SUBMISSION BY DR WAYNE HERDY.

PREAMBLE.

I am a general practitioner practicing in a regional group practice in South-East Queensland, where I have practised for over 15 consecutive years. I have been in general practice for over 30 years, in suburban or regional practices, solo and groups, and have practiced in seven countries. For at least the past decade, I have regularly had not less than 130 patients on my database in residential aged care facilities, and a greater number of aged patients in the general community. I have served on two Aged Care Panels and acted as Chair of one of those for as long as the GP Aged Care Panel Initiative existed. I am President of one Local Medical Association, Vice-President of another (in which I was the President for four years), and Vice-Chair of a Division of General Practice. I serve on the Medication Advisory Committees of at least seven residential aged care facilities. I am a Branch Councillor of AMA Queensland and represent AMAQ on an aged care committee. I am a Federal Council of the AMA and for at least four years have served on the AMA committees responsible for aged care policy.

I cite the above as indicative of my level of experience. The views expressed herein are my own views, are expressly not stated as representing the views of any of the organizations which I serve or have served, and should not be taken as indicative of the views of any organization.

My contribution is largely focused on patients in a residential aged care facility (RACF), and is confined to a general practitioner (GP) perspective.

1. GP INCENTIVIZATION

It is central to medical thinking that all patients, and especially those with chronic and complex pathology, should have ready access to a doctor. Most of the routine medical needs of residents of RACF can be met by a GP supported by the usual range of medical specialists and allied health personnel (AHP) encountered in typical community environments.

Australian GP's have a long track record of cost-effective and efficient delivery of medical services. The Australian government has acknowledged that GP's are central to delivery of health care in this country. It is a central assumption that GP's will continue to lead primary aged care in the community and in RACF.

Accepting that assumption, a first focus of any enquiry into aged care in RACF should be to facilitate and encourage GP attendances at RACF. This submission does not discuss the workforce shortage issues, a national issue which has a solution in train.

Fewer than 20% of Australian GP's attend RACF's at all, and only around 6% of GP's attend RACF's regularly. The average age of a GP who does regularly attend RACF's is around 57 years, and a majority of those GP's will retire within the next decade. It is critical to encourage younger GP's to adopt RACF as a major component of their practices.

1.1. REMUNERATION

When the GP Aged Care Panels existed, many or most of the 199 Panels developed a business plan to demonstrate that RACF practice could be economically competitive with surgery-based practice. Universally, they demonstrated the reverse, that there is an economic disincentive to select RACF practice in preference to office-based practice.

1.1.1. MEDICAL BENEFITS SCHEDULE REBATES.

The simplistic response is to call for increased rebates for RACF attendances. The Medical Benefits Schedule (MBS) rebate does not strictly determine the fee that a doctor charges. However, in the case of aged care patients, most of whom are not financially well endowed and all of whom are otherwise disadvantaged, there is a strong moral imperative to charge a fee equal to or close to the MBS rebate amount. Most aged care services are bulk-billed.

An alternative frequently discussed among GP's, but rarely implemented, is to charge residents a substantial private fee and expect the patient (in reality, their family) to bear the out-of-pocket cost until the Medicare safety net threshold is reached. After the safety net is reached, the patient qualifies for a larger rebate and suffers less out-of-pocket expense.

If the government were to increase the MBS rebate for RACF visits, the sequel would be an expectation that rebates for all out-of-office attendances would be increased, and then that rebates for office-based attendances would increase proportionately. That is not a solution that government can afford to countenance, but it is an outcome that equity demands.

1.1.2. OTHER NON-FEE-FOR-SERVICE PAYMENTS.

The government preferred approach has been to initiate incentive payments as grants to GP's who perform specific numbers of RACF services per annum.

In my view, the programme is flawed in two ways. Firstly, the quantum offered is really too small to have any material impact as an incentive, relative to a typical GP's annual income. For a GP who has a substantial RACF practice and attends dutifully to those patients, the incentive amounts to less than 50 cents per visit. Second, the thresholds set are far too low, comprising just over one service per week to qualify for the first step, and just over two services per week to qualify for the second step.

A meaningful incentive would be significantly larger. To be a real incentive to accept larger numbers of RACF patients, it would need to have thresholds set at a much higher level. In round terms, I would recommend an incentive ten times the present quantum, with thresholds set at ten times the current numbers of services.

