$188 million is broadly allocated on a per capita basis to states and territories for continued service provision, and \$13.2 million for the Australian Government to implement a national program of initiatives.

Palliative care is administered, funded and supported both nationally and in each state and territory. In addition to funding provided through the Australian Health Care Agreements, states and territories provide funding for planning and delivering palliative care and related services within their jurisdictions. Medical education and training is one aim being addressed by states and territories as part of an overall strategic approach to addressing workforce education and training needs in palliative care.

## **National Palliative Care Program**

In addition to the funding outlined above, the Australian Government has committed a further \$55 million over four years in the 2002 Federal budget for national activities to support improvements in the standard of palliative care offered in local communities.

Under the National Palliative Care Program, funding is available to improve the quality of palliative care through the provision and co-ordination of a national program of initiatives. The Program is being implemented across six broad priority areas. These include:

1. Provision of an expanded range of medications for palliative care in the community
2. Assistance for families and increased support to other care networks
3. Education, training and support for the primary care workforce
4. Increasing the range and reach of palliative care services
5. Capacity building in the palliative care research community
6. Performance information development.

Details of the specific initiatives being progressed within each of these priority areas are available on the National Palliative Care Program website at <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/Palliative+Care-1>.

## **Palliative Care Intergovernmental Forum**

The Palliative Care Intergovernmental Forum (PCIF) was established in 1998 to assist in the implementation of the *National Palliative Care Strategy*, and reach agreement on strategies to develop, refine, implement and report on high level palliative care performance indicators under the Australian Health Care Agreements. The committee consists of representatives from the Australian Government and state and territory governments who work in the area of palliative care. Through the PCIF the state and territory governments advise the Australian Government on palliative care issues in their jurisdictions.

### **3. RESEARCH STUDY INTO THE EDUCATIONAL, TRAINING AND SUPPORT NEEDS OF GENERAL PRACTITIONERS IN PALLIATIVE CARE**

#### **Overview**

In 2002, the Australian Government commissioned Mount Olivet Community Services to undertake a research study to identify options to meet the educational, training and support needs of general practitioners (GPs) providing palliative care.

The activities for the research were determined by the following Terms of Reference:

- to map the current education, training and support opportunities that are available for GPs regarding palliative care;
- to identify the gaps or barriers (if any) in education, training and support that may exist for GPs caring for palliative care patients, specifically for those patients from the population groups of Indigenous and transcultural communities, rural and remote communities and patients in home-based and residential aged care facilities;
- to identify how these gaps or barriers may be addressed;
- to identify what additional resources (if any) might be required to meet these needs;
- to explore opportunities for GPs from a range of areas of practice to gain professional exposure to, and experience in, palliative care; and

- to determine the most appropriate way in which any palliative care education, training and support programs and/or activities for GPs may be delivered.

The final report of the GP Research Study was provided to the Department in June 2003.

### **Outcomes**

The GP Research Study identifies a number of options to support GPs to gain skills, improve their knowledge, and increase their professional exposure to and experience in palliative care. The Australian Government Department of Health and Ageing is committed to providing better quality and effectiveness of primary care service provision in Australia, and will continue to draw on these options to inform activities undertaken under the National Palliative Care Program.

A copy of the Executive Summary of the GP Research Study is attached ([Attachment A](#)).

### **Progressing the Proposed Strategies**

The findings and options identified by the GP Research Study are consistent with the activities currently being progressed under the Australian Government's National Palliative Care Program.

The following presents an outline of how each of the options identified in the final report of the GP Research Study are being progressed.

## **OPTION 1**

*In regard to undergraduate medical training:*

- (i) *That the Commonwealth consider targeting specific outcomes-based funding for university medical schools to provide palliative care training.*
- (ii) *That the Australian Medical Council (AMC) consider linking accreditation of medical schools to the compulsory provision of palliative teaching at an undergraduate level.*

### **Actions**

Professional education and awareness are key objectives of the *National Palliative Care Strategy* and initiatives supporting undergraduate medical training are currently being progressed through the National Palliative Care Program.

The Australian Government Department of Health and Ageing administers and funds a range of initiatives to develop the medical workforce and improve the accessibility, quality and safety of care using educational, recruitment and service delivery programs.

While targeting specific outcomes-based funding for university medical schools falls outside the scope of the National Palliative Care Program, the Department is addressing the issue of palliative care training.

The Department has provided funding through the National Palliative Care Program for the development of undergraduate palliative care curriculum resources. A consortium headed by

Queensland University of Technology in conjunction with Flinders University and Charles Darwin University is developing these resources which will enable palliative care approaches and techniques to be incorporated into the undergraduate curriculum of medical practitioners, nurses and allied health professionals. A project website has been established that includes options for registering interest in the project, sharing of information and providing feedback about the activities of the project. The website address is [www.pcc4u.org](http://www.pcc4u.org). The development of these resources and supporting teaching materials will enable palliative care to be integrated into a variety of curriculum contexts, and delivered via a variety of flexible modes of delivery.

The Department is also funding the Queensland University of Technology to develop a principles paper for the inclusion of a palliative approach to aged care in undergraduate nursing curricula. The principles will comprise a description of the core values, desirable graduate capabilities and principle for teaching and learning palliative care in undergraduate nursing courses.

There are a number of national and state-based bodies concerned with the setting of standards for accreditation, education and training, professional development and workforce planning in relation to prevocational medical graduates in Australia. The Australian Medical Council is the national standards body for basic medical education and training which assesses and accredits medical schools.

As part of their strategy to facilitate uptake of the educational resources in undergraduate curriculum, the Queensland University of Technology project team will approach the Australian Medical Council to link the accreditation of medical schools to the compulsory provision of palliative teaching at an undergraduate level. In addition to these discussions, the project team will take an approach which seeks to explore any alternative solutions which would encourage the inclusion of palliative care in the already crowded curriculum for undergraduate medical training.

## **OPTION 2**

*To specifically include palliative care within the national training program for interns to encourage local hospitals employing junior staff to teach palliative care within the hospitals education programs.*

### **Actions**

The *National Palliative Care Strategy* sets out objectives for increasing awareness and understanding of palliative care. In relation to professional awareness, Objective 1.3 supports the ‘awareness of palliative care as an integral part of the health care system, with all health care providers responsive to the clinical and social needs of people who are dying and their families’.

As part of their training to become a doctor, students undertake prevocational training as an intern in the hospital system. Postgraduate Medical Councils in each state and a national body, the Confederation of Postgraduate Medical Education Councils, play a key role coordinating, planning, resourcing and accrediting the training of interns. Intern training programs are state based and it is up to hospitals within each state to set curriculum that meets the requirements of the medical registration boards. The Department will undertake to

write to the Chair of the Confederation of Postgraduate Medical Education Council to explore the possibility of including palliative care in prevocational medical training.

The National Palliative Care Program currently funds two initiatives which aim to support medical training in palliative care.

Funding has been provided through the National Palliative Care Program to Austin Health in Victoria to implement the Respecting Patient Choices Program, which focuses on providing patients and their families with opportunities to discuss and document their choices in relation to end of life care.

