Chapter 6

The professional workforce and its development

6.1 This chapter will examine the composition of the professional palliative care workforce and its ability to meet the needs of the ageing population. It will begin by considering the role of palliative care specialists, including doctors, nurses and occupational therapists. Ways to improve and support workforce education and training in palliative care, including through scholarships and funding arrangements, will be discussed. Finally the chapter will look at the scope for changes and enhancements to the current healthcare curriculum and the need to embed awareness of palliative care more broadly across the health workforce (including in general practice) will also be covered.

The palliative care workforce profile and challenges

6.2 The committee heard evidence of the need for capacity building within the palliative care workforce. The following section provides an overview of the current workforce profile, the concept of multidisciplinary teams and future workforce challenges. It also looks at different workforce roles including specialist physicians and nurses as well as occupational therapists and general practitioners.

6.3 Most information the committee received about workforce was in relation to specific professions or roles. The Victorian Healthcare Association's submission noted that 70 per cent of the total palliative care workforce was over 40 years of age and that almost 35 per cent is over 50 years of age.[1]

6.4 In relation to aged care workers, Ms Wendy Porter, Residential Care Manager, Western Australia, for Aged and Community Services Australia, told the committee that the aged care workforce would need to treble over the next 30 to 40 years 'and a large proportion of that workforce will need generalist skills in a palliative approach to care'.[2] Ms Angela Raguz, General Manager, Residential Care for HammondCare, also commented that a shift in perception was needed to make aged care a more desirable area in which to specialise:

> It is about how we get those experts to come on board and to move beyond that view: 'Oh, it's aged care—that's a bit daggy. I don't want to spend time in aged care.' For young doctors and nurses it is not the sexiest part of the industry to select. So it is about getting it within undergraduate training, looking at training people on the ground in the nursing homes across a broad scale. And it is not just about setting up distinct units, even though

1 Victorian Healthcare Association, *Submission 57*, p. 5.

2 Ms Wendy Porter, Residential Care Manager, Western Australia, for Aged and Community Services Australia, *Committee Hansard*, 10 July 2012, p. 19.

> that is an ideal. It is about lifting the bar across the whole of aged care, be it in people's homes or in facilities.[3]

6.5 Professor Patsy Yates, President Elect of Palliative Care Australia, told the committee that addressing workforce issues in palliative care entailed not only providing education opportunities and up-skilling the existing workforce, but also being 'bold and brave in looking at new and innovative models that might actually be more sustainable in addressing the future that we are going to face in terms of increasing demand'. For example, the role of nurse practitioners has been successfully implemented in the palliative care environment, although not yet to a consistent degree, particularly in aged and community care settings.[4]

6.6 At a public hearing, Mr Trevor Carr, Chief Executive of the Victorian Healthcare Association, also illustrated the broad challenges to the palliative care workforce profile over coming decades:

> I think that in aged care and some elements of palliative care—so moving aside from the science of palliation to the emotional welfare side of palliation—there is a tremendous opportunity for people to specialise in this sort of area, just as there is for people, through TAFE VET qualified education, to specialise in home care type services. So our view is that we need to be moving towards that. There is no dataset that I have seen recently that suggests that in 20 years time we are going to have anywhere near the university qualified clinical profile that we have today, so that leaves us with two choices: either we change the models of care and the range of people providing them or we become more aggressive importers of clinicians—and generally that is not a good solution because of a range of issues, not least of which is: what does that leave in the countries that you are actually taking them from?[5]

6.7 The committee heard that the palliative care workforce needed to be based around multidisciplinary team approaches, supported by appropriate funding models. Multidisciplinary teams include specialist palliative care physicians and nurses, general physicians, general practitioners, nurses, psychologists, occupational therapists and carers.[6] The Australian Nursing Federation described 'new and emerging roles' within palliative care teams which include palliative psychological medicine specialists, general practitioners with special interests in palliative care, caregiver network facilitators and advanced practice roles such as palliative care consultants in physiotherapy or pharmacy.[7] The Pharmacy Guild of Australia's

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3 Ms Angela Raguz, General Manager, Residential Care for HammondCare, *Committee Hansard*, 2 July 2012, p. 21.

4 Professor Patsy Yates, President Elect of Palliative Care Australia, *Committee Hansard*, 10 July 2012, p. 12.

5 Mr Trevor Carr, Chief Executive of the Victorian Healthcare Association, *Committee Hansard*, 4 July 2012, p. 14.

6 See Australian Nursing Federation, *Submission 85*, p. 11.

7 Australian Nursing Federation, *Submission 85*, pp. 11–12.

submission stated that community pharmacists should be integral members of all interdisciplinary palliative care teams 'as good palliative care depends enormously on teamwork and effective symptom control'.[8]

6.8 Mr Trevor Carr, Chief Executive of the Victorian Healthcare Association, argued that the multidisciplinary team approach had not been achieved due to the constraints of current funding drivers.[9] He emphasised the 'proof of concept' around the nurse practitioner[10] model for palliative care, particularly medication management:

> The early conceptualisation of nurse practitioners in Australia was that nurses would have access to billing through the MBS. Whether we use that mechanism or not, we need to break down the barrier to ensure that practitioners who have clinical skills and the understanding of the drivers of the need for care for that particular care model have access to delivering and designing care for the consumer, rather than it being a professionally demarcated decision based on funding models.[11]

Palliative care medicine specialists

6.9 The committee heard that currently there are around 160 to 200 palliative care physicians nationally,[12] although data does not indicate whether they are full-time equivalents and the estimates do vary. When asked how many palliative care physicians there should be per 100 000 population, Associate Professor Rohan Vora told the committee that the Australian and New Zealand Society of Palliative Medicine (ANZSPM) advocated a figure of one per 100 000.[13] The Royal Australian College of Physicians estimated that the current supply of palliative care doctors was approximately half of the ratio recommended by the ANZSPM.[14] Palliative Care Australia's submission stated that 1.5 palliative care physicians per 100 000 would be the preferred ratio.[15]

6.10 The Royal Australasian College of Physicians (RACP) gave evidence that there was an undersupply of specialist palliative care medicine physicians. Dr Leslie Bolitho, President of the RACP, commented on some of the key workforce challenges for palliative care:

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8 Pharmacy Guild of Australia, *Submission 51*, p. 9.