1.1.3. CONTRACTS BETWEEN HEALTH PROVIDERS AND NURSING HOME PROVIDERS

Periodically, the question of service agreements is raised, whereby doctors are invited to contract with the operators of RACF's to provide medical services. Rarely do such invitations provide for financial remuneration. The operators of RACF's simply do not have funding sufficient to pay an attractive professional salary, and usually act as if they have no understanding of the level of remuneration that might be attractive to a potential GP contractor (even though hospital doctor remuneration rates are readily ascertainable).

If a RACF operator wished to employ doctors to exclusively work in the RACF, salary packages comparable to hospital senior staff would be necessary, and sufficient numbers of doctors (at least three) would need to be contracted at any time, to provide for leave allowances and on-call commitments. That represents a million-dollar-a-year commitment. That implies that the RACF operator would be accommodating a very substantial number of patients, at least a few thousand, and presumably dispersed among several locations. Such an option would only be open to a large operator of a series of RACF within a confined geographic area.

If a RACF operator wished to contract with a GP for part-time services, the remuneration would necessarily be attractive, and under present arrangements RACF's are simply not funded to pay GP's. Until RACF's are funded to provide adequate nursing staff, it is difficult to envisage the government providing funding sufficient to offer any incentive payments for enhanced medical services.

1.2. WORK CONDITIONS

Surveys of GP's regarding attitudes to attending RACF's universally demonstrate that the disincentives and dissatisfactions relate strongly to work conditions. In order to make RACF practice a realistic alternative to office-based practice, the work conditions would have to be comparable with office practice, including:

- a dedicated and accessible car park
- ready 24-hour access through secure doors
- an office equipped for GP practice
- ready access to patients
- ready access to files
- ready access to a trained nurse familiar with patients
- computer equipment with software designed for GP requirements
- an examination area and couch and basic examination equipment.

Doctors entering RACF practice usually seek to integrate the RACF practice with their office practice, with partial success at best. GP's who have extensive RACF practices have implemented various structures to accommodate the above areas of practical concern. All involve compromises. Since the industry standard for general practice involves computerized practice with a high level of interface with other providers, especially pathology and imaging specialists, that same standard must apply to RACF practice. I am not aware of any practitioner whose RACF practice meets the technology standards now accepted as the norm in office practice.

Round-the-clock access to GP services is an ideal that is not met in office-based practice, but a reasonable compromise is available to over half of Australians, mostly urban-dwellers, by the machinery of after-hours deputizing services. In RACF practice, the GP is assisted by having

nurses monitoring patients. The information available on initial telephone contact has not been provided by a lay person but has been refined and appraised by another health professional before the doctor is called. However, the quality of information offered to the doctor is variable [see 4.3 below re RACF nurses and admissions to hospitals]. Agreements with respect to after-hours cover would need to be acceptable to both the GP and the RACF operator, and give patients ready access to safe quality medical services.

The AMA has advocated that it should be an accreditation requirement for RACF operators that they have resources and protocols to ensure that all patients admitted to a RACF have assured access to medical care. The factors mentioned above are described to illustrate what GP's would seek in order to enhance that access. The most important of these is access to IT and IM comparable to the office norm.

1.3. PROFESSIONAL INCENTIVES

Governments often fail to recognize that a major incentive for professionals is the opportunity for professional satisfaction, which in some cases outweighs any considerations of remuneration or work conditions.

GP's who have substantial RACF practices would feel that their work was valued if they were able to achieve appropriate recognition. The accepted forms of professional recognition for classes of doctors (as distinct from individuals) are teaching privileges, research opportunities, academic recognitions, and more specific remuneration.

Teaching opportunities are often enjoyed by doctors as an expression of recognition of their worth. In the current context of inadequate training resources and training places for pre-vocational and vocational training for the still-increasing numbers of medical graduates, RACF's represent an unequalled opportunity for training in expanded settings. Teaching also offers opportunity for augmenting GP's incomes from an education budget rather then from the health budget.

GP's are time-poor professionals but many would welcome the opportunity to undertake or be involved in research projects. This should be supported by appropriate research grant funding. Since GP's are not research-oriented, most would welcome administrative and statistician support, which could well be provided through specific funding of their learned College, a University department, or a Division of General Practice.