The aim of the Respecting Patient Choices Program is to develop a sustainable, transferable model for integrating community and hospital based advance care planning. It has the potential to provide a framework for hospitals to inform junior staff of advanced care planning for patients and provide in-service training within teaching hospitals. This has been shown to improve communication between patients and their families as well as between patients and their doctors around health care choices, and has the capacity to improve the safety and quality of care by reducing unnecessary and unwanted medical intervention.

The development of the undergraduate curriculum resources outlined under Option 1 will support the inclusion of palliative care approaches and techniques into the undergraduate curriculum of medical practitioners, which may then translate into intern training programs.

### **OPTION 3**

*An opportunity exists for General Practice Education and Training (GPET) to support palliative care service providers to liaise with local training consortia to develop and implement innovative educational palliative care programs in accordance with the Royal Australasian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) curricular requirements. The programs should reflect the needs of the prevailing palliative caseload of the district and include the needs of groups that are disadvantaged with respect to palliative care, such as Indigenous populations and people in residential aged care facilities.*

#### **Actions**

The Australian Government provides funding to General Practice Education and Training (GPET) to work with a wide range of organisations involved in general practice education and training, and to promote better co-ordination at all levels of the general practice education continuum.

GPET's brief includes working closely with the medical profession so that the training provided meets standards set by the relevant colleges such as the RACGP and the ACRRM. GPET also addresses education and training in respect of Aboriginal and Torres Strait Islander health through the establishment of a separate Aboriginal and Torres Strait Islander Health Training Reference Group. GPET is providing a framework for this to happen by promoting regionalisation of training and integration of vocation training with undergraduate and continuing education.

Initiatives undertaken by GPET to facilitate education and training in palliative care are at the discretion of GPET Board which is separate to the National Palliative Care Program. The Department will undertake to write to the Chair of General Practice Education and Training to explore the possibility of implementing educational palliative care programs.

The National Palliative Care Program is developing a range of innovative programs to meet the education and training needs of primary health care workers, including general practitioners.

Programs currently underway, or being developed that provide opportunities for general practice education and training include:

- Palliative Care in Aged Care - a web-based postgraduate education program which brings together the knowledge bases of both applied gerontology and palliative care. A Graduate Certificate and Graduate Diploma designed for nurses, allied health professionals and general practitioners are being offered, available on a part-time or full-time study basis. This program is being implemented through Flinders University and was developed by the International Institute of Hospice Studies within the Department of Palliative and Supportive Services at Flinders University, and the Centre for Ageing Studies. Scholarships are available to encourage students to undertake the course including places for indigenous health workers.
- Australian Palliative Residential Aged Care – guidelines for a palliative approach for staff, including general practitioners, working in or with residential aged care facilities. These guidelines have been developed to facilitate effective palliative care practices in aged care facilities. A national palliative care education and training program is currently being developed and implemented to support the national uptake of the guidelines.
- Program of Experience in the Palliative Approach – aims to provide primary health care practitioners with an opportunity to develop skills in the palliative approach by undertaking a workforce placement with a palliative care specialist service within a metropolitan or larger regional service. This initiative currently focuses on providing opportunities for nurses and allied health professionals. This initiative is currently being expanded to provide placements for general practitioners.
- Caring Communities Program - provides community-based organisations with an opportunity to improve the capacity of their community to care for someone with a life-limiting illness. A range of activities have been funded through this initiative, with education and training projects including support to palliative care service providers to liaise with local training consortia, development of an interactive education strategy in rural and regional areas of Queensland, and funding to enable Mount Olivet Hospice to conduct training workshops in palliative care in conjunction with local primary health care providers.
- Post-Graduate Diploma in Health Promoting Palliative Care – a course which enables general practitioners to improve their skills in health promotion in the area of palliative care. It is available nationally, including in rural areas by distance education, through the La Trobe University Melbourne.

- Opioid Medication in Palliative Care: GP Resource Project - Palliative Care Australia, (the national, non-government peak organisation representing the interests of the Australian palliative care sector) is currently developing a competency based training course and information resources for general practitioners on the safe prescribing of palliative care medications, focusing on opioids. Endorsement of the training course by the RACGP is a requirement of the project as this will facilitate accreditation through the Continuing Professional Development program used by GPs to maintain vocational registration.

In addition to National Palliative Care Program activities, the Australian Government also provides funding for the Medical Specialist Outreach Assistance Program (MSOAP) through the Rural Specialist Support Program. MSOAP aims to increase and maintain the skills of regional, rural and remote general practitioners and specialists, and to upskill and provide professional support for local medical practitioners and other health professionals. MSOAP provides assistance to encourage more medical specialists to visit rural areas, providing much-needed specialist services for rural patients closer to home. As at February 2004, MSOAP funded over fifty palliative care services nationally.

#### **OPTION 4**

*In relation to palliative care education and training for established GPs:*

- (i) *Support the development and implementation of a national core set of skills for GPs in palliative care; this could be achieved through the peak bodies of palliative medicine, such as ANZSPM, working in collaboration with the peak bodies of general practice education, such as RACGP and funded by the Commonwealth.*
- (ii) *Support the development and implementation of innovative and locally adapted educational programs in palliative care for established GPs across urban, regional and rural and remote locations; this could be achieved through collaboration of specialist palliative care providers with local Divisions of General Practice and funded by Commonwealth or State Governments.*
- (iii) *Provide financial support, through relevant Commonwealth or State-based funding bodies, for GPs who undertake substantive clinical palliative placements and postgraduate study in palliative care.*

#### **Actions**

The Australian Government, through the National Palliative Care Program, has recognised the need to support palliative care education and training by funding a range of initiatives which specifically target the palliative care workforce, including established general practitioners (GPs). Many of these initiatives which are outlined in response to Option 3 (above) have been developed in consultation with peak bodies including those representing palliative care and general medicine. The establishment of a national core set of skills is a future aim for existing GP education and training programs which currently target the development of core skills through a wide range of mechanisms.

The proposed expansion of the Program of Experience in the Palliative Approach to include GPs, as described in response to Option 3 (above), is one example where the Australian Government is supporting the development and adaptation of an innovative educational program. Scoping for this project has included wide consultation with GPs, their representative organisations and specialist palliative care providers to ensure that flexible and appropriate models are developed which will enable GPs to gain maximum benefit from short-term workplace placements within specialist palliative care services.

The development of the Opioid Medication in Palliative Care: GP Resource Project, described in response to Option 3 (above), is an example of where the need for core skills has been clearly identified along with the need for a flexible education and training program. A consultation process involving a range of medical and palliative expertise has been established to inform the development of this program that will lead towards the development of core skills in the prescribing and management of palliative care medications. Consultation processes are also being undertaken to ensure that these core skills can be implemented into a range of settings through the development of appropriate education and training programs. Education and training programs which offer flexibility in delivery will increase the capacity of Divisions of General Practice to respond to GP education and training needs in this area.