9 Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard*, 4 July 2012, p. 11.

10 Nurse practitioners are registered nurses educated to a master's degree level.

11 Mr Trevor Carr, Victorian Healthcare Association, *Committee Hansard*, 4 July 2012, p. 11.

12 Associate Professor Rohan Vora, President-Elect, Australasian Chapter of Palliative Medicine, *Committee Hansard*, 2 July 2012, p. 16, suggested around 200, and indicated that Health Workforce Australia had made a lower estimate of 162.

13 Associate Professor Rohan Vora, Australasian Chapter of Palliative Medicine, *Committee Hansard*, 2 July 2012, p. 16.

14 Royal Australian College of Physicians, *Submission 29*, p. 7.

15 Palliative Care Australia, *Submission 98*, p. 19.

> We have to also take into special consideration the rural, remote and culturally sensitive communities, including Indigenous health, and children and adolescent palliative care is another specific area requiring attention. We see the federal government specialist training program and the potential of tele-health's role in the training and supervision of trainees and provision of services to our patients as a step in the right direction. Many of the members of this committee will be familiar with the dual training pathways which the college is promoting in order to address underprovision of specialist services in rural areas. While this model currently focuses on general medicine paired with other specialties, there is potential that this could also include palliative care services in the future.[16]

6.11 Dr Yvonne McMaster, a retired palliative care doctor, described to the committee the critical and highly specialised role of palliative care physicians, who look after not only the patient's physical symptoms but a range of other complex needs:

> How do you help people deal with all the practical, emotional and spiritual problems they face at the end of life? What can help when the going gets tough is regular contact with highly competent, reliable clinicians who can guide the patient on a well-trodden path—well trodden for the clinicians but new and scary for the patient. We walk the path with the person and their family, and it helps. As ANZSPM, the Australian and New Zealand Society of Palliative Medicine, say in their excellent submission to you, they 'listen to the spirit of the patient' and attend to 'the multiple fears, concerns and regrets that proximity to mortality entails'. Some doctors or nurses are able to do this on their own; many need the help of a multidisciplinary team. Palliative specialists also have a role in encouraging wise decision-making regarding appropriate practice goals: whether to persist in trying to prolong life in the face of serious side-effects of treatment or to focus mainly or wholly on improving quality.[17]

6.12 Dr McMaster stated that the current palliative care workforce was deeply demoralised. She described a 'tremendous contraction' in the New South Wales workforce over the last 15 years and advocated better pay as well as specific Medicare item numbers for palliative medicine to better recognise the work undertaken by specialists, which would help to attract more people into the workforce:

> It has been so sad to see that services which were flourishing and people coming in were very interested to do palliative medicine are not doing as much now.
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> **…**They are not paid as well as procedural specialists of course but they can be better recognised in pay. There could be specific item numbers such as the geriatricians have. They have a very good item number for a very

16 Dr Leslie Bolitho AM, President, Royal Australasian College of Physicians, *Committee Hansard,* 2 July 2012, p. 10.

17 Dr Yvonne McMaster, *Committee Hansard,* 24 April 2012, p. 70.

> complex assessment. There could be item numbers like that for palliative medicine, because most of palliative medicine is complex assessments.[18]

6.13 Associate Professor Mark Boughey, Co-Deputy Director of the Centre for Palliative Care, told the committee that nationally the number of doctors wanting to train as a specialist in palliative medicine was on the rise:

> The positions around Australia are increasing. As a membership, we have over 250 fellows in Australia who would be considered specialists in palliative medicine. That does not mean they are all actively practising.
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> We have a two-pronged approach in the training process. The chapter allows for people who have had training in any other clinical specialty to come in and retrain as a palliative medicine specialist or we can have people going by the direct route as a physician going on to be a specialist. There is also the capacity to do a six-month diploma in clinical palliative medicine. You get bidirectional training of GPs, geriatricians, respiratory physicians and other people who are in the medical arena for whom palliative care becomes important to them.[19]

6.14 Associate Professor Boughey also observed that for those who choose to work in palliative care, 'financial reward does not tend to factor into it'.[20]

6.15 The committee discussed the need for paediatric palliative care specialists with Dr Jenny Hynson of the Australia and New Zealand Paediatric Palliative Care Group. She noted that while the demand for such specialist positions was not likely to be great, she spoke of the need for a system that would be sustainable into the future.[21]

Palliative care nurses

6.16 Nurses will be the main carers for most people who are dying, regardless of care setting.[22] Ms Angela Raguz, General Manager, Residential Care of HammondCare, told the committee that the aged care sector does not currently have a lot of palliative care trained nurses:

> In fact, in aged care, your ratio of registered nurses to direct care staff is, in a good nursing home, one registered nurse for probably 25 residents. In

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18 Dr Yvonne McMaster, *Committee Hansard*, 24 April 2012, p. 73. See also Mr Peter Cleasby, *Committee Hansard*, 2 July 2012, p, 51.

19 Associate Professor Mark Boughey, Co-Deputy Director, Centre for Palliative Care, *Committee Hansard*, 4 July 2012, p. 54.

20 Associate Professor Mark Boughey, Centre for Palliative Care, *Committee Hansard*, 4 July 2012, p. 55.

21 Dr Jenny Hynson, Australia and New Zealand Paediatric Palliative Care Reference Group, *Committee Hansard*, 4 July 2012, p. 33.