There is at present no regular opportunity for GP's to undertake formal post-graduate training in geriatric practice. GP's would value having a career structure built around obtaining a certificate or diploma level qualification in aged care and/or palliative care.

The value of holding such a qualification would be greater if it were rewarded financially, e.g. by being a pre-requisite for the annual aged care incentive payment. [There is a precedent for this proposal. GP's need to hold a certificate-level qualification in mental health in order to qualify for payment for mental health MBS item numbers.]

2. USUAL TREATING DOCTOR

Doctors are generally opposed to the idea of patient registration or enrolment, mostly because it is an avenue to capitation or other payment methods which are not based on fee-for-service. However, we recognize that many of our patients, especially the aged or disabled, are *de facto* "registered to" or "enrolled with" a usual treating doctor (UTD), in the sense that they rarely seek primary care from any other GP.

GP's commonly complain that other doctors, especially those in walk-in clinics and larger corporate practices, usurp a function of the UTD, in that such clinics often write a Health Assessment (HA) and Care Plan or the like without having any long-term commitment to the patient. The UTD then is faced with uncertainty about fragmented care, often not knowing whether EPC referrals to AHP have been written or how many of the limited number of EPC-referred AHP services the patient has actually used. Further, if the UTD does write a HA and Care Plan, they will not be paid a MBS rebate for those services.

Similarly, Medicare will not pay the rebate for a Comprehensive Medical Assessment (CMA) performed by a GP on admission to a RACF if the patient has had a CMA performed by another GP in another RACF in the previous 12 months.

The UTD provisions have been relaxed by Medicare only a little. The real UTD can now telephone Medicare to ascertain whether a named patient is eligible for a HA and Care Plan, i.e. to determine if another GP has performed a HA and Care Plan in the previous 12 months. However, there is no provision to prevent a casual GP contact from claiming for a HA or Care Plan, nor is there any provision to permit a UTD to write (and be paid for) a subsequent HA and Care Plan within the expiry period of the other HA and Care Plan.

I propose that a structure should be created whereby (without introducing patient registration or enrolment) Medicare recognizes a specific GP as the patient's UTD based on pre-determined criteria, such as a history of prior contact over not less than 3 months, or admission to a RACF under a new GP who intends to care for that patient for the duration of the RACF admission. With regard to the latter, if a patient has a CMA written by a GP in one RACF, and transfers to another RACF under another new GP, the second GP should then be recognized as a new UTD and the patient should be eligible for rebate for a new CMA, even if the transfer is within 12 months of the earlier CMA.

2.1. GP'S AS THE REGULAR DOCTOR IN RACF

A universal finding by the Aged Care Panels was the dilemma caused by GP's who attend RACF's where they have only one or two patients. A contrast was drawn with those GP's who had significant numbers of patients at the RACF.

A GP who has only one or two patients at a particular RACF poses several practical problems such as:

- with few patients in a location remote from the office, a GP is less likely to regularly attend the RACF
- the GP and RACF do not have a stable ongoing relationship and so have less effective communication
- the GP who is not a regular attender at the RACF is working in an unfamiliar environment, unfamiliar with the systems of access to rooms, the staff and their capabilities, the records system and the medication order forms, and with other protocols

- the GP and pharmacy do not have a regular or close relationship, so the communication lines for medication changes and prescription demands and writing are less secure and more likely to frustrate the GP and pharmacist and RACF staff.

The converse applies for a GP who has a large number of patients at any RACF. Familiarity with all aspects of the workplace enhances efficient functioning and quality and safety of care.

Further, a GP who attends any RACF frequently is likely to be asked by staff to attend to casual consultation with another GP's patient for an acute episode. This occurs most commonly where the patient's UTD is known to be a poor attender or is not expected to attend the RACF within a reasonable period of time.

In short, the GP with small numbers of patients at any RACF is an encumbrance to himself and the RACF and the patient, and cannot provide the mechanical functions of RACF attendance as well as can be provided by a GP who has a close affiliation with the RACF. In my experience, most RACF's have over 90 per cent of their patients serviced by two or three GP's. In my experience, the facility and the patients are best served, especially with respect to casual attendances or mutual cover for planned absences such as vacations, where three GP's care for the entire resident population in that RACF.

