ENHANCING PALLIATIVE CARE IN RURAL AUSTRALIA

BUILDING FLEXIBLE, CONNECTED, COMMUNITY-RESPONSIVE SYSTEMS

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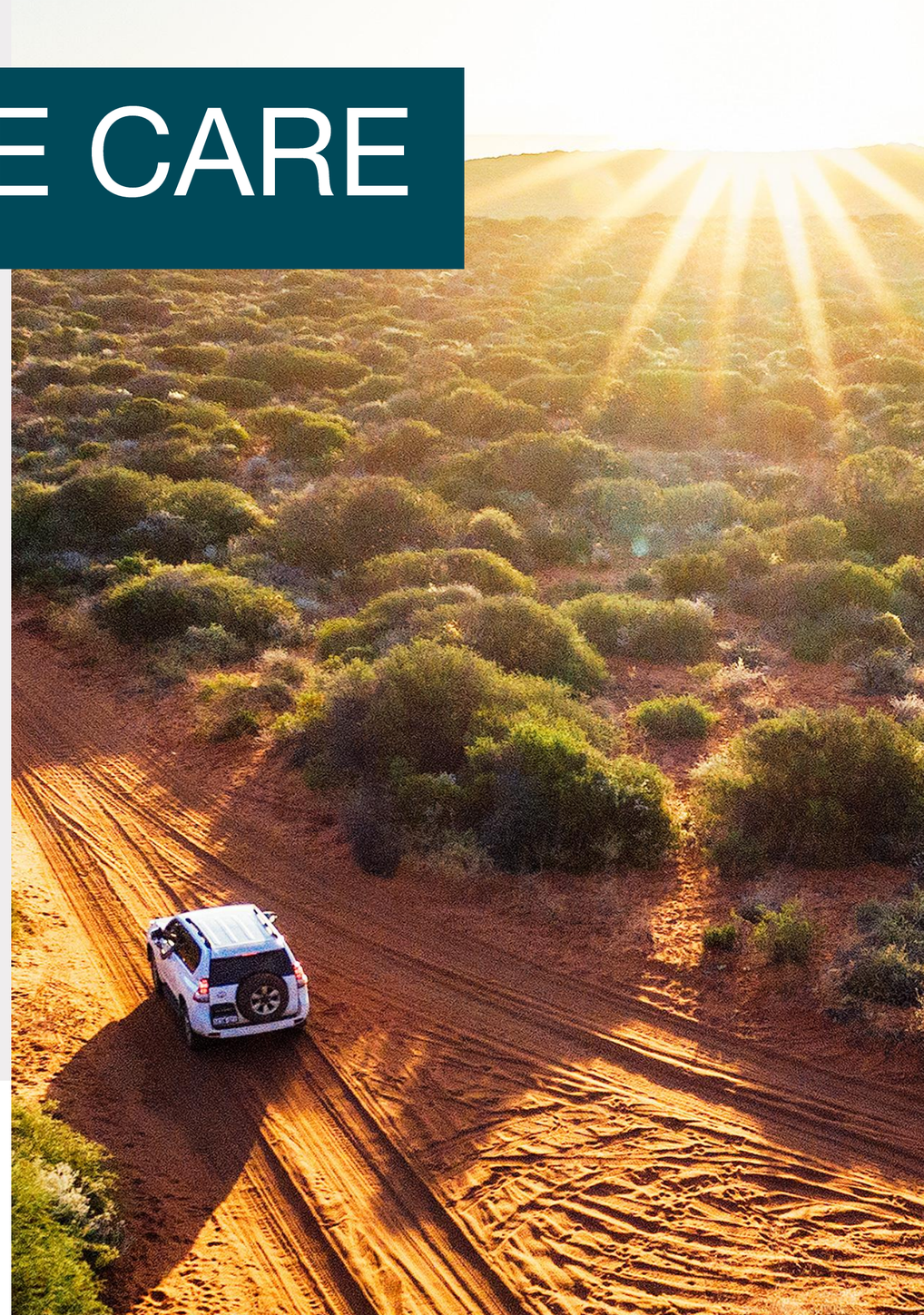
UTS

IMPACCT Improving Palliative, Aged and Chronic Care through Clinical Research and Translation



ACKNOWLEDGEMENT OF COUNTRY

I have travelled here from Yamatji Country in rural Western Australia.