22 Professor Jane Phillips, Professor of Palliative Nursing, University of Notre Dame and St Vincent's Sacred Heart, Sydney, *Committee Hansard*, 2 July 2012, p. 59.

> some nursing homes you may have one registered nurse looking after 70-odd residents.[23]

6.17 The Australian Nursing Federation (ANF) explained the benefits of having certified specialist palliative care nurses working in the provision of palliative care. While registered nurses, within their scope of practice, can provide palliative care and can administer prescribed medicines, specialist palliative care nurses have expertise in the palliative requirements of people as they progress through their illness:

> So, as far as scope of practice goes, all nurses can provide palliative care and they determine their own scope of practice. They are responsible and accountable for the care that they provide, and they would only provide care to their level of competence. So they look for support and expertise from other health practitioners where they determine that that is not their scope of practice any further. Where we have nurses who have qualifications in palliative care, they are providing a greater level of care according to their competence, right up to the point where they are a nurse practitioner.[24]

6.18 Ms Catherine Pigott, Member of the ANF, explained the role of specialist palliative care nurses further, particularly in providing information to the family of the patient about what is happening and why:

> Some of the things that we would be doing around medication in particular would be providing information to the patient and the family about why that medication has been started—particularly around morphine; people have a number of different myths about morphine, so it gives them information about why they might be on morphine—what we are doing, why we have changed it from perhaps oral medication to syringe driver medication, what is happening with the person, why things might be changing and why we might be having a different type of medication or perhaps no medication. We would add an adjuvant medication if they have a different type of pain. That is what the nurse's role is: to talk to the patient, and particularly the family, about what is happening with the person, why things are changing, where we are going, what to expect and what sort of side effects to look for when we administer the medication—because people might be a little bit nervous if we give them some morphine, but in fact what is happening, of course, is that their body is deteriorating and that is what they are dying from, not from an overdose of morphine. So it takes a lot of education, a lot of information provision and a lot of family support for us to be able to do that, and that is where your specialty nurse knowledge comes in particularly.[25]

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23 Ms Angela Raguz, HammondCare, *Committee Hansard*, 2 July 2012, p. 21. See also Palliative Care Nurses Australia, *Submission 45*, p. 5.

24 Ms Julianne Bryce, Senior Federal Professional Officer, Australian Nursing Federation, *Committee Hansard*, 24 April 2012, p. 37.

25 Ms Catherine Pigott, Member, Australian Nursing Federation, *Committee Hansard*, 24 April 2012, p. 37.

6.19 The ANF told the committee that there were slightly in excess of 330 000 nurses and midwives in Australia[26]; however, the ANF also stated it was difficult to estimate the numbers of nurses with palliative care qualifications in the Australian workforce. This was because there is no regulatory requirement to have a palliative care qualification to be able to work in the area:

> Ms Pigott:…It is a similar thing to cancer nursing in that people can say that they are a specialist palliative care nurse, but that does not necessarily mean they have the education completed…
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> Ms Bryce: Some obviously have experience from having done further education in continuing professional development. Others have a formal postgraduate qualification up to master's level. So there is quite a variance in the preparation for working in the area of palliative care. There is no regulatory requirement to have a palliative care qualification in order to be able to work in palliative care, because there is such a range of care that is provided.
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> Ms Coulthard: Good basic general nursing care is palliative care, so the specialist add-on of knowledge of medications and knowledge of specific clinical care for palliative care does not deny that most nurses are already able to provide good palliative care. There is also a range of nurses who have developed good clinical skills through clinical work and who have had very little extra training or education.
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> Senator MOORE: But there is no regulation.
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> Ms Coulthard: No.[27]

Occupational therapists

6.20 The committee also heard from occupational therapists who described their role in palliative care as a 'newer' development. Their focus is 'looking at how people actively live until they die'.[28] This includes self-care activities such as showering and dressing, home and domestic duties, community activities, work and leisure/recreational activities.[29] According to Ms Deirdre Morgan, Senior Occupational Therapist, Palliative Care for Peninsula Health:

> Palliative care was developed initially as a service to provide terminal care. With advances in health care and people living for longer now, people have palliative care for a much longer period of time. They are living for much longer with impaired function, much longer at home with families, where

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26 Ms Julianne Bryce, Australian Nursing Federation, *Committee Hansard*, 24 April 2012, p. 39.

27 Ms Catherine Pigott, Ms Julianne Bryce, Ms Robyn Coulthard, Member, Australian Nursing Federation, Senator Claire Moore, *Committee Hansard*, 24 April 2012, p. 36.

28 Ms Deirdre Morgan, Senior Occupational Therapist, Palliative Care, Peninsula Health, Victorian Palliative Care Special Interest Group, Occupational Therapy Australia, *Committee Hansard*, 4 July 2012, p. 17.

29 Occupational Therapy Australia, Victoria Division Oncology and Palliative Care Services in Australia, *Submission 59*, p. 2.