The GP education and training in opioid medication management is supported by other resources which include *Therapeutic Guidelines: Palliative Care* published in 2001 and the *Australian Medicines Handbook Drug Choice Companion: Aged Care* published in 2003. The therapeutic guidelines aim to demystify palliative care and provide practical advice to health care providers. The handbook, which is accessible at [www.amh.net.au](http://www.amh.net.au), provides summarised information for treatment of conditions commonly confronting older Australians where medicines are the main or usual method of treatment. It also provides a practical resource to those prescribing and/or administering medicines to older Australians and is targeted at health care professionals including GPs.

Funding has also been provided through the National Palliative Care Program to the Repatriation General Hospital in South Australia to undertake the Palliative Care Trial which seeks to enhance the ability of GPs to manage their palliative care patients more effectively using the Enhanced Primary Care items of the Medicare Benefits Schedule. This research study is aimed at improving the care of people who need palliative care through case conferencing and an educational strategy known as academic detailing.

The Palliative Care in Aged Care project described in response to Option 3 (above), is an example where the Australian Government has provided financial support for GPs and other health professionals to undertake postgraduate study in palliative care. Funding for twenty scholarships, including four scholarships for indigenous students, has been included in the overall funding for this project.

## OPTION 5

*For reasons related to patient/carer preference, equity, cost effectiveness and to promote GP participation in the delivery of palliative care:*

- (i) Extend government funding to existing inreach generalist models of community-based care services to enable them to provide continuity of care and 24-hour medical cover, perhaps by employing GPs with an interest in palliative care.*
- (ii) Fund the development of innovative pilot inreach and generalist models of palliative care across urban and rural community settings where none exist. The models should include provision of 24-hour medical cover to ensure continuity of care for patients in home based and residential aged care facilities. Such services must be developed collaboratively in local settings to address specific local circumstances and needs.*
- (iii) Fund community based bereavement support services as part of the inreach generalist model of service provision.*

### **Actions**

As outlined in response to previous Options above, a number of initiatives are currently underway which have the potential to improve the development of inreach and generalist models of care across urban and rural community settings. These include:

- Palliative Care Trial;
- Respecting Patient Choices Program;
- Program of Experience in the Palliative Approach; and
- Opioid Medication in Palliative Care: GP Resource Project

The Rural Palliative Care Program is a further example where a generalist model of palliative care has been developed across rural community settings. This Program, which is managed through the Australian Divisions of General Practice, is funding eight rural Divisions of General Practice to develop and implement models of multidisciplinary care in their local communities. These models seek to improve the response and coordination of primary health care for palliative care patients, their families and carers. The Program also seeks to reduce the burden on the acute setting, through reducing inappropriate or costly admissions. The various projects facilitate after hours access to call out and provide additional support for clients and families.

In addition to these more formal programs, the Department is liaising with other organisations to promote GP participation in the delivery of palliative care. These organisations include the Department of Veterans' Affairs and the RACGP who have been involved in the development of the Palliative Care Trial.

With regards to community-based bereavement support services, the Department not only recognises the need to enhance the skills of both the specialist palliative care workforce and allied health practitioners in working collaboratively across professional boundaries, but also the need to ensure that any planning process is undertaken in consultation with a multi-

disciplinary group of people with a specific bereavement focus, including those with a more general or academic palliative care focus.

To progress this issue the Department hosted a bereavement workshop in December 2003. The focus of the workshop was to discuss prevention of longer-term health and social problems in complex bereavement; to identify domains of action and responsibility; and to identify any appropriate national initiative for bereavement in palliative care in the context of the National Palliative Care Program.

Following the workshop it was agreed that a literature review be undertaken to establish the current evidence base for the assessment and management of complex grief following bereavement. The literature review, which is due to commence in the near future, will contribute towards work at the national level to improve the evidence base for bereavement support.

## OPTION 6

*Improving palliative care for transcultural communities requires two elements:*

- (i) *The Commonwealth should examine interventions which educate and support GPs working with the transcultural communities to adopt clinical and management practices that establish a general practice framework for the provision of community-based palliative care services.*
- (ii) *Transcultural communities require interventions that enable individuals and families to appreciate the potential health benefits provided by general practice in Australia.*

### Actions

Improving palliative care for transcultural communities, including both multicultural and Indigenous Australian communities, is a key element of the *National Palliative Care Strategy*, which states the need to pay particular attention to the broad range of social, cultural and spiritual needs and expectations of the Australian community. Professional education and awareness are also constant themes throughout the Strategy with a focus on supporting the care needs of people who are dying and their families.

The issues raised in this Option are addressed in articles published in the September 2003 palliative care supplement to *The Medical Journal of Australia (Vol 179)* which highlight the need to equip GPs with specific information concerning culturally related customs or attitudes relevant to medical practice, and that education and training needs to include a focus on cultural competence.

In order to support GPs working with multicultural and Indigenous Australian communities and to enable individuals and families to appreciate the potential health benefits provided by general practice in Australia a range of initiatives have been progressed. These include:

- *Multicultural Palliative Care Guidelines (1999)* - through Palliative Care Australia, for health professionals and others working in or associated with palliative care;

- Australian Palliative Residential Aged Care– guidelines for a palliative approach which make specific reference to cultural and Indigenous Australian issues;
- Respecting Patient Choices Program – which includes information, education and training to support GPs in their work with multicultural and indigenous communities in the hospital setting. The Program is being trialled in the community setting within residential aged care facilities including one Greek oriented facility and one Italian oriented facility. GPs will be supported as part of this trial;
- The expansion of the Program of Experience in the Palliative Approach - to include GPs, as described in response to Option 3 (above), will incorporate information for GPs on managing their palliative care patients from multicultural and Indigenous Australian communities;
- Opioid Medication in Palliative Care: GP Resource Project, described in response to Option 3 (above) includes a component for the development of consumer resources for multicultural communities;
- National Indigenous Palliative Care Practice Principles, described in response to Option 1 (above) includes GP educational resources aimed at improving the care provided to Indigenous Australians;
- National Indigenous Palliative Care Needs Study provides an outline of the needs of indigenous clients, including in the primary care setting; and
- An Information for Carers series of brochures has been developed by Carers Australia in a range of community languages which enables GPs and other health professionals to hand out culturally appropriate palliative care information.

## OPTION 7

*Support production and maintenance of an electronic regularly up-dated palliative care information base concerning aspects of death and dying, directed to patients/carers and GPs. Patient/carer documents need to be written in user friendly language and be culturally representative of Australia's population. This could be achieved by the Commonwealth Government tendering for a consortium to produce, maintain and promote the existence of the site to GPs.*

### **Actions**

The *National Palliative Care Strategy* has a particular focus on improving the availability and sharing of research and educational materials in palliative care.

In acknowledging the need to support an information base concerning palliative care, the Department has engaged Flinders University, South Australia, to develop a conceptual model and business plan for an Australian Palliative Care Knowledge Network. This project is scoping the viability of developing a broader Knowledge Network to enable funders, services, providers and the broader community to access information about palliative care in Australia. The work is due to be completed in November 2004.