I would like to acknowledge the traditional custodians of the land on which this conference takes place, the Kaurna people.

Thank you for accepting me on your country.

RURAL COMMUNITIES AT THE FRONTLINE OF CHANGE

Global pressures converging:

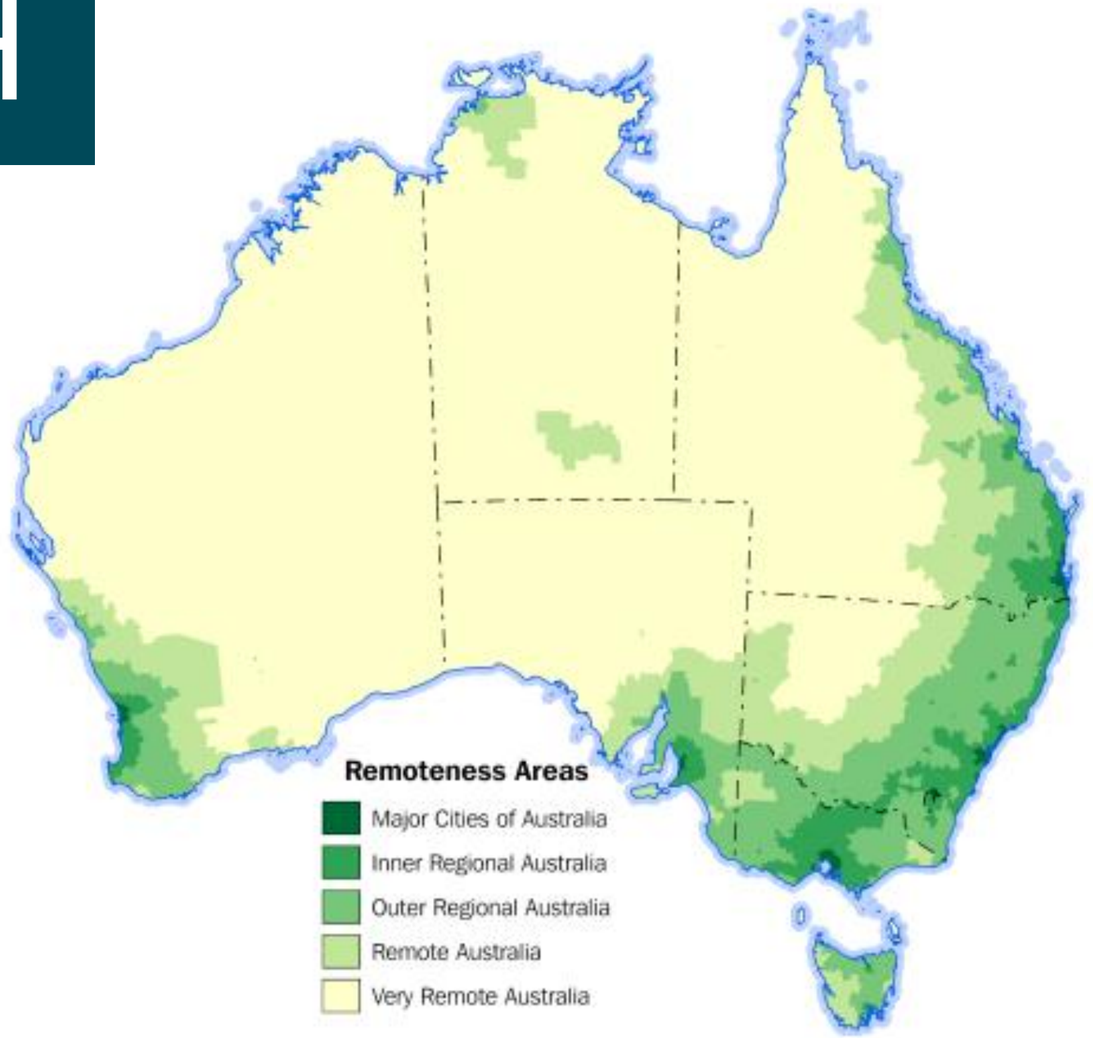
- Population ageing; by 2050, 1 in 6 people globally will be aged over 65 years[1]
- Increasing chronic disease burden
- Escalating palliative care demand
- WHO estimated a global nursing shortage of 5.9 million nurses;[2] 89% of these shortages concentrated in low- and lower-middle-income countries[3]
- 45% of the global population live in rural areas, where these pressures are over-expressed