However, there are good reasons why GP's attend RACF's where they have only one or two patients. Most commonly, it is because the GP has been caring for the patient in the community prior to admission to RACF, and both GP and patient wish to continue the established relationship.

There is an underlying ethical principle that patients must be free to choose the doctor of their choice. While I would not suggest that such an ethical principle should ever be compromised, the outcome is one which creates material inconvenience to all carers and compromises safety and quality of care. I offer no solution to that ethical dilemma.

Most patients admitted to RACF find themselves in locations too far from their UTD, or find that their UTD does not attend that RACF. Over 90 per cent of patients admitted to RACF are admitted under the care of a GP who already attends the RACF but has never encountered that patient before. Most patients therefore have their care transferred to a new GP. In practice, the patient or family are usually given a list of GP's who attend the RACF, and offered a choice. Since families often reside near the RACF (which is commonly the reason for selecting a particular RACF even if remote from the patient's former home), they are sometimes able to make an informed choice of GP from local knowledge. However, in most cases, the selection of GP is virtually at random. Alternatively, some RACF's automatically admit a patient under the GP whose patient previously occupied the now-vacant bed. Although the RACF correctly should ask the GP whether they are prepared to accept an incoming patient, invariably the GP who is a regular attender at the RACF does accept all new admissions. With a considerable amount of pressure on the time of GP's who regularly attend RACF's, this type of *ad hoc* arrangement for allocation of patients to GP's works remarkably well.

The Aged Care Panels performed a number of assessments to determine the most efficient number of patient for a GP to attend at each RACF visit. It is my understanding that the greatest efficiency was achieved with at least 8 patients per visit. This was partly influenced by the prevailing MBS rebate, which distributes the supplementary visit fee according to the number of patients attended, but the MBS was not the determinative factor.

3. COLLABORATIVE TEAM ARRANGEMENTS

3.1. PRACTICE NURSES

The AMA has sought to persuade government to extend the roles that Practice Nurses can perform, on the basis of for-and-on-behalf-of the GP, with MBS rebates payable to the GP who employs the practice nurse. This is a principle which has worked extraordinarily well in the case of GP's employing PN's to perform tasks such as vaccinations and wound dressings. It has been proposed that the principle be extended to PN's having part of the GP's role delegated to them in the RACF environment.

This is a principle which I endorse. However, I do not believe that the attendance of a PN will extend the workload capability of a GP in RACF's unless the GP is attending a significant number of patients at each visit. Trial will be required to illustrate the minimum number of patients required to justify a PN attendance for each visit, but I anticipate that the efficient number will be not less than 8 patients, and more likely of the order of 20 patients. I refer to my arguments above with respect to UTD's, and GP's as the regular doctor in RACF.

The government proposes to cease the present Practice Nurse item numbers in the MBS and replace them with an annual grant. If this proposal is enacted, any similar item number for PN attendances at RACF's is not likely to eventuate.

3.2. NURSE PRACTITIONERS

Nurse Practitioners (NP's) are different from PN's. They are trained to a higher level, and expect to work in an independent role, not in a delegated role. There is an expectation that NP's will be employed in the RACF environment to reduce the workload of GP's. It is very difficult to envisage how this could be practicable. There are many functions that a NP could not perform without the intervention of a GP, e.g. writing death certificates. NP's would have to work in collaboration with a GP. It would be unlikely that a single GP could justify the services of one NP even if the GP were exclusively devoted to RACF practice. It seems cumbersome to expect that two or several GP's attending one RACF could coordinate their activities to collectively justify the services of one NP. It is possible to envisage that a NP would be employed by the RACF with the intent that the number of telephone calls and emergency department referrals. However a NP were to fit into the RACF environment, it would be an essential pre-requisite that the NP share the nursing and medical records – any other arrangement would fragment information, fragment care, and introduce additional dangers affecting quality outcomes.

3.3. EPC ACCESS TO ALLIED HEALTH PROFESSIONALS.

The current MBS provides that a GP can write a Care Plan and Team Care Arrangement (or in the RACF a Comprehensive Medical Assessment and contribution to Team Care Arrangement), as a consequence of which the patient qualifies for Extended Primary Care (EPC) access to an Allied Health Professional (AHP) but only for 5 services in 12 months. Statistically, most patients (statistics encompass mostly patients in the wider community) only utilize an average of 3 of those potential AHP services. However, patients with complex and chronic diseases,

including most aged care patients whether or not they reside in a RACF, require many more than 5 services per annum from the several classes of AHP envisaged in the programme.

I propose that the number of AHP services accessible under an EPC Team care Arrangement should be uncapped, or at least the cap set at a much higher level. Experience has been that most patients will still continue to access only 3 services per annum, but those patients who have highest need will have access to services most appropriate to their medical conditions.

3.4. PHARMACY

In 5 below, I will outline the customary relationship between GP and pharmacy. It is salutary to remark at this point that the relationship of pharmacies requesting prescriptions (with a high error rate which wastes the GP's time) and GP's providing prescriptions (with a high rate of untimely prescriptions, which compromises the pharmacists' business plan) produces tension between the two professions that is unproductive and unnecessary.

Another source of tension between GP's and pharmacists is the all-too-common practice of generic substitution of prescribed medications. Doctors are especially sensitive to pharmacists making successive generic substitutions, which we believe to be motivated by profit motives in the face of potential health risks created by generic substitutions.

Pharmacists are health professionals with their own roles, and structures should be in place to incorporate them as members of the health team. Presently, they participate in preparing Residential Medication Management Reviews (RMMR's) but otherwise participate very little in a collaborative way. Whatever collaboration does occur is on an individual basis, not in a structured way comparable to the current policy of pharmacists being present for hospital ward rounds.

3.5. ROUND-THE-CLOCK PHARMACY

RACF's have a problem with obtaining after-hours pharmacy supplies. Some GP's habitually visit RACF's after-hours, others do so on a demand basis. If a medication is added or changed, the RACF should have the capability to put changes into effect immediately. I believe that most after-hours changes involve prescriptions for antibiotics for acute infections.

Most RACF's have an imprest arrangement with their contracting pharmacy, which provides a supply of the most commonly prescribed after-hours medications, held on the RACF premises. For most patients, this arrangement is adequate, although there are technical issues which have not been clearly confirmed to be legal.

A problem arises if the GP orders a medication which is not routinely held in the imprest stock. In my experience, this most commonly occurs with late-stage palliative care patients, in whom late-night medication changes are not uncommon.

The most common protocol is:

- the RACF staff contact the pharmacy
- the pharmacist attends his dispensing pharmacy and dispenses the required medication

- the medication is dispatched, often by taxi – this is further problematic, since it is now commonplace for RACF's to contract with a pharmacy that is a considerable distance from the RACF, so it becomes a matter for negotiation whether a substantial taxi fare will be paid by the pharmacy, the RACF, or the patient.

A less common protocol is that the contracting pharmacy, if remote from the RACF, will have an arrangement with a local pharmacist to dispense after-hours medications. Less commonly, a member of the RACF staff will physically attend a local pharmacy to obtain supply.

Whatever the arrangement, it occasionally arises that the pharmacy that contracts to service the RACF has to create an *ad hoc*, sometimes unsatisfactory, and sometimes expensive solution to the problems of providing round-the-clock medication supplies. The *ex tempore* nature of the pharmacy supply under such circumstances should be addressed in a formal agreement between the pharmacy and the RACF.

3.6. HOSPITAL DISCHARGE MEDICATION PROTOCOLS.

The process of discharge from the acute sector to the community sector, including RACF's, is being refined as a separate process with an intent to make the transfer as seamless and safe as possible.. The transmission of information is improving, especially electronic communication of discharge summaries. Often that depends on recognition of the identity of the UTD. The overall discharge process does not require further comment in the light of that evolving process, with one exception.

About a third of RACF patients discharged from the acute sector are re-admitted within two weeks. About 80% of those re-admissions are due to medication errors. Most of those medication errors are due to failures of communication between the discharge process and the community pharmacy. Most of those errors are avoidable by a simple process developed by the Redcliffe Hospital pharmacy and the Aged Care Panel that then existed in that region. The protocol involved a simple exchange of information between the hospital pharmacy and the community pharmacy. I recommend that State departments of Health re-visit alternatives for discharge medication safety.

3.7. MEDICAL SPECIALISTS

Access to medical specialists for aged persons in the community is dictated as much by logistic limitations (transport, escorts) as by the workforce limitations. Assisted transport from home or RACF to specialist rooms and back is a valuable community resource which is most commonly performed by volunteer organizations