



The Australian draft National Palliative Care Strategy: Is primary palliative care at a crossroads?

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EDITORIAL

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On paper, palliative care should be core business for general practice. Both disciplines emphasise holistic care for people (1, 2), with the major difference being the intense nature of care in the last stages of life, and the short time span. With a GP's longitudinal knowledge of patients, and the likelihood that they have shared the journey of the final illness with the patient, it should be beyond dispute that there should be a central role for general practice in palliative care.(3)

It is important to acknowledge that the development of palliative medicine as a discipline has been a huge boon to the care of dying people. There is no doubt that expertise in the area has led to significant advances in the medical management of advanced symptoms, and that specialist palliative care services have developed sophisticated services that provide outstanding care to patients and their families. However, Palliative Care Australia planning documents acknowledge that specialist services will never be able to provide all care for all dying people, and acknowledges the importance of a primary care sector skilled in palliative care in their planning documents. (4)

Moreover, the need for care for the dying will accelerate in the foreseeable future. Australia's population is ageing, and with this will come a significant expansion in chronic illness, and death from frailty and non-malignant disease. This will exacerbate the challenge to provide palliative care for all people who need it.

Disturbingly, it appears that general practice is not rising to the challenge to the extent that it should be. In both urban and rural settings, 25% of Australian GPs state they are not willing to provide palliative care. (5, 6) Barriers to

participation in palliative care include: lack of time, home visits, family commitments, and personal commitments. GPs who did not provide palliative care were more likely to be younger, part time, overseas trained, employees rather than practice owners, and a trend to female gender. (5) This is particularly concerning, because the demographics of the general practice workforce are shifting in all of these directions. (7)

The Australian Government has provided excellent support to palliative care over the last decade, which has enabled a raft of important initiatives and has led to undoubted system improvement. Its recently released draft palliative care plan (8) has five goals:

1. To significantly improve the appreciation of dying and death as a normal part of the life continuum.
2. To enhance community and professional awareness of the scope of, and benefits of timely access to, palliative care services.
3. Appropriate and effective palliative care is available to all Australians based on need.
4. To support the collaborative, proactive, effective governance of national palliative care resources and approaches.
5. To build and enhance the capacity of all relevant sectors in health and human services to provide quality palliative care.

These proposed goals are appropriate. However, enhancing the palliative care capacity of general practice and primary care should be a central element of the plan, but is not. Goal three (Box 1) is clearly aimed at the development of special disease based palliative care programs, specialist nursing services, nurse practitioners, and special interest practitioners in broader areas. This clearly does not target the generalists who provide palliative care as part of their broader remit, rather those whose primary function or special interest is palliative care. It appears to aim to expand the specialist and build a quasi-specialist palliative care workforce. By default, this may be at the expense of facilitating broader development of the whole workforce.

Goal five (Box 2), which aims to improve the capacity of the broader workforce, is similarly concerning. Apart from providing education to improve the skill and confidence of the generalist workforce (one of nine strategies), the strategies outlined are nearly all related to the further development of existing specialist services, or the



development of service delivery models where primary care is something of an onlooker.

The big weakness of the proposed approach is that it makes the identification and management of people needing non-malignant palliative care very difficult. Non-malignant palliative care patients are scattered across a range of care providers including specialist medical services, aged care facilities, community care, and generalist hospitals. The only place where they all come together is general practice. A more logical means of facilitating palliative care for all is through general practice, to relevant community providers, rather than the other way around. The latter approach requires the development of a multitude of smaller programs, rather than a more unified approach. In the UK, this program is called the Gold Standards Framework, has been embraced by the National Health Service, and is part of the Quality Outcomes Framework that determines how GPs in the UK are paid.⁽⁹⁾ Importantly, promotion of primary care more broadly is an essential plank of the Australian Government's broader health agenda. ^(10, 11)

Can primary care deliver palliative care? Is its track record sufficiently robust that it can demand a more central role? Or, as seems the case, has the horse bolted? It depends on the point of view – 75% of GPs are prepared and willing to offer palliative care. It seems more logical to strengthen the commitment of the 75% and work systematically to engage the 25%, than it is to promote a more fragmented delivery model.

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PEER REVIEW

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CONFLICTS OF INTEREST

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FIGURES

Box 1 – Draft National Palliative Care Plan -Goal 3

- Resolve definitional issues surrounding palliative care.
- Support the evolution of appropriate models of palliative care service provision. This may include:
 - o nurse led units of both home based and in-patient services where nursing care is the predominant need of a client and/or need for specialist medical services are limited
 - o expansion of the role of Nurse Practitioners within palliative care
 - o expansion of the palliative care special interest role for Aboriginal Health Workers
 - o development of palliative care special interest workers (medical, nursing, allied health and volunteers) in all chronic disease services to act as central resource and collaborating agents between chronic care services, their clients and specialist palliative care. This will increase the capacity and self sufficiency of chronic care units to better meet the needs of their clients as they reach the end of their lives
 - o evolution of models proven to be effective in meeting the needs of those clients with particular palliative care needs such as children and adolescents, people living at home, and people within the justice system.
- Develop a national template for palliative care pathway with triggers for referral for specialist palliative care services. Specialist services for specific diseases (renal, motor neurone disease, Parkinson's disease, dementia, mental illness, and disability) can then customise this template for their own setting.
- Implement a national roll out of an end of life care pathway in all acute care settings.

Box 2 Draft National Palliative Care Plan - Goal 5

Action will be undertaken to:

- Identify and implement funding models that explicitly promote flexibility to meet the needs of the patient and their family. This may include:
 - o Funding based on assessed need
 - o Funded care packages, including rapid access / rapid response options
 - o Fund holding by appropriate providers, including aged care services, to be able to navigate and source appropriate care regardless of location.
- Explore new and enhanced roles for aged care providers in palliative care.
- Undertake further research and ongoing monitoring of the relative cost of care and cost effectiveness of care models in the last year of life, particularly savings to be gained through appropriate hospital avoidance for clients approaching the end of their life
- Undertake further work to identify, classify and cost specialist palliative care clients and their care.
- Provide enhanced, coordinated support for carers, volunteers, communities of carers and carer respite. Continue to support carers through established networks, use of appropriate assessment tools and appropriate resource material and education.
- Remove structural and funding barriers to coordinated, flexible local care delivery for people at the end of life regardless of where they live.
- Further improve the skill and confidence of the generalist workforce to work with clients at the end of their life.
- Enhance online palliative care support and resources through the development of 'communities of interest'.
- Promote the existence of online palliative care resources to all health and human service providers with links to service specific and disease specific websites.