Flinders University has also been engaged to design and develop a electronic database to store palliative care literature and report abstracts and evaluations. This database, at [www.caresearch.com.au](http://www.caresearch.com.au), has the capacity to collect and store data from research projects around Australia and overseas, and has the potential to facilitate multi-site research projects.

The Department, through the National Palliative Care Program, also provides financial support to Palliative Care Australia in recognition of the critical importance of maintaining a strong consumer and non-government voice in the palliative care sector. Palliative Care Australia provides an important electronic information base for patients and GPs.

In addition, the *Therapeutic Guidelines: Palliative Care* and the *Australian Medicines Handbook Drug Choice Companion: Aged Care*, as described in response to Option 4 (above), have been developed to provide advice to medical practitioners on care of their palliative care patients.

## OPTION 8

*Provide community-based palliative care services with adequate funding capacity to rapidly respond to unexpected episodes of patient deterioration, thus avoiding unnecessary and costly admissions to in-patient units. This might mean the provision of a GP for immediate medical review, a community nurse for overnight monitoring or the provision of home equipment such as oxygen.*

### Actions

To support the *National Palliative Care Strategy*, the Australian Government has made available a total of \$201.2 million throughout the five years of the Australian Health Care Agreements (2003-2008) for palliative care. Of this, \$188 million is broadly allocated on a per capita basis to the states and territories for continued service provision, and \$13.2 million to the Australian Government for the implementation of the National Palliative Care Program.

State and territory governments provide specific funding within their jurisdictions for palliative care which is in addition to funding provided through the Australian Health Care Agreements. The Australian Government does not direct how the states and territories undertake palliative care service provision in their jurisdictions, however, the National Palliative Care Program provides a mechanism to facilitate the implementation of initiatives to support community and professional awareness and understanding of, and professional commitment to, supporting the care needs of people who are dying and their families.

The Department is working closely with Palliative Care Australia regarding the development of information about community-based palliative care services. Palliative Care Australia have recently published two booklets, *Palliative Care Australia Standards for Palliative Care Provision*; and *Palliative Care Service provision in Australia: a Planning Guide*. The *Planning Guide* was developed in consultation with the members of Palliative Care Australia and key stakeholders, to influence palliative care service delivery and improve patient and carer needs over the next decade.

Funding has been provided under the National Palliative Care Program to support the care needs of people with a life-limiting illness:

- Some of the projects under the Caring Communities Program (referred to under Option 3) are specifically directed at providing greater support to palliative care clients to avoid entry to inpatient units. These include the Palliative Care Dementia Interface Project being undertaken by the University of Western Sydney, and the South West Perth

Collaborative Community Palliative Care Project being undertaken by Murdoch Community Hospice Inc.

- Respecting Patient Choices Program; which aims to ensure patients' choices about their end of life medical care are respected. This program represents a sustainable, transferable model for integrating community and hospital based advance care planning; and
- Rural Palliative Care Program, which seeks to reduce the burden on the acute setting, through reducing inappropriate or costly admissions. The program facilitates after hours access to call out and provides additional support for clients and families.

In 2002/03 and 2003/04 the Palliative Care Equipment Program provided funding totalling \$3 million nationally to organisations in each state and territory to facilitate the purchase of equipment that can be loaned to families and carers for people choosing to die at home (including residential aged care facilities).

Community based care is also supported through the provision of approximately \$11 million over four years for respite for carers of people with a life-limiting illness. The National Palliative Care Program is providing this funding through the Commonwealth Carer Respite Centres nationally. The funding includes some operational funding to assist centres in establishing links and referral processes with palliative care organisations and services.

## OPTION 9

*Fund locum support and salary subsidy to allow GPs to attend palliative care education and training sessions. A characteristic of fee-for-service general practice is that GPs are time pressured and time-out can translate to lost revenue. Time is one of the fundamental barriers to GPs obtaining education.*

### Actions

The *National Palliative Care Strategy* supports the inclusion of palliative care education as an integral part of all medical, nursing and allied health undergraduate training and ongoing professional development through the development of appropriate training modules.

The Department is particularly cognisant of the need to provide an opportunity for GPs to access palliative care education and training whilst at the same time acknowledging that uptake opportunity is limited for some applicants because of their inability to leave their region for any period of time, or because of the potential for lost revenue.

Some of the projects under the Caring Communities Program (referred to under Option 3) are specifically directed at providing education and training for GPs in innovative ways:

- An education strategy to increase the palliative care capacity of primary health care providers working in rural and remote areas of Queensland. This program is based upon travelling workshops delivered to local venues by palliative care specialists working in collaboration with local primary care provider generalists. GPs attending the workshops attract continuing professional development points.
- The Mornington Peninsula Division of General Practice is funding GPs practicing in the catchment area covered by Peninsula Hospice service to leave their practices to experience palliative care as provided by a community palliative care service, in a 15 bed

in-patient palliative care unit and by an acute hospital consultancy team. Funding supports GPs who have given up fee-for-service consultations to attend training.

Both the Rural Palliative Care Program, through the coordination of care and development of partnerships, and the Program of Experience in the Palliative Approach for GPs (both referred to in response to Option 3) seek to address this need by facilitating access to education and training for local providers. The Program of Experience in the Palliative Approach initiative for GPs will also target rural and remote medical practitioners as the priority group for participation in placements. Processes will be implemented to ensure a minimum number of participants are recruited from areas in the Accessibility/Remoteness Index of Australia codes: Moderately Accessible, Remote and Very Remote.

The Program of Experience in the Palliative Approach and the Palliative Care in Aged Care postgraduate education program (also referred to in response to Option 3) are two education and training initiatives funded through the National Palliative Care Program which have been advertised in a broadcast by the Rural Health Education Foundation on 'Palliative Care for Indigenous People' during June 2004. In addition, three Rural Health Education Foundation broadcasts on palliative care have been made into training videos which provide important information on specific topics. These include *Palliative Care for Indigenous People*, *Grief and Bereavement in Palliative Care* and *Palliative Care: Managing Pain and Grief*.

## **OPTION 10**

*Establish an auspicing body to oversee the investigation and trialing of funding models that encourage GPs to provide palliative care.*

### **Actions**

While we recognise that an auspicing body may have the potential to undertake this work, funding has been provided through the National Palliative Care Program to support a significant research program through the National Health and Medical Research Council which is undertaking investigations in a number of areas around assessing current systems of service delivery. In 2003/04, the research program was enhanced to support further research in palliative care and priorities for research include models of care delivery.

In 1999 the Australian Government introduced the Enhanced Primary Care package of initiatives to ensure that, where possible, health care is community-based, increasingly focused on prevention, and better coordinated and directed to finding new and effective ways to manage chronic illness. This package included funding for:

- Coordinated Care Trials;
- investigation of effective falls prevention;
- chronic disease self management; and
- new Medicare Benefits Schedule item numbers that would enable GPs to be reimbursed for the time they spent in coordinating the care of patients with chronic conditions and complex multi-disciplinary needs.