> the burden is greater. So we are newer in the palliative care sphere partly because of the changes and medical advances.[30]

6.21 Some of the main workforce issues raised with the committee by occupational therapists were:

- the lack of community occupational therapists in most community palliative care services;
- the current workforce structure having a medical, nursing and supportive care focus, influenced by symptom control and psychospiritual support, with less of a focus on enabling people to participate in everyday activities; and
- a distinct lack of broader allied health input to provide holistic care including physiotherapy, speech therapy, social work and psychology.[31]

The rural workforce

6.22 The committee heard that getting enough palliative care staff to work in rural and regional areas was always going to be a challenge. Dr Yvonne McMaster advocated a scheme which would create incentives for palliative care specialists to practise in rural areas:

> I believe that we could really do something dramatic in the country if we advertised overseas and got people in the rural towns. They would then have to have a rotating registrar coming from city practices backwards and forwards every term, and all those young doctors doing palliative medicine would have the experience of country life because attracting people to the country has been hard.[32]

6.23 Professor Katherine Clark of Catholic Health Australia emphasised the need for hubs of palliative care specialists to ensure there is adequate care and support right across Australia:

> We cannot have specialist hospices and specialist clinicians in every small hamlet across Australia. Our country is too vast and our population is too sparse. We cannot have that, so we need formalised agreements between different parts of Australia and we need to ensure that the hub is upskilled and adequate enough to provide support that does not become burdensome to that unit, so we can promise care to all Australians who require it.[33]

6.24 Similarly, Mr Peter Cleasby, President of Palliative Care New South Wales, stated that it was unrealistic to expect a palliative care specialist to be available in every country town or even major regional town. However, he outlined to the

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30 Ms Deirdre Morgan, Victorian Palliative Care Special Interest Group, Occupational Therapy Australia, *Committee Hansard*, 4 July 2012, p. 17.

31 Occupational Therapy Australia, Victoria Division Oncology and Palliative Care Services in Australia, *Submission 59*, pp. 4–5.

32 Dr Yvonne McMaster, *Committee Hansard*, 24 April 2012, p. 73.

33 Professor Katherine Clark, Catholic Health Australia, *Committee Hansard*, 2 July 2012, p. 35.

committee some concerns about the availability of palliative care doctors, despite the presence of excellent palliative care nurses servicing rural communities:

> We have struggled in New South Wales. There was a time when we had one specialist trained palliative care doctor outside the Newcastle-Sydney-Wollongong metropolitan basin; there was only one for the rest of the state and she was up in Lismore. There are now two between Newcastle and Lismore and there is no-one west and there is still no-one south. So specialist palliative care physicians in regional and rural New South Wales is a significant issue still not addressed. That is part of our major workforce issue. In most of those rural and regional areas we currently have fabulously experienced and appropriately trained specialist palliative care nurses doing a great service. There are limitations to their services. As the presenter in the session before us said, nurses cannot prescribe so they have to rely on another prescriber to accept the thoughts that they are offering and to act upon them. Those rural nurses, who are, as I say, the backbone of good palliative care in those areas, have themselves expressed concern about succession planning. Many of them are older, nearing the end of their career, and the system is not allowing opportunities for people to be trained up to replace them. That is a major concern in New South Wales about how one is going to go about doing that when budgets are so tight.[34]

The role of general practitioners

6.25 The committee heard views about the role of general practitioners (GPs) in palliative care. As primary care physicians, the role of the GP has changed significantly over time. Gone are the days when home visits and after-hours consultations were commonplace. Dr Yvonne McMaster said the expectations that GPs become heavily involved in end-of-life care were too high as they are so busy.[35]

6.26 Ms Angela Raguz, General Manager, Residential Care for HammondCare, commented that 'we do struggle to get GPs who have the knowledge and the expertise to be able to deal with people at the end of their life well'.[36] Dr McMaster also made the observation:

> A proportion of the GP workforce is made up of overseas born and trained doctors with no palliative care knowledge or understanding or willingness to take advice from specialist palliative care nurses—'You make too much fuss about dying; you have to expect to suffer', one nurse was told. Another nurse wrote, 'GP competence in palliative care in rural areas is vital but sadly lacking.'[37]

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34 Mr Peter Cleasby, President, Palliative Care New South Wales, *Committee Hansard*, 2 July 2012, p. 49.

35 Dr Yvonne McMaster, *Committee Hansard*, 24 April 2012, p. 70.

36 Ms Angela Raguz, HammondCare, *Committee Hansard*, 2 July 2012, p. 21.

37 Dr Yvonne McMaster, *Committee Hansard*, 24 April 2012, p. 71. To meet the psychological, social and clinical needs of people who need palliative care in rural areas, Dr McMaster advocated for more social workers and case coordinators.

6.27 The Australian Nursing Federation observed that in many rural communities, GPs themselves are not easily accessible. Its submission outlined a number of other concerns in relation to GPs and appropriate provision of palliative care:

> …General Practitioners with an interest and specialty in palliative care are rare in rural and remote areas. There is sometimes a disinclination for General Practitioners to participate in the process of teamwork in delivery of quality palliative care, in particular due to lack of understanding of current principles of palliative care; and a focus only on pain management. It is fair to say that General Practitioners in rural areas have issues similar to nurses in accessing education and professional development. Further, General Practitioners are often unavailable on weekends and after hours, leading to unnecessary hospitalisation of patients requiring care which would be deemed by a palliative care team nurse to be uncomplicated palliative care.[38]

6.28 The South Australian government noted workforce limitations in general, and mentioned GP availability in particular:

> One of the impediments to increasing the capacity of primary health care providers is inadequate funding and staffing to meet increasing demand. The ability for general practitioners in particular to provide visits to patients at the end of their life in their home or in a residential care facility is currently limited.[39]

In this case, the issue appeared to be not the GP workforce in general, however, but the capacity to visit palliative care patients 'in place'.

6.29 Associate Professor Deborah Parker, Director of Blue Care Research, told the committee about a study she conducted where GPs were encouraged to attend a palliative care case conference. About 50 per cent of residents in aged care facilities who had been given a prognosis of less than six months to live had their GP attend a case conference. She explained:

> This study specifically focused on the use of case conferences and engaged the GPs with well-organised timeslots, coordinated by the nurses and a clear process to be followed to ensure that time limits were adhered to and that the GPs could claim, using the EPC [Enhanced Primary Care] Medicare items. In this instance, with this support of a well-funded research project, we can achieve the 50 per cent of GPs coming to a palliative care case conference for residents. You can imagine what the norm is when that sort of support is not available. I can tell you that the incidence of getting a GP to come to a residential-care facility to conduct a palliative case

38 Australian Nursing Federation, *Submission 85*, p. 3.

39 South Australian Government, *Submission 27*, p. 6.

> conference is almost non-existent. This project showed significant improvements in family satisfaction and resident outcomes.[40]

Education and training in palliative care

6.30 The committee heard from witnesses that education and training for the palliative care workforce could be improved in some crucial areas. This could occur as part of both undergraduate and postgraduate training of healthcare workers, as well as through continuous professional development of both specialists and the broader health profession. Improvements in training and education could also be achieved through increased Commonwealth funding for training and places and scholarships.

