Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Submission No: 67

Submitted by: Australian and New Zealand Society of Palliative Medicine

Publication: Making the submission and your name public

Attachments: See attachment

Submitter Comments:

anzspm
Australia New Zealand Society of Palliative Medicine

23 December 2021

For the Attention Of:
Health and Environment Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Health and Environment Committee,

ANZSPM Submission re: *Inquiry into The Provision of Primary, Allied and Private Health Care, Aged Care and NDIS Care Services and its Impact on the Queensland Public Health System*

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) notes the important work of the Health and Environment Committee (the Committee) in conducting this inquiry.

ANZSPM is a specialty medical society that facilitates professional development and support for its members. ANZSPM promotes the discipline and practice of palliative medicine to improve the quality of care delivered to patients and families living with life-limiting illnesses. Our members include palliative medicine specialists as well as primary health and other medical practitioners, who either practice or have an interest in palliative medicine.

ANZSPM strongly supports specific attention to the following areas related to this inquiry: ensuring equitable access to the quality palliative care, increasing access to palliative care in rural and remote Queensland, supporting seamless transitions in care settings, and addressing the emerging needs for palliative care in aged care settings. We provide comments and recommendations on these areas where relevant, according to the topics of focus outlined in the Inquiry's Terms of Reference.

Suite 6, Level 5, 490 Northbourne Avenue Dickson ACT 2602 / PO BOX 7001 Watson ACT 2602 / anzspm.org.au
P. +61 2 6189 2244 / E. info@anzspm.org.au / ABN 54 931 717 498

1.

A) PRIMARY AND ALLIED HEALTH CARE

Ensuring Equitable Access to Quality Palliative Care

All Queenslanders deserve equitable access to quality palliative care when they need it, and this includes the bereavement and post-bereavement support that the specialty provides to carers and families. Attention to equitable access to palliative care is particularly important when considering the growing demand from aged care and dementia care. ANZSPM has identified the following issues for achieving quality palliative care, which require particular attention over the coming three years:

1. **Seamless transitions** within acute care and in primary and community care (including hospices), in aged care environments, and in the transitions between care contexts.

2. **Supportive policy and funding settings:** Currently there is an urgent need to address the shortage of skilled palliative care specialists in the health workforce, and to ensure that the necessary training, professional development, and support are provided to those general practitioners and specialists who provide palliative medicine. We are concerned that Queenslanders urgently need easy and consistent access to palliative care, and that this needs to match the accessibility of voluntary assisted dying support. This requires a stronger workforce and a system that ensures the necessary referrals and support services are there for people at any stage of their life-limiting illness.

3. **Addressing emerging/specialised needs:** ANZSPM advocates for improved models of ethical support for people seeking voluntary assisted dying, such that they are aware of the palliative support that can be provided within the health system. It is also important that the structures are in place within the QLD health system to support the delivery of culturally safe care, and that new supports and professional development offerings are available to meet the needs of the most vulnerable people in our community across the lifespan. This includes the frail aged and those living with a dementia diagnosis.

Increasing Access to Palliative Care in Rural, Regional, and Remote Queensland

Disparities in the provision of palliative care are particularly evident in rural, regional, and remote regions of Australia, with Queensland being no exception. Queensland's rural population is aging at a faster rate than the metropolitan population, which contributes to a higher total disease burden rate.[1] Rural and remote patients are also more likely to face barriers in accessing general practitioners (GPs) and specialists, and lower attendance rates including lower participation in health screenings may be contributing to late diagnoses and poorer health outcomes. In terms of the provision of palliative and end-of-life care, these trends can increase the burden on local generalist health services, under-resourced residential aged care, and specialist palliative care services covering rural and remote areas.

In rural and remote areas, palliative care is mostly provided by GPs, community and palliative care nurses, and residential aged care staff. In areas without specialist palliative care services, access and quality of palliative care is often

[1] Queensland Health 2020, *The health of Queenslanders 2020. Report of the Chief Health Officer Queensland*, Queensland Government, https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1011286/cho-report-2020-full.pdf.

determined by the interest, knowledge, initiative, and capacity of GPs. Specialist palliative care services (SPCS) support GPs in the provision of palliative care, but do not have the workforce to lead the care of the majority of patients. Palliative medicine is complex, sensitive, and often time-intensive work, which means that Medicare billing may not be adequate for delivering quality care in these settings. These varied combinations of health professionals and services create disparities in access and quality of health services for rural and remote patients. It also means that it is difficult to determine exactly who delivers palliative care in these areas.

There are positive features to palliative care provision in rural and remote settings when compared to metropolitan areas. Local hospitals and local health professionals offer a sense of familiarity and community for many patients. However, this sense of community and continuity of care is being threatened due to reliance on temporary and locum positions to meet need.

While it is clear that more specialist support is needed, there remains no substantial incentives for staff specialists to move to and work in rural and remote settings. Similarly, there is little incentive and assistance for rural generalists already in the community to undertake palliative care training and ongoing professional development. Due to the spread of rural populations across large areas, rural palliative patients will likely always rely more on generalist support compared to the urban population. For this reason, a model which encourages experienced general practitioners to develop relationships with palliative medicine staff specialists who can provide ongoing support, training and joint visits would do more to improve palliative care long-term.