STRUCTURAL PRESSURES IN RURAL HEALTH

1 in 3 Australians live in rural areas.

Key structural pressures:

- Workforce maldistribution[4]
- Fragmented service delivery[5]
- Geographic isolation and travel burden[6,7]
- Limited specialist access[5]
- Smaller and itinerant workforce[8]
- Resource and infrastructure constraints[5]
- Dependence on generalist clinicians[7]



ABS

RURAL EXPERIENCES OF CARE AND DYING

- Distance and travel shape care experiences
- Care often occurs within close-knit communities
- Desire to remain within community
- Families carry substantial caregiving responsibility
- Rural clinicians frequently hold dual relationships (professional and personal relationships with their patients)
- Continuity and local knowledge matter deeply
- Feeling safe and supported becomes critical

AUSTRALIA:
NURSE-LED SPECIALIST SUPPORT

Regional Queensland, Australia[11]

- Nurse-led palliative care consultancy supporting aged care facilities
- Comprehensive care planning involving families, staff and General Practitioners (GPs)
- Anticipatory prescribing and preparation for deterioration
- Responsive after-hours support
- Reduced hospital transfers and improved symptom management

FINLAND: AFTER-HOURS CARE

North Karelia, Rural Finland[9]

- Paramedics integrated into planned palliative care pathways
- Direct access to patient care plans and escalation pathways, including ability to call a specialist palliative care physician for advice
- Access to pre-identified palliative care beds when required
- Provide after-hours care to those areas without an existing service
- Led to reduced reliance on emergency departments

Existing workforces can be organised differently to improve rural palliative care access and continuity.

JAPAN: ELECTRONIC INFORMATION SHARING

Rural Japan[10]

- Rural clinic and rural nursing home connected through a shared IT platform
- Real-time information sharing between nurses and general practitioners, specifically used for palliative care patients
- Improved communication during periods of deterioration
- Reduced emergency hospital transfers
- More people able to remain within the nursing home for end-of-life care

CANADA: TELEHEALTH

Rural Nova Scotia, Canada[13]

- Home-based palliative care consultations using telemedicine, performed alongside home-visit by an RN
- Rural patients connected directly with specialist clinicians
- Reduced travel burden for patients and families
- Earlier access to specialist advice and symptom management
- Supported care closer to home

SIMILAR CHALLENGES.

DIFFERENT SOLUTIONS.

RECURRING ELEMENTS.

- Multidisciplinary care
- Primary and community-based care
- Honouring existing rural clinician relationships
- Feeling safe, prepared and supported
- Timely access to specialist palliative care
- Timely access to equipment
- Information technology and communication systems
- Sustainable funding
- Innovation and quality improvement

A RURAL PATIENT STORY

Patient and Family

Joe

- 76-year-old wheat farmer
- Lives in a small rural town in WA , which is 200 km from the larger regional centre (which is 500kms away from Capital city)
- Metastatic prostate cancer
- Wishes to remain on his farm for as long as possible

Mary

- Wife and primary caregiver
- Deeply connected to the farm and local community
- Balancing caregiving, harvest season & future planning

Rural Context

Their Reality

- Small tight-knit rural community
- Limited local healthcare infrastructure and small local clinical team
- Long travel distances
- Reliance on coordination between local, regional & metropolitan services

MULTIDISCIPLINARY, PRIMARY CARE AND SPECIALIST-GENERALIST PARTNERSHIPS

- Existing relationships with local clinicians matter
- Primary and community-based care remain central
- Strategically timed input from specialist palliative care clinicians
- Multidisciplinary planning improves coordination
- Local knowledge strengthens continuity and responsiveness