6.31 Professor Patsy Yates, President Elect of Palliative Care Australia, described the 'ad hoc' approach to education in palliative care over the last few decades:

> More recently in Australia we have a recognition that people are dying in all sorts of areas of our communities and in our health services and so we need to have all health professionals prepared with at least some capability in providing end-of-life care. In Australia we have gone some way in understanding that and trying to tackle the issue of getting it integrated into undergraduate programs. There has been some progress but still there is a great difference across the country in how that is taken up.[41]

6.32 Qualification and skill levels must be improved to ensure that palliative care in Australia is supported by an appropriately skilled workforce. Mr Nicolas Mersiades, Senior Aged Care Adviser for Aged and Community Services Australia, argued:

> There is a lot more work to be done to ensure that the qualifications and the skill levels of staff are adequate to deliver a palliative care approach and that there is also ready access to specialist information and advice where needed in those cases where symptom management is much more complex.[42]

6.33 Palliative Care Nurses Australia advocated for palliative care education for all health professionals, including Indigenous health workers and personal carers in the aged care setting at both undergraduate and postgraduate level.[43]

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40 Associate Professor Deborah Parker, Director, University of Queensland/Blue Care Research and Practice Development Centre, Blue Care, *Committee Hansard*, 2 July 2012, pp. 2–3. See http://www.uq.edu.au/bluecare/comprehensive-evidence-based-strategy-to-address-the-palliative-care-needs-of-people-residing-in-residential-aged-care-facilities-racfs-cebparac (accessed 12 September 2012). Associate Professor Parker also informed the committee of a palliative approach educational toolkit, funded by the Department of Health and Ageing.

41 Professor Patsy Yates, President Elect, Palliative Care Australia, *Committee Hansard*, 10 July 2012, p. 12.

42 Mr Nicolas Mersiades, Senior Aged Care Adviser, Aged and Community Services Australia, *Committee Hansard*, 10 July 2012, p. 20.

43 Mr John Haberecht, President, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 58.

Commonwealth funding for workforce training

6.34 When questioned as to how the Commonwealth Government supports training for the aged care workforce, the Department of Health and Ageing (the department) explained to the committee a range of initiatives to address training requirements. Since 2007, more than $252 million has been invested in more than 41,800 aged care training places:

> Included as part of these training places is education to improve the palliative care skills and knowledge of people working in aged care. This includes understanding the needs of people approaching the end of life, understanding the palliative approach to care of people and their family, and developing and implementing a care plan for people at the end of life.
>
> Support also includes funding for people working in aged care to undertake specific units from the palliative care skill set. The skill set comprises a set of training units and enables people working in aged care to gain targeted skills that can be transferred readily into their caring role.[44]

6.35 The department also noted that it provides funding through the Encouraging Better Practice in Aged Care initiative to 'support the uptake of evidence-based, person-centered and better practice in aged care'. This initiative focuses on improving staff knowledge and skills and resource development. Three projects funded under this initiative are specifically targeted at encouraging a palliative approach in residential aged care:

> 1. A good death in residential aged care: optimising the use of medicines to manage symptoms in the end-of-life phase.
>
> 2. …Encouraging best practice palliative care in residential aged care facilities from rural and remote communities.
>
> 3. The implementation of a comprehensive evidence-based palliative approach in residential aged care.[45]

6.36 In addition, the department stated it was supporting the development of a program to look at 'appropriate models of practice for aged care nurse practitioners':

> The program aims to test and evaluate a range of financially viable practice models that can be implemented across both home care and residential aged care settings. In this program nurse practitioners are working in a range of clinical specialties, including palliative care, to assist in improving the care of older people.[46]

6.37 The recently announced Commonwealth aged care reform package includes $1.2 billion for a Workforce Compact to be implemented over four years from July

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44 Department of Health and Ageing, answers to questions on notice (question 5), received 23 May 2012.

45 Department of Health and Ageing, answers to questions on notice (question 5), received 23 May 2012.

46 Department of Health and Ageing, answers to questions on notice (question 5), received 23 May 2012.

2013. The government says that this is aimed at improving the capacity of the aged care sector to attract and retain staff through higher wages, improved career structures and enhancing training and education opportunities.[47]

6.38 The ANZSPM called for Commonwealth funding for accredited positions for training in palliative medicine.[48] Its submission stated:

> To meet the future workforce need it is imperative that more doctors are trained in the specialty of Palliative Medicine. Currently a major rate limiting step is the funding of positions by State and Territory governments. A minority of positions are funded through the STP [Specialist Training Program].
>
> Accreditation of training positions is performed independently by the RACP (Royal Australasian College of Physicians) Palliative Medicine Education Committee. As such, there are more accredited positions than there are trainees. To increase the number of Palliative Medicine Specialists for the future ANZSPM proposes that funding is provided according to numbers of accredited positions, rather than on the basis of historical allocations, usually to public hospitals.[49]

6.39 Some other issues raised by witnesses in relation to Commonwealth support for training included:

- calls for funding of Commonwealth training places to match assessments by Health Workforce Australia of future palliative care workforce needs, both generalist and specialist[50]; and
- the level of workforce support and training being provided by the Commonwealth to allied health professionals. This equated to around $12.5 million per year across Australia according to Mr Rod Wellington, Chief Executive Officer of Services for Australian Rural and Remote Allied Health (SARRAH). Mr Wellington observed that this was far less funding for support and training than what is provided to general practitioners and nurses.[51]

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47 See Living Longer. Living Better – Aged Care Reform Package, Department of Health and Ageing, April 2012 http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-aged-care-reform-measures-toc~ageing-aged-care-reform-measures-chapter6.htm (accessed 12 September 2012).