In February 2004 a new and separate palliative care benefits section was introduced into the *Schedule of the Pharmaceutical Benefits* with five medications receiving approval for initial listing. This will provide an expanded range of medications for palliative care in the community. GPs provide the majority of community based palliative care with back up from

specialised interdisciplinary teams, and will see on average 3-5 palliative patients in their practice each year. Most patients choose to be looked after in the community for the majority of their palliative care. Effective community access to palliative care medications for clinicians is therefore crucial to providing optimal quality of care outcomes.

## **OPTION 11**

*Fund innovative models that determine and implement baseline standards for liaison between public hospital staff and GPs with respect to discharge planning for palliative patients.*

### **Actions**

A number of initiatives already in place address this option including the:

- Hospital Integration Issues in Rural and Remote Areas project, which will examine discharge planning issues in rural and remote areas;
- Respecting Patient Choices Program, which will incorporate information for GPs and staff regarding discharge planning; and
- Rural Palliative Care Program, which is examining discharge planning issues through the establishment of localised protocols and service agreements with key partners in the projects. An example in case is the localised agreement with base hospitals established under the Griffith Area Palliative Care Service Model. This model focuses on continuity of care, 24 hour access and an integrated multidisciplinary model of care.

The issue of discharge planning will also be incorporated into the undergraduate curriculum educational resources currently being developed by Queensland University of Technology (refer to Option 1 above).

## **SUMMARY**

A primary care perspective underpins the current 'Palliative Care in the Community' 2002 budget measure, with skill development in the primary care workforce being a key component in delivering on this measure.

Generally, people prefer to die with the support of family and friends, within their local community. Much of this care is delivered by local providers who know the person and family – particularly GPs and community nurses – with support from specialist services when needed. Whilst the initiatives outlined above go some way to supporting the education and training needs of GPs, gaps still exist and the Department is working with key stakeholders to identify and address these issues.

In addition to the Australian Government initiatives outlined above, it should be noted that state and territory governments also fund a wide range of projects in their own jurisdictions through funding received under the Australian Health Care Agreements. An example of such a project is the WA Combined Palliative Care Outreach Service, which provides palliative care education and a consultation and advisory service for general practitioners and other medical specialists in rural and metropolitan Western Australia. The service is administered by the Sir Charles Gairdner Hospital Palliative Care Service.

**RESEARCH STUDY INTO THE EDUCATIONAL, TRAINING AND SUPPORT  
NEEDS OF GENERAL PRACTITIONERS IN PALLIATIVE CARE – JUNE 2003**

**Executive Summary**

This research was commissioned by the Commonwealth Department of Health and Ageing and sits within the National Palliative Care Strategy, 2000. It informs the Department about options to meet the identified educational, training and support needs of general practitioners (GPs) in palliative care. These options will contribute to palliative care patients dying within the setting of their choice, with optimal symptom control and with a pattern of care that is culturally appropriate and supportive of the patients' carers.

The research was directed by Dr Liz Reymond and conducted by a national collaborative consortium of palliative healthcare professionals, researchers, educators and general practice service providers. The partnership included:

1. Mount Olivet Hospice Community Services and Little Company of Mary Health Care Services.
2. Centre for General Practice, University of Queensland.
3. School of Rural Health, University of Melbourne.
4. Redcliffe-Bribie-Caboolture Division of General Practice (RBCDGP).
5. Royal Australian College of General Practitioners (RACGP).

The management team received assistance and input from an Expert Reference Group comprising:

- The Chairman, Chapter of Palliative Medicine, Royal Australasian College of Physicians
- The Chairman, Australian and New Zealand Society for Palliative Medicine
- Representation from the Quality Assurance and Continuing Professional Development Unit, South Australian Branch of the RACGP
- Representation from Palliative Care Australia
- The Director, Western Australian Centre for Rural and Remote Medicine
- A consumer and Indigenous health representative
- The Spiritual Director, Karuna Hospice Services

The activities of the project were determined by the Terms of Reference for the study:

- to map the current education, training and support opportunities that are available for GPs regarding palliative care;
- to identify the gaps or barriers (if any) in education, training and support that may exist for GPs caring for palliative care patients, specifically for those patients from the

population groups of Indigenous and transcultural communities, rural and remote communities and patients in home-based and residential aged care facilities;

- to identify how these gaps or barriers may be addressed;
- to identify what additional resources (if any) might be required to meet these needs: and
- to explore opportunities for GPs from a range of areas of practice to gain professional exposure to, and experience in, palliative care; and
- to determine the most appropriate way in which any palliative care education, training and support programs and/or activities for GPs may be delivered.

## **Project Design**

The research component of this report was designed to identify the gaps or barriers in the education, training and support opportunities that may exist for GPs in palliative care. These needs were identified from the perspectives of the GPs themselves as well as from the perspectives of significant others, ie recently bereaved carers and specialist palliative care service providers. Informants were sampled across the target population groups of Indigenous and transcultural communities, rural and remote communities and patients in home-based and residential aged-care facilities. Identified needs were then used to determine options to satisfy those needs.

The education, training and support needs of GPs for the delivery of palliative care were identified using three different approaches.

In Module 1 a national stocktake was conducted to establish the educational and training opportunities currently available to GPs. This module surveyed potential providers of palliative education, both clinical and academic, and explored available education options in terms of course content, benefits accrued to GPs for course participation (e.g. CPD points), uptake rates and any perceived barriers to participation.

In Module 2 a national stratified random sample of GPs was interviewed by telephone to determine their perspectives of the palliative education, training and support requirements of GPs, to identify factors that facilitate or hinder their provision of palliative care, and to identify their preferred learning styles. Both GPs who practised palliative care, as well as GPs who did not practise palliative care, were sampled.

In Module 3 a purposive sample of key palliative informants from the three target population groups was recruited, across Australia, to discuss their perspectives of the education, training and support needs of GPs for palliative care. Key informants included triads or diads of a bereaved carer, the GP and the specialist palliative care service provider, if any, who had recently been involved in the care of the same palliative patient. It was reasoned that the triangulation of the perceptions of these key stakeholders would allow a 'balanced scorecard' approach to the identification of the needs of GPs in palliative care.

## **Project Findings**

The following is a summary of the main points of the research findings.

### *Module 1*

Module 1 identified 551 agencies across Australia as potential providers of education and training opportunities for GPs. Of these, 424 responded to the questionnaire, but only 57 identified their organisation as a provider of GP education.

Currently, both the number and range of education and training opportunities available to established GPs are limited. Eight universities offer post-graduate degree and diploma courses though typically the uptake for these courses is low. Six of the responding GP Education and Training Consortia offer palliative education to GP Training Registrars but this education is not inclusive of established GPs. Some clinical service providers offer clinical attachments with their in-patient units, however the demands of a busy GP surgery schedule tend to preclude the majority of GPs from being involved.

Most education and training opportunities for GPs occur as a collaboration between specialist palliative care service providers and Divisions of General Practice. Greatest up-take of these opportunities occurs when the course is of shorter duration, when it is delivered locally and when it is accredited for CPD points. There is little palliative care education delivered face-to-face in more rural and remote areas of Australia.