To adequately incentivise rural GPs to undertake palliative care education, funding is required to cover course/conference fees, travel, accommodation, and locum relief costs. ANZSPM has recently recommended to the Department of Health that the Rural Procedural Grants Program (RPGP), Practice Incentives Program (PIP) Procedural GP payment, and GP Procedural Training Support Program (GPPTSP) be expanded to incentivise a greater uptake of palliative care training amongst rural generalists, and to fund greater palliative care provision by rural generalist services.

Special attention to the cultural needs of Aboriginal patients and their families also needs to be considered by those providing palliative care and bereavement care services. These considerations can include providing care on country, supporting dying on country, involving Aboriginal Liaison Officers, and facilitating Sorry Business and Smoking Ceremonies. It is important that palliative care services in rural and remote locations can fulfil cultural wishes.

Supporting Seamless Transitions Between Care Settings

ANZSPM has identified the following immediate priorities for work to support seamless transitions between care settings:

- Establishing collaborative networks across specialties to build referrals and teamwork (priority societies include: Geriatrics, Respiratory, Cardiology)
- Health system supports that establish and maintain strong networks amongst specialists in their local context
- Identifying best practice examples of integration with primary and community care and promulgating these health system models
- Developing benchmarks to measure improvement in patient and family experience over time.

B) AGED AND NDIS CARE

Addressing Emerging Needs for Palliative Care in Aged Care Settings

People in aged care settings, including those with complex dementia or chronic health conditions, should have improved access to specialist palliative expertise and specialist palliative care services. Particularly, ANZSPM supports the expansion of the Australian Department of Health's Specialist Dementia Care Program, to treat those people with severe manifestations of behavioural and psychological symptoms of dementia (BPSD). However, there should also be an overall greater emphasis in aged care on integrating a palliative approach to care. Most residents of aged care facilities are in their final years and months of life and would thus benefit from access to palliative care. The configuration of palliative care services should follow the guidance provided in Palliative Care Service Development Guidelines (2018)[2] to match the clinical care with complexity of need, be provided by a multidisciplinary team, and include afterhours access and bereavement support.

In the context of aged care services generally, there is often an assumption that residents of aged care facilities are "clinically stable", and as a result, actively seeking access to key health professionals may not be seen as critical. However, the prevalence of life-limiting illness and multimorbidity in aged care means that care may be complex, may be symptomatic, and may need to change rapidly to meet changing needs . Sufficient support for multidisciplinary assessment and management should be available. This care should include access to after-hours management, and should proactively address new issues in accordance with the preferences, values, and wishes of the resident and their families. Future care planning with the resident and their family, including advanced care planning, should occur soon after admission into an aged care service and be repeated at key timepoints during admission such as when new clinical symptoms occur, after hospital admissions, or with decline in functional ability .

A service model needs to address the following areas (which are aligned with the recommendations in the Palliative Care Service Development Guidelines (2018)[3]:

- Minimal training and continual professional development requirements for RACF and general practitioners in palliative care
- Capacity to assess the need for, administer and monitor effectiveness/side effects of S8 and S4 medications 24 hours a day
- Palliative Care that can be delivered and adjusted due to changing needs 24 hours a day (with level of service dependent on complexity of need)
- Access to specialist palliative care, dementia, geriatric and/or aged care psychiatry clinicians, which is essential for those with more complex clinical issues.

The importance of addressing these issues was amplified in the work and recommendations of the Australian Royal Commission into Aged Care Quality and Safety.

[2] Palliative Care Australia 2018, *Palliative Care Service Development Guidelines*, https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-Service-Delivery-2018_web-1.pdf.
[3] Ibid.

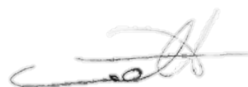
ANZSPM recommends that staff and general practitioners working in residential aged care should be required to receive training in palliative care management including symptom management and rationalisation of medications for residents who are appropriately recognised as having palliative care needs. This may include anticipatory prescribing of opioids and medications to ease distress, pain, nausea, and seizures. Equipment including syringe drivers and subcutaneous access consumables should be available at the RACF. Additionally, subcutaneous medications commonly used in end-of-life care must be readily available for control of symptoms (including after-hours access to a prescriber and pharmacist services or storing of medications safely on-site). It is concerning that where RACFs have only an on-call registered nurse after hours rather than on-site, patients requiring as-needed medications after hours or over the weekend have to wait for the on-call RN to be called in to administer the medications. An adequate RACF model must include capacity to assess the need for, administer and monitor effectiveness/side effects of S8 and S4 medications 24 hours a day.

ANZSPM believes that all patients in RACFs require a patient-centred approach to their care. Residents need access to allied health and therapies which encourage social engagement in a safe environment, as well as physical and emotional well-being. Consideration should be given to resident's "physical, psychological, cultural, social and spiritual experiences and needs" as stated in the National Palliative Care Standards.[4] RACF staff, attending GPs, and other health professionals should be conversant with the National Palliative Care Standards with regards to delivering care that is patient-centred, appropriate to the needs of family and carers, and inclusive of bereavement care.

CONCLUDING COMMENTS

ANZSPM commends the Queensland Government for its interest in the intersections between the public health system, private health system, aged care, and NDIS care services. We encourage you to contact our Chief Executive Officer, Janice Besch ████████, if we can be of further assistance to your work.

Yours sincerely,



Dr Christine Mott

ANZSPM President

[4] Palliative Care Australia 2018, *National Palliative Care Standards – 5th edition*, https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/11/PalliativeCare-National-Standards-2018_Nov-web.pdf.