48 Australian and New Zealand Society of Palliative Medicine, *Submission 33*, pp. 13–14. See also Dr Yvonne McMaster, *Committee Hansard*, 24 April 2012, p. 70.

49 Australian and New Zealand Society of Palliative Medicine, *Submission 33*, pp. 13–14.

50 Ms Wendy Porter, Residential Care Manager, Western Australia, Aged and Community Services Australia, *Committee Hansard*, 10 July 2012, p. 19.

51 Mr Rod Wellington, Chief Executive Officer, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 24 April 2012, p. 30.

Training and scholarships for nurses

6.40 Palliative Care Nurses Australia (PCNA) and the ANF appeared before the committee to discuss qualifications and training options for post-graduate study in palliative care nursing.

6.41 The ANF described undergraduate nursing courses as having 'a very full curriculum', noting the optional Palliative Care Curriculum for Undergraduates program (mentioned in further detail below). For the specialist palliative care nurse, there are a number of graduate certificates, graduate diplomas and masters degrees that are run by institutions such as the Australian Catholic University, Edith Cowan University, La Trobe University and the University of Melbourne.[52]

6.42 Professor Jane Phillips noted that postgraduate palliative care nursing qualifications were expensive to obtain and particularly prohibitive for many nurses.[53] Ms Catherine Pigott, Member of the ANF, outlined the costs of postgraduate study:

> Ms Pigott: The cost of them ranges. For a graduate certificate you are talking between $5,000 and $10,000. Around $6,000 and $7,000 is the average mark for a graduate certificate in university. For a graduate diploma it would be double that. For masters it is variable depending on whether it is masters by research or masters by coursework.
>
> CHAIR: It is expensive, in other words.
>
> Ms Pigott: For nurses, yes.[54]

6.43 Mr Jason Mills, National Committee Secretary for PCNA, described his nursing training at the University of Canberra and his graduate year in Victoria:

> In the curriculum where I studied palliative care was not an elective and it was not a core unit, per se. It was embedded within a subject of chronic illness … [T]here is discrete representation and it does differ across the university sector across the different states. For example, some universities have a subject on spiritual care whereas others do not.[55]

6.44 He told the committee that he decided he wanted to be a palliative care nurse after volunteering in a hospice. He also spoke of encountering a passion among his fellow students to pursue palliative care but also then coming across a systemic resistance to this desire in his graduate year:

> … among the cohort that I studied with, my peers, I did see that flame being sparked within the subject. It was very well articulated in the course and I witnessed it amongst my peers. I was pleasantly surprised that there was within the future generations of nurses a passion there if it were given a chance to be linked. In my graduate year I in some ways met some

52 Ms Catherine Pigott, Australian Nursing Federation, *Committee Hansard*, 24 April 2012, p. 35.

53 Professor Jane Phillips, *Committee Hansard*, 2 July 2012, p. 59.

54 Ms Catherine Pigott, Australian Nursing Federation, *Committee Hansard*, 24 April 2012, p. 35.

55 Mr Jason Mills, National Committee Secretary, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 59.

> resistance. There seems to be a perception, which perhaps stems from a society with the view of protecting young people from death, that we need to shield people from it. That runs counter to it; it is not so productive. I came across the view in many forums that you should not and cannot work in palliative care until you have at least ticked off five or six years in general medical surgical nursing. I was a little shocked at that because that was the whole reason that I wanted to become a nurse.[56]

6.45 Mr Mills told the committee he received a competitive scholarship from the Victorian Government which was administered through Palliative Care Victoria to do his graduate certificate in palliative care. The scholarship was worth about $2,600 and the course itself was about $7,500.[57]

6.46 Access to funding for further education in palliative care is complicated by the breadth of the healthcare sector and competition for the same pool of funding. PCNA suggested to the committee that dedicated funding be set aside, which 'would go a long way to nurturing the future workforce in palliative care'.[58] PCNA's submission recommended dedicated scholarship funding for postgraduate studies in palliative care on a national level, rather than palliative care clinicians competing for the generic and highly competitive Postgraduate Nursing and Allied Health Scholarship and Support Scheme (NAHSSS):

> Many clinicians wanting to further their clinical knowledge and develop advanced practice skills in palliative care are consistently missing out on funds through the generic NAHSSS. This results in frustration and disillusionment regarding any higher education aspirations such clinicians may have held. Such barriers to further education ultimately impede quality improvement of clinical staff practising in a dynamic environment of evidence-based practice (with an everchanging evidence base) and adversely affect bedside care of palliative patients.[59]

6.47 PCNA also called for recognition of the specialist skills acquired by palliative care nurses:

> We recommend creation of a credentialling program to recognise specialist palliative care nurses and a national rollout of the existing competency standards for specialist palliative care nurse.[60]

6.48 The ANF also discussed with the committee the issue of postgraduate scholarship funding for nurses to gain further qualifications in palliative care. However, the shortcomings of these current arrangements were noted (the ANF has made representations to the Department of Health and Ageing to have scholarship

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56 Mr Jason Mills, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 60.