### *Module 2*

Module 2 interviewed 178 GPs Australia-wide. Of these, 85 reported on their recent care of a palliative patient. This cohort of GPs self-assessed the success of their care of patients highly, with nearly 70% rating their success at dealing with physical symptoms, psychosocial/spiritual issues and communication/access to services as either successful or very successful. GPs reported little trouble with the management of physical symptoms.

Communication was described as the most difficult aspect of care. GPs reported a perception that they were being excluded from the team conducting the palliative care and hospitals were criticised for the level of communication they exercised with GPs and patients.

GPs reported that the personalities of the GP and the patient, and the relationship between them, makes the care of the patient easy or difficult. Some GPs expressed the opinion that some of their colleagues did not have a personality that was suited to the provision of palliative care.

GPs expressed the need for core palliative care skills to be taught at all levels of GP training and practice. Barriers to participation in palliative education included time pressures, competing interests, lack of enthusiasm and rural GPs reported distance as a barrier to face to face educational opportunities.

### Module 3

Module 3 included 75 in-depth interviews with carers, GPs and specialist palliative care providers across 21 different sites from all states and territories in Australia. In general, there was good agreement between the perceptions of carers, GPs and specialist palliative care providers. There was also a high degree of concordance with the qualitative results from Module 3 with those of Modules 1 and 2.

The findings of this module confirm that motivated GPs can, and do, provide high quality community-based palliative care. All carers, regardless of cultural background or geographical location, need co-ordinated palliative care that includes a compassionate and available GP capable of providing symptom control. To provide seamless care the GP needs effective liaison with other service providers, who are adequately resourced in terms of staff and infrastructure, to ensure supportive and pre-emptive care. Carers also have an on-going need for information about many aspects of death and dying and specific information relating to the patient's condition.

The majority of carers were more than satisfied with the level of care provided by the patient's GP, often in conjunction with community nurse support:

*\*Cd 18: "He (GP) prepared me....I knew (husband's) dignity was going and there was no hope....and later (GP) rang me and said 'I am going to give him this patch' – Fentanyl patch – and he advised me to go up Tuesday morning, before he got too drowsy so I could have a long talk with (husband), which I did and that was the first time he said to me 'let me go' and I was able to release him so it was good.....that was something that was given to me by (GP) and the RNs. I am grateful for that."*

*\*C - denotes Carer, d - sampling unit recruited via GP, 18 – number of sampling unit*

Findings concerning co-ordination of care and the availability and delivery of services were often less favourable. Co-ordination of care was less than optimal when there was poor liaison and communication between GPs and other service providers. This frequently resulted in poor patient outcomes.

Probably the most important barriers to the provision of palliative care as identified by GPs themselves were the time required to deliver satisfactory palliative care and the lack of remuneration for its delivery. Those GPs who deliver palliative care expressed satisfaction with their delivery of that care.

Specialist palliative care service providers acknowledged that GPs, particularly in urban settings, are becoming disempowered with regard to the provision of palliative care due to poor communication and liaison.

Carers, GPs and specialist palliative care providers all agree that the co-ordination, delivery and level of service provision associated with community-based palliative care can be improved.

## *Options*

Fulfilling the educational, training and support needs of GPs as identified by this research requires a seachange approach both to the education of GPs and to the delivery and funding of generalist palliative care providers. Options that address these needs are presented below. The options assume four widely held beliefs.

- The development of the National Strategy for Palliative Care reflects the commitment of the Commonwealth, State and Territory governments to the delivery of quality palliative care accessible to all people who are dying.
- It is not desirable, and in future it will not be possible, for all palliative patients to receive the type of care currently provided by specialist palliative care services.
- Most Australians would prefer to be cared for and die in the setting of their choice, which is often their home.
- GPs accept palliative care as a part of their role as generalist health providers and they are well positioned within the primary healthcare environment to coordinate and deliver best-practice palliative care.

## **Education and Training Needs**

Most of the GPs involved in this research recognised that their undergraduate and postgraduate training in palliative care was deficient.

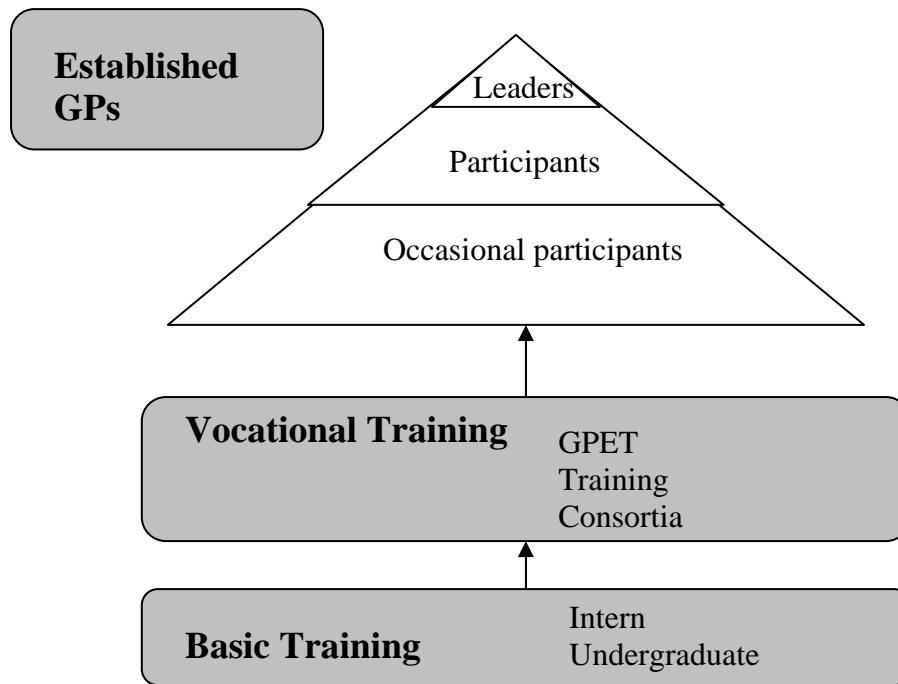
Some of the skills that underpin the practice of palliative care, such as basic communication skills, symptom control management and skills for dealing with death and dying, are generic to all medical practitioners. These skills should be incorporated into basic medical training at the undergraduate level, they need to be reinforced at the vocational training level, and they need to be extended throughout the medical careers of GPs as a part of their continued professional development.

Most GPs consider palliative care to be a core part of their medical role. Nonetheless, within the population of GPs there is a wide range of commitment to the delivery of palliative care and to the maintenance of palliative up-skilling. This range includes:

- 1) Those with a particular interest in palliative care who are willing to provide leadership for GPs in this field.
- 2) Committed GPs who are willing to keep their palliative knowledge up to date and provide competent palliative care.
- 3) Others who opt not to provide palliative care, or only provide occasional care and who may or may not take advantage of palliative care skills enhancement opportunities.

Figure 1 is a graphical representation of the points raised above. Options to overcome gaps in GP education need to address the populations at each level of this figure and, in addition, solutions need to be tailored to the practice location of the GP.