JOE AND MARY

- Local rural GP and community nurses remained central to care
- Regional Palliative Care Team supported local GP and local nursing staff
- In-person and telehealth meetings
- Case conferencing used to discuss symptom management, future planning, equipment needs and transfer pathways

INFORMATION TECHNOLOGY AND COMMUNICATION SYSTEMS

- Telehealth supports timely access to specialist palliative care expertise
- Supports multidisciplinary case conferencing and care planning
- Facilitates communication between geographically dispersed teams
- Supports symptom management and clinical decision-making
- Enables education, mentorship and clinician support
- Strengthens local care delivery rather than replacing local clinicians

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- Shared documentation platform

TIMELY ACCESS TO EQUIPMENT

- Timely access to hospital beds and mobility equipment
- Access to medications
- Equipment being available when needs changed (pre-planning and logistics)
- Supported families to feel they could continue providing care at home

FEELING SAFE, PREPARED AND SUPPORTED

Safety, preparedness and feeling supported shapes rural experiences of dying

- Feeling safe, prepared and supported strongly influenced rural palliative care experiences
- Access to 24/7 after-hours support reduced fear, uncertainty and isolation
- Honest communication and trajectory signposting improved preparedness
- Psychosocial support strengthened coping for patients and families
- Patient and family education increased confidence managing care at home
- Flexible respite and practical support reduced caregiver burden

JOE AND MARY

After-hours support

- 24/7 phone and VC access to regional palliative care clinicians
- Local on-call nursing support during periods of instability
- Volunteer paramedics briefed on Joe's care plan

Anticipatory planning

- Clear escalation pathways
- Planned transfer to the multipurpose service if required
- Respite and terminal care options identified early
- Post-death plans discussed with the family

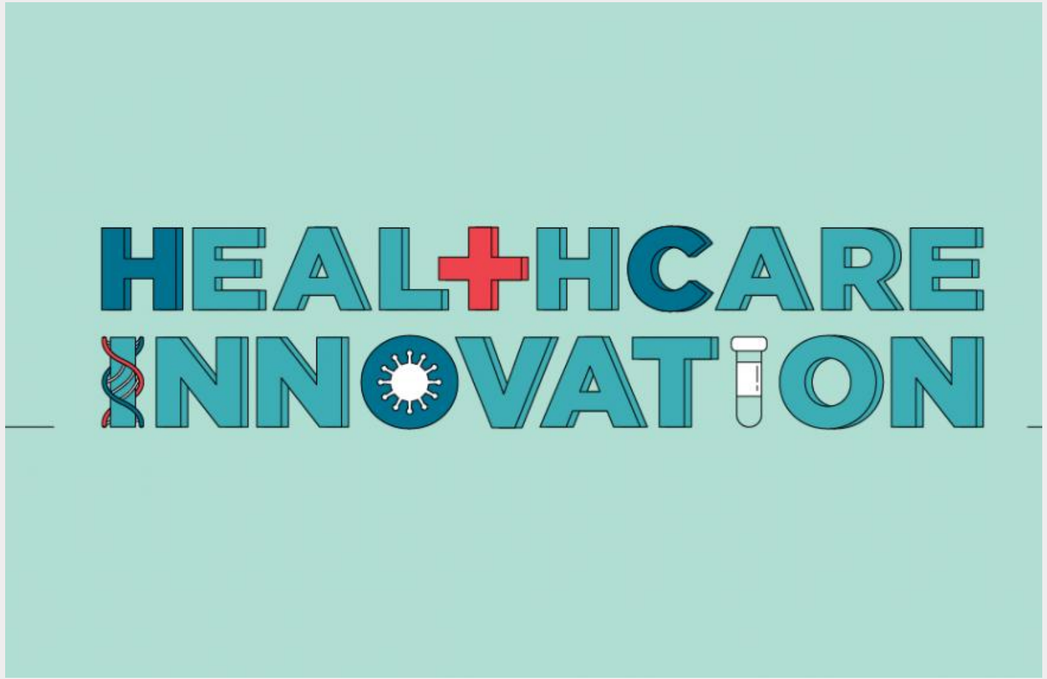
Psychosocial Support

- Ongoing psychosocial support from the regional team
- Bereavement planning with the social worker