57 Mr Jason Mills, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 59.

58 Mr Jason Mills, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 60.

59 Palliative Care Nurses Australia, *Submission 45*, p. 8.

60 Mr John Haberecht, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 59. See Palliative Care Nurses Australia, *Submission 45*, p. 8.

funding increased).[61] The ANF also cited the difficulty for staff to get time off to actually undertake intense further studies. Workforce shortages in regional areas make this particularly difficult. For rural and remote area nurses, postgraduate study can be hard to access, so continuous professional development is usually undertaken through short courses, including through online education.[62]

Other training issues

Better training of aged care staff

6.49 The committee heard concerns about the level of training in palliative care principles being provided to staff working in aged care. For example, Dr Yvonne McMaster pointed to the urgent need for training by palliative care specialists on symptom control and end-of-life care for nursing home staff. She described the situation in nursing homes as 'Dickensian':

> Some of the most difficult cases—you have been hearing about dementia today—are managed by the least trained staff: little girls with six weeks training and no concept of real care. Yet it seems that these places are to be the new hospices and the now hospices are to become only acute short-stay facilities. This attempt to save state funds and shift costs onto the Commonwealth should be resisted to the death.[63]

6.50 Alzheimer's Australia called for mandatory training and support for staff of aged care facilities in relation to artificial nutrition, hydration, antibiotics, pain management, hospitalisation, resuscitation, differences in cultural values and beliefs around dying, advanced care directives and the law.[64]

Training in oncology

6.51 Associate Professor Frances Boyle, Former Executive of the Medical Oncology Group of Australia, told the committee that specialist palliative care doctors and nurses needed to be integrated at every level of cancer care in Australia. This would entail making oncology training positions available which is currently difficult to do:

> If we are talking about an expansion of the palliative care workforce, we have got to do our bit to make sure that those training positions are available at our end to pull them in so that, if they are going to be involved earlier in the care of cancer with patients, they need to know more about chemotherapy, more about radiotherapy, and they need to be involved in communication training with our trainees, not just on their own. So we would be certainly very willing to look at methods to increase access to training. For instance, at our hospital, which is a private hospital, we have put in an application for an extended settings job to rotate the palliative care

61 Ms Elizabeth Foley, Australian Nursing Federation, *Committee Hansard*, 24 April 2012, p. 36.

62 Ms Geri Malone, Australian Nursing Federation, *Committee Hansard*, 24 April 2012, p. 36.

63 Dr Yvonne McMaster, *Committee Hansard*, 24 April 2012, p. 71.

64 Dr Ron Sinclair, Consumer, Alzheimer's Australia, *Committee Hansard*, 24 April 2012, p. 2.

> trainees into. Like everybody else, we are waiting to find out what happens about that funding, but certainly there are an increasing number of oncology units in Australia that could be providing some training for palliative care physicians.[65]

The palliative care curriculum

6.52 The committee heard from witnesses that the curriculum studied by those entering the health workforce needs to include education in quality end-of-life care. Ongoing support through continuing professional development is also required.[66] The committee was pleased to hear about current programs and training modules in palliative care—specifically the Palliative Care Curriculum for Undergraduates and the Program of Experience in the Palliative Approach.

6.53 Palliative Care Australia (PCA) explained to the committee that working in palliative care needed to be made an attractive career choice for doctors, nurses and allied health professionals.[67] Dr Yvonne Luxford, Chief Executive Officer of PCA, noted that exposure to palliative care in undergraduate training was required to cultivate this interest among health professionals. She explained that the College of Physicians includes practitioners of palliative medicine, but noted that palliative care is not taught across the curriculum.

6.54 Dr Luxford told the committee about a government-sponsored program called PCC4U—Palliative Care Curriculum for Undergraduates[68]—which 'has some reach into the various undergraduate curriculums of health professionals, but not nearly enough'.[69] Professor Jane Philips, Professor of Palliative Nursing at the University of Notre Dame, noted that the PCC4U curriculum is embedded within her university's three year nursing degree and that medical schools and allied health school are also able to utilise content from that program, allowing emerging clinicians to be exposed to palliative care.[70]

6.55 The committee also heard about PEPA—the Program of Experience in the Palliative Approach.[71] Offered as postgraduate informal education, PEPA is supported by the Department of Health and Ageing and is aimed at educating health professionals who do not have specialist palliative care expertise but who have an interest in the area.[72] PEPA is also targeted to Indigenous health workers, with

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65 Associate Professor Frances Boyle AM, Former Executive, Medical Oncology Group of Australia, *Committee Hansard*, 2 July 2012, p. 46.

66 See for example Dr Yvonne Luxford, *Committee Hansard*, 24 April 2012, p. 18.

67 Dr Yvonne Luxford, Palliative Care Australia, *Committee Hansard*, 24 April 2012, p. 21.

68 Palliative Care Curriculum for Undergraduates, www.pcc4u.org, (accessed 28 September 2012).

69 Dr Yvonne Luxford, Palliative Care Australia, *Committee Hansard*, 24 April 2012, p. 21.

70 Professor Jane Phillips, *Committee Hansard*, 2 July 2012, p. 59.

71 See Welcome to PEPA, www.pepaeducation.com (accessed 10 October 2012)

72 Mr John Haberecht, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 58.

location-specific resources to account for different palliative care needs around Australia.[73]

Enhancing knowledge and awareness of palliative care in the health curriculum

6.56 Palliative Care Nurses Australia suggested enhancement of the undergraduate health curriculum by embedding palliative care principles, through programs such as PCC4U. While noting the 'crowdedness' of the undergraduate curriculum, PCNA stated that palliative care should be a basic component of all health professional curricula and also called for the establishment of professional mentor programs.[74]

6.57 When asked how many universities around Australia have a chair of palliative care, the Centre for Palliative Care responded that there were five or six.[75] Dr Yvonne McMaster told the committee that medical students need to be inspired by 'charismatic palliative care specialists of the highest calibre' in teaching hospitals:

> That is what catches the attention of the students and attracts them to the specialty. Universities must teach palliative medicine, and the teachers must be able to inspire young people to go into a specialty where they can really make a difference to people's lives and wellbeing.[76]