Figure 1: Hierarchy of target medical populations for the delivery of palliative care education relevant to general practice.



*i. Undergraduate Medical Training*

Palliative care training should be introduced as a routine requirement of all undergraduate medical curricula.

There is a great deal of inertia in university medical schools in relation to curriculum change for a variety of reasons. In regard to medical undergraduate teaching of palliative care, the Commonwealth may wish to employ a funding initiative similar to that used for the establishment of the schools of rural health.

Another avenue to facilitate change is the Australian Medical Council (AMC), which holds responsibility for the five yearly accreditation of medical schools.

**Option 1:**

*In regard to undergraduate medical training:*

- i) That the Commonwealth consider targeting specific outcomes-based funding for university medical schools to provide palliative care training.*
- ii) That the AMC consider linking accreditation of medical schools to the compulsory provision of palliative teaching at an undergraduate level.*

## *ii. Intern Training*

Intern training is a state responsibility. A national training program with clearly defined content has been developed and is administered in each state. While palliative care is not a specific subject, the elements of palliative care are raised in different disciplines, as well as in generic learning objectives.

### **Option 2:**

*To specifically include palliative care within the national training program for interns to encourage local hospitals employing junior staff to teach palliative care within the hospital's educational programs.*

## *iii. Vocational Training*

Vocational training for general practice takes undifferentiated doctors who have completed hospital training to develop the skills required for unsupervised practice.

Vocational training for GPs has undergone major changes in the last three years. Training is now the responsibility of locally based consortia, funded by General Practice Education and Training (GPET). The fellowship of the Royal Australian College of General Practitioners (FRACGP) is the endpoint of training, and the curriculum set by the RACGP must therefore be covered. Additionally, the Australian College of Rural and Remote Medicine (ACRRM) has a primary curriculum for rural GPs that must be met to qualify for the FACRRM.

### **Option 3:**

*An opportunity exists for GPET to support palliative care service providers to liaise with local training consortia to develop and implement innovative educational palliative care programs in accordance with the RACGP and ACRRM curricular requirements. The programs should reflect the needs of the prevailing palliative case load of the district and include the needs of groups that are disadvantaged with respect to palliative care, such as Indigenous populations and residential aged-care facility residents.*

## *iv. Established General Practitioners*

These are the majority of the GP population who are established in practice and who, according to Figure 1, are classified as occasional participants, participants or leaders. These GPs have received little, if any, formal training in palliative care.

A minimum palliative care skill set needs to be promoted to all GPs. For standardisation it is appropriate that this core skill set should be determined nationally.

### *Occasional participants*

For GPs considered occasional participants, areas of education and training could be limited to the minimum skill set and a knowledge of local resources and how to access them, if required.

For best patient outcomes, GPs need to be able to ‘opt-in’ or ‘opt-out’ of palliative care, ie to become occasional participants at some time. Reasons for opting in and out can vary over the career span of the GP and include factors such as family commitments, personal bereavement, lack of opportunity to maintain palliative skills or personal practice preferences. Resources and supports need to be made available for GPs who opt-out to encourage them to opt-in at a later time if circumstances change.

### *Participants*

For GPs considered participants, areas of education and training should extend beyond the minimum skill set to include in-depth knowledge of palliative care across the five quality domains relating to palliative care, these being physical, psychological, social, cultural and spiritual. These GPs also require a good working knowledge of available palliative infrastructure resources, including a relationship with a specialist palliative medical officer who can function as a clinical support resource.

Regular visits by palliative care teams to regional, rural and remote areas are essential to deliver palliative care education to GPs practicing within these locations. Ideally, these should be conducted by services willing to provide clinical support to these areas, so that personal relationships with the local practitioners can be forged.

### *Leaders*

New educational and training opportunities need to be created for GPs considered leaders in the field of general practice palliative care. These GPs have significant clinical loads of palliative patients and are viewed as a palliative care resource within their local general practice environment.

It is these GPs who are likely to be advocates for the future and expanding role of general practice in palliative care. They are essential to furthering the development of comprehensive palliative care networks within general practice that will be required as the ageing population increases the demand for community-based palliative care services. The development of a career path for these individuals is important.

#### **Option 4:**

*In relation to palliative care education and training for established GPs:*

- i. Support the development and implementation of a national core set of skills for GPs in palliative care; this could be achieved through the peak bodies of palliative medicine, such as ANZSPM, working in collaboration with the peak bodies of general practice education, such as RACGP, and funded by the Commonwealth.*
- ii. Support the development and implementation of innovative and locally adapted educational programs in palliative care for established GPs across urban, regional and rural and remote practice locations; this could be achieved through collaboration of specialist palliative care providers with local Divisions of General Practice and funded by Commonwealth or State Governments.*
- iii. Provide financial support, through relevant Commonwealth or State-based funding bodies, for GPs who undertake substantive clinical palliative placements and/or postgraduate study in palliative care.*

*Support needs of GPs in community-based palliative care.*

Meeting the support needs of GPs is necessary to encourage their participation in the delivery of palliative care. Those support needs include service delivery models that optimise patient/carer outcomes by up-skilling and re-empowering GPs; strategies to meet the information requirements of carers; and strategies that address the barriers of time, remuneration and poor liaison in the provision of palliative care by GPs.

*i. Service delivery across the target populations.*

This research, in agreement with many other Australian studies and reports before it, indicates that one of the greatest impediments to co-ordination of care, for all palliative patients, is poor communication and liaison between GPs, hospitals and hospital-based specialist outreach services.

\*SPCd 05: "...the patient rings up the GP saying 'I'm in all this pain' and the GP often doesn't even know that they have been in hospital let alone that their disease process is so far advanced or they have been referred to the palliative care team. So I guess the communication with the GPs is inadequate."

\* SPC - denotes specialist palliative care service provider

Best-practice in communication involves a rationalisation of the number of people and service providers involved in a patient's care, rather than teaching communication skills and invoking complex protocols. For this reason and also for reasons of equity of access, cost effectiveness of resource distribution and patient preference, it is time to consider a paradigm shift from outreach specialist palliative care service delivery to inreach generalist-based service delivery.

Inreach models are community focussed and based services capable of funding home-based palliative care across urban and rural settings. In addition to a funding role, these services establish inreach liaison with hospitals or hospices for complex case management on an as-needed basis. These models ensure co-ordination of services is closer to the patient, thus decreasing patient confusion regarding service roles.

There are many advantages to an inreach model of palliative care.

- It can be developed and configured specifically to the local catchment demography.
- In this model the GP appropriately provides the bulk of palliative medical care to the community, which acts against GPs becoming deskilled and disempowered by increasing their exposure to palliative patients and ensuring significant 'ownership' of patient management.
- Specialist hospital-based units become free to focus on the provision of education and research as well as providing consultative services and accepting referrals and admissions, if necessary, for complicated cases of care.
- As co-ordination of services is vested in the local community, this model also promotes community-based ownership of the service. It can facilitate local community development of palliative care infrastructure, including home equipment, cost and provision of respite care and community-based hospices.
- The model offers a cost effective solution to meeting the increasing demands for services from an ageing population.