COMMUNITY SUPPORT FOR HARVEST

SUSTAINABLE FUNDING ENABLES INNOVATION, EVALUATION AND SERVICE IMPROVEMENT

- Dedicated funding enabled rural service innovation
- Supported development of place-based solutions
- Created capacity for evaluation and research
- Allowed services to adapt to local community needs
- Generated evidence to inform future rural palliative care delivery



FROM UNDERSTANDING TO ACTION

Policy provides the structures through which rural palliative care systems are enabled, coordinated and sustained.

Policy shapes:

- Workforce capability
- Service coordination
- Funding and infrastructure
- Access pathways
- Integration between services
- Education and system priorities

GLOBAL POLICY: STRONG BUT IMBALANCED

Strong areas of focus:

- Workforce development
- Coordination and continuity
- Leadership and service organisation

Comparatively limited policy focus:

- Patients and families
- Community-based primary care
- Frontline rural clinicians

“The issue was not absence of policy –
but imbalance in where policy effort was concentrated”

JURISDICTION-LEVEL POLICY IS CRUICIAL

Jurisdiction-Level Policy

- Tailored to local realities
- Reflects local workforce needs
- Responds to geography and service structures
- Supports implementation and operationalisation

National Policy

- Strategic direction
- Federal funding priorities
- National consistency
- Elevates palliative care as a priority

WHERE TO NEXT?

Current focus

Semi-structured interviews with Australian leaders in:

- Rural health
- Rural palliative care
- Palliative care
- Policy reform

Emerging areas of discussion include:

- Strengthening specialist in-reach to support rural clinicians
- Organising services into hubs, spokes and networks
- Using evidence-based tools to create a shared language
- Building workforce capability through education and partnerships
- Flexible approaches to funding and service delivery
- Strengthening specialist-generalist collaboration

WHAT CAN RURAL CLINICIANS DO?

- Strengthen local capability and confidence
- Build integrated relationships with specialist services
- Use case conferencing and anticipatory care planning
- Use telehealth for escalation, mentorship and education
- Develop flexible after-hours and escalation pathways
- Strengthen trajectory signposting and family preparedness
- Build around existing workforce strengths (“grow your own”)

“Rural capability already exists –
the challenge is how we better support, connect and sustain it?”

SUPPORT FROM METRO

- Build integrated specialist-generalist partnerships
- Provide timely in-reach support during complexity escalation
- Use telehealth to support rural clinicians and families
- Support case conferencing and shared care planning
- Provide mentorship, education and relationship-building
- Reverse-placements into rural settings to understand local realities
- Support local delivery of care rather than replacing it

“The goal is not moving rural patients to expertise – but moving expertise towards rural patients and clinicians.”

EDUCATING FOR RURAL HEALTH

- Ruralise the nursing curriculum[9]
- Use authentic rural clinical scenarios and complexity
- Prepare graduates for resource-constrained practice
- Strengthen rural placements and longitudinal exposure
- Build confidence in communication and anticipatory planning
- Support rural research and workforce development
- Contribute to rural palliative care evidence generation and data collection
- Partner with rural communities and services in research and evaluation

"Rural healthcare should not be taught as a niche exception – but as a core component of nursing education."

POLICY LEVERS FOR CHANGE

- Codesign context-responsive rural policy with rural people
- Recognise rural workforce turnover and itinerancy
- Support housing, childcare and community infrastructure
- Strengthen telecommunication and digital infrastructure
- Support flexible Medicare and Activity Based Funding approaches

BUILDING ON RURAL STRENGTHS

- Rural communities already hold substantial capability, relationships and knowledge
- Continuity, flexibility and local partnerships are existing rural strengths
- Rural clinicians are already delivering complex care in resource-constrained settings
- Sustainable reform requires connection, support and integration around existing local systems
- Future models must remain flexible, context-responsive and community-connected

“The task is to better support, connect and sustain them”

THANK YOU

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