RACGP
Royal Australian College *of* General Practitioners

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Human Services Inquiry
Productivity Commission
Locked Bag 2, Collins Street East
Melbourne VIC 8003

Dear Commissioner King

Productivity Commission preliminary findings report

The Royal Australian College of General Practitioners (RACGP) thanks the Productivity Commission for the opportunity to comment on the preliminary findings report (the report) released in September 2016 as part of the inquiry on introducing competition and informed user choice into human services. Two sectors identified for reform in the report, public hospitals and specialist palliative care, have significant overlap with the general practice sector. Following is a response to the discussion and preliminary findings on these sectors.

Public hospitals

Preliminary finding 4.1 suggests that greater user choice benefits patients when they have access to useful consumer oriented information on public hospital services and when referring practitioners support patients to make decisions.

In Australia, general practitioners (GPs) are the practitioners who most commonly prepare referrals. The role of GPs in supporting patient choice is already well established and patients are currently supported to choose a provider or service. It is the case however, as identified by the report, that sufficient information to support patient choice is often unavailable to both the patient and GP. Any work undertaken at a federal or state/territory level to provide this information should involve collaboration with GP and patient groups to ensure relevance to end users.

An additional consideration for the Productivity Commission should be the way in which GPs are supported to assist patients to exercise informed choice. General practice consultations are predominantly time-tiered. Increasing the expectation on GPs to support patient choice beyond current practices, when sufficient information is available to inform both the GP and the patient, will increase the length of consultation and likely increase the cost of care to the patient. While these factors should not prevent efforts to increase user choice, they are relevant considerations when recommendations from this inquiry are being formulated.

Specialist palliative care

Specialist palliative care services rely on effective partnerships with GPs and other providers. Improved interactions and greater integration between community and specialist palliative care services is necessary to improve information flow and support continuity of care.

Therefore, the RACGP recommends that the Productivity Commission take a whole-system view when considering how user choice can be supported when palliative care services are needed. Any efforts to introduce greater competition in the palliative care sector would require the establishment of clear standards and means for ensuring accountability.

Section 5.1 – Defining specialist palliative care

The definition provided by the World Health Organisation (WHO) is the generally accepted definition of palliative care. Reflecting the broad range of expectations of palliative care services and the 'palliative approach', the WHO definition is more inclusive than the definition in Section 5.1.

WHO Definition of Palliative Care

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

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Source: World Health Organisation. WHO Definition of Palliative Care. http://www.who.int/cancer/palliative/definition/en/

The distinction made in the report between specialist palliative care services as either inpatient or community based care does not present the full picture of the palliative care system in Australia. While models vary, there is significantly more overlap between community and hospital based palliative care than represented in the report. Some health networks offer inpatient and outpatient palliative care services, in addition to a dedicated palliative care ward. For example, Western Health in Victoria provides palliative care outpatient services in conjunction with oncology outpatient services. A nurse from a community based palliative care service is involved in these services, improving coordination between hospital and community based palliative care services.

In rural and remote areas, without access to palliative care specialists, inpatient and community based palliative care is provided by GPs working across these settings.

Section 5.2 – Scope to improve outcomes

In reference to discussion on efficiency, the report suggests that costs to funders (government) increasing access to community palliative care services would be offset by reductions in hospital spending. However, this ignores the costs to family/carers of caring for the person receiving community palliative care services in the home. Costs (eg pharmaceuticals, equipment) that would normally be borne by the palliative care service funder are shifted to the family or carer, in addition to the burden of lost wages and lost educational or employment opportunities due to the carer's role.

The RACGP supports the suggestion that improvements in advance care planning may prevent treatments or interventions towards the end of life that have little benefit to patients. Early referral and improved education, to ensure referral timing is appropriate, would improve patient outcomes and efficient use of palliative care services.

Supply characteristics

The lack of acknowledgement of the role of GPs in providing palliative care services is an oversight, particularly in the rural and remote service context. Palliative care is a core component of general practice training. While the Productivity Commission has focused on specialist palliative care services, addressing system constraints and barriers impacting on GP-led palliative care would also increase user choice and improve patient outcomes. Given their interdependence, the extent to which GP-led palliative care is available affects the delivery of specialist palliative care services.

Barriers to GPs providing palliative care services include:

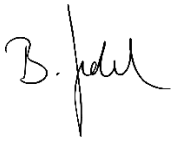
- time and workload constraints
- inadequate remuneration and support for home and residential aged care facility visits and longer consultations
- a lack of remuneration for non-face to face work undertaken to support the patient
- recognition of the GP palliative care skill set
- restrictions on admitting rights in rural and remote areas
- limited integration of electronic health records across sectors.

Greater supply and access to palliative care services should be achieved by empowering and supporting GPs to take a lead role in providing and coordinating end-of-life care, particularly in rural areas. This would also increase user choice and ensure efficient use of specialist palliative care services. Currently, understanding the supply of GP-led palliative care and the potential market is hindered by data collection and recognition of GP contribution.

The RACGP's *Vision for general practice and a sustainable health care system* presents a model for the implementation of the patient centred medical home model in Australian general practice. The medical home model would better support general practices to deliver palliative care services to their patients, through supporting access to and coordination of care more effectively than current arrangements

If you would like additional information about the RACGP's response to the report, please contact me or Mr Roald Versteeg, Manager – Advocacy and Policy on 03 8699 0408 or roald.versteeg@racgp.org.au

Yours sincerely



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