All inreach models are unique and develop from matching available resources with existing local care patterns and the service philosophy. It is usually not possible to translate a model that is successful in one area to another. Consequently it is difficult to be prescriptive about compulsory elements for these services. Nonetheless, one element that does require consideration is after-hours medical cover for both patients from home-based environments and patients from residential aged-care facilities. This research recognises that after-hours availability of GPs, particularly in urban and some regional areas, is a real problem for palliative patients. An increasing proportion of urban practices use deputising services to provide after-hours cover. This impacts on continuity of care because deputising service staff do not know the patients and are subject to high turnover rates. Another element that requires

consideration for inclusion into inreach models is the need expressed by carers for bereavement follow-up.

### **Option 5:**

For reasons related to patient/carer preference, equity, cost effectiveness and to promote GP participation in the delivery of palliative care:

- i) *Extend government funding to existing inreach generalist models of community-based palliative care services to enable them to provide continuity of care and 24 hour medical cover, perhaps by employing GPs with an interest in palliative care.*
- ii) *Fund the development of innovative pilot inreach and generalist models of palliative care across urban and rural community settings where none exist. The models should include provision of 24 hour medical cover to ensure continuity of care for patients in home-based and residential aged care facilities. Such services must be developed collaboratively in local settings to address specific local circumstances and needs.*
- iii) *Fund community-based bereavement support services as part of the inreach generalist model of service provision.*

### *ii. Palliative care for transcultural communities*

Despite striking commonalities between transcultural communities in terms of fluency in English, a history of social dislocation in their homelands, strong family and religious allegiances and gender relationships, there are often marked differences in the outcomes of palliative care.

Addressing these differences will require a shift in attitudes of GPs and the transcultural communities.

### **Option 6:**

*Improving palliative care for transcultural communities requires two elements:*

- i) *The Commonwealth should examine interventions which educate and support GPs working with transcultural communities to adopt clinical and management practices that establish a general practice framework for the provision of community-based palliative care services.*
- ii) *Transcultural communities require interventions that enable individuals and families to appreciate the potential health benefits provided by general practice in Australia.*

### iii. Carer Information requirements

Carers frequently express the need for information about many aspects of care. They want information that is honest, reliable, reassuring and up-dated. Most patients and carers appreciate verbal information, though due to their emotional state they can have difficulty remembering what was said. Conversations need to be repeated, revisited and up-dated. Often the process of the repeated communication is therapeutic in itself and certainly written information cannot substitute for this process. However, if verbal information is accompanied or followed up by brief written packages, communication can be enhanced.

#### **Option 7:**

*Support production and maintenance of an electronic, regularly up-dated palliative information base concerning aspects of death and dying, directed to patients/carers and GPs. Patient/carer documents need to be written in user friendly language and to be culturally representative of Australia's population. This could be achieved by the Commonwealth Government tendering for a consortium to produce, maintain and promote the existence of the site to GPs.*

### iv. Time

Every GP interviewed face-to-face, and almost all of the GPs in the national random sample, reported that time was one of the most important barriers to their provision of quality palliative care.

The time available to GPs is partly due to existing practice demands and thereby to local shortfalls of GP and local practice patterns. These workforce issues are critical and must be addressed to free up the time required for GPs to practice palliative care.

In the interim a solution to this time barrier is the provision of a level of staffing and infrastructure for local generalist support services that includes the capacity to rapidly respond to changes in patients' requirements. Palliative care patients are often characterised by unheralded periods of rapid deterioration. If the deterioration is not matched by immediate increases in home support services unnecessary admissions to in-patient units can result. Funding agreements with generalist service providers need to ensure this reserve capacity.

#### **Option 8:**

- i) *Recognise the needs to address national and regional shortages in the GP workforce.*
- ii) *Provide community-based palliative care services with adequate funding capacity to rapidly respond to unexpected episodes of patient deterioration, thus avoiding unnecessary and costly admissions to inpatient units. This might mean the provision of a GP for immediate medical review, a community nurse for overnight monitoring or the provision of home equipment such as oxygen.*

Time pressures also impact on the ability of the GP to undertake postgraduate palliative education. GPs need to be encouraged to take time out to up-date their palliative education. The offering of financial incentives to GPs would send a clear message that their on-going provision of palliative care is valued. Incentives could include a payment of a subsidy for the time taken to attend palliative education sessions, and the cost of providing medical cover to the practice for the duration of the absence.

### **Option 9:**

*Fund locum support and salary subsidy to allow GPs to attend palliative care education and training sessions. A characteristic of fee-for-service general practice is that GPs are time pressured – time-out for education can translate to lost revenue. Time is one of the fundamental barriers to GP’s obtaining education.*

## *v. Remuneration*

Many GPs consider palliative care to be one of their most valued services, though the most poorly remunerated. Economically, GPs working in a fee-for-service environment find it difficult to justify the provision of palliative care.

*GPd 19:* “It all involves time...If you go for a home visit; while we are not expending practice expenses as such, the return on the home visit, with travelling time is very mediocre – it’s a situation where we hardly ever charge a fee for that service and it is probably one of the most valued services that we offer and yet we charge the least for it.”

*GPd 09:* “If I stayed back at the surgery, and saw kids with sore ears I would probably triple the income.”

Remuneration and workforce issues are likely to be partly responsible for the difficulties reported, especially in urban settings and after hours, in obtaining GPs willing to cover palliative patients in both home-based and residential aged-care facility environments.

It is critical to remunerate GPs for the time required to practice palliative care and at a level likely to encourage them to remain in the palliative care workforce. Such remuneration needs to reflect both the real and opportunity costs of providing palliative care. In short remuneration needs to make palliative care an economically viable option for GPs.

There are different mechanisms that could be utilised to provide remuneration for GPs, for instance:

- Specific HIC items for palliative care provision.
- Changes in PIP payments to reflect the number and complexity of palliative patients cared for at home.
- Addition of a SIP for palliative care.
- Payments of hourly VMO rates to GPs from community health services for shared patients.

**Option 10:**

*Establish an auspicing body to oversee the investigation and trialing of funding models which encourage GPs to provide palliative care.*

*vi. Liaison*

The quality of the hospital discharge plan can determine the extent to which GPs participate in palliative care - discharge plans can actively mitigate against GPs maintaining their palliative skills. Poor discharge planning can provide GPs with late information or occasionally with no information, typically when the patient has had an intra-hospital transfer to a palliative care unit. GPs can be excluded from the palliative team or left with trivial roles such as prescription or referral writing. All these factors disempower the GP with respect to their provision of palliative care. This disempowerment is more prevalent in urban rather than rural and remote areas. There is a need to develop discharge planning models that empower GPs to be involved in palliative care.

**Option 11:**

*Fund innovative models that determine and implement baseline standards for liaison between public hospitals and GPs with respect to discharge planning for palliative patients.*

In the future those baseline standards could be implemented as a requirement of funding at the private health service/State government interface hospital accreditation, as well as the State/Commonwealth interface.