6.58 Associate Professor Andrew Cole, Chief Medical Officer for HammondCare, expressed worry about how little of the curriculum for the training of health professionals is devoted to end-of-life care:

> All of us are most concerned about the very small amounts of clinical teaching time given to healthcare students—medical, nursing and allied health—as they learn about end-of-life care compared with, for example, the time given to learning about the care of infants and children. In my own university [University of New South Wales], the medical students would spend a term in each of first, second and third years learning about beginnings, growth and development and they would spend about a week learning about palliative care and care at the end of life. At Sydney University, they spend about half a day.[77]

6.59 Associate Professor Mark Boughey explained that the Centre for Palliative Care, an academic research and education centre at the University of Melbourne, encourages early exposure to palliative medicine:

> Prof. Boughey:…we are then going into the hospitals and trying to encourage intern placements, junior doctors and early trainees so they get an exposure. They may never go to palliative medicine but they get an

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73 Dr Yvonne Luxford, Palliative Care Australia, *Committee Hansard*, 24 April 2012, p. 23.

74 Mr John Haberecht, Palliative Care Nurses Australia, *Committee Hansard*, 24 April 2012, p. 58.

75 Associate Professor Jennifer Philip, Catholic Health Australia, *Committee Hansard*, 4 July 2012, p. 54.

76 Dr Yvonne McMaster, *Committee Hansard*, 24 April 2012, p. 70.

77 Associate Professor Andrew Cole, Chief Medical Officer, HammondCare, *Committee Hansard*, 2 July 2012, p. 17.

> exposure about what palliative care and palliative medicine is all about that they can carry into whatever area they go.
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> Senator FIERRAVANTI-WELLS: Would that be at undergraduate level?
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> Prof. Boughey: It depends on the priorities of any university. Somewhere like Melbourne University that we are associated with has moved to a postgraduate model. They have about a two-week program built into two separate parts of their four-year course. They have taken a fairly serious approach to palliative care being part of that training.[78]

6.60 In comparison to training offered at other institutions, a two week program may be seen as quite substantial:

> Some other universities may only have a few hours or a few lectures in a six-year period. That is not to say that palliative care does not get mentioned in the disease profile of all the training; it is just the specialist area where the people who work in palliative care have access to students. In many ways medicine is more organised than nursing, allied health or other areas of training. I do not think in occupational therapy or physiotherapy it is actually part of the undergraduate training. Once you get away from medicine, it falls off quite precipitously in Australia. There is nothing to say there is a minimum standard in training for students in this area, even though it is so much a part of our work.[79]

6.61 According to Associate Professor Boughey, there are different needs for workforce development depending on the health professional:

> At the moment we might have nurses who have had a great deal of experience but that experience is not recognised in a structured way so that, say, a young graduate nurse can be told: 'This is your career. If you want to become a career specialist in palliative care, these are the stepping stones to move towards it.' It is much more organised in the medical field. For a psychologist who wants to work in the area there is not really any training pathway other than being experienced in death and dying, which does not necessarily mean that they have had the training.[80]

6.62 Associate Professor Boughey cited the success of a palliative care training program in Victoria which has encouraged promising workforce developments:

> To give an indication: their program was set up five years ago—there was a two-year pilot and then three years into the program—and it has gone from having only five or six trainees in palliative care medicine to about 35 positions and 17 trainees. That is significant growth in a three-year period. It is all because we have centralised, coordinated, brought the trainees

78 Associate Professor Mark Boughey, Centre for Palliative Care, and Senator Concetta Fierravanti-Wells, *Committee Hansard*, 4 July 2012, p. 54.

79 Associate Professor Mark Boughey, Centre for Palliative Care, *Committee Hansard*, 4 July 2012, p. 55.

80 Associate Professor Mark Boughey, Centre for Palliative Care, *Committee Hansard*, 4 July 2012, p. 55.

> together and provided value-added education. We are getting people move to Victoria from interstate, whereas before we had to move to other parts of Australia because our training requires us to do certain terms that were not available in Victoria. It is an interesting model. Queensland is taking up a view that they want to develop a similar program and process to keep their trainees in Queensland. So things are happening but it is on a state-by-state basis at the moment.[81]

Committee view

6.63 The committee strongly endorses the interdisciplinary and team-based models of care about which it received evidence, and noted the importance of nurse-led teams in providing care in this sector. These multidisciplinary teams need to be effectively resourced and well trained.

6.64 The committee recognises that the palliative care workforce must be properly equipped with the knowledge, skills and experience to provide high quality end-of-life care to people with terminal illnesses, as well as to their families and carers. The committee heard that through enhancements to the health workforce curriculum, in both undergraduate and postgraduate settings, a broader awareness of the principles of palliative care will become more greatly embedded within the health system and not just among specialist palliative care providers. The committee believes it is important that such awareness be developed in the healthcare community, so that health practitioners refer patients to specialist palliative care in a timely manner; patients get the most appropriate care; and the healthcare system is not used inefficiently through patients with palliative care needs being inappropriately placed in acute care settings.

6.65 The committee understands the critical role played by nurses in providing quality palliative care. Greater opportunities for nurses to develop their knowledge and specialise in palliative care nursing through postgraduate education should be pursued. The committee sees merit in the creation of a dedicated scholarship fund to assist nurses aspiring to gain postgraduate qualifications and considers that the Commonwealth Government should establish such a fund.

Recommendation 9

6.66 The committee recommends that medical workforce training include being educated about existing pathways to specialist palliative care, ensuring that this care is applied effectively to best meet patient need.

Recommendation 10

6.67 The committee recommends that the Australian government create an ongoing and dedicated national scholarship fund for postgraduate studies in palliative care nursing.

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81 Associate Professor Mark Boughey, Centre for Palliative Care, *Committee Hansard*, 4 July 2012, pp. 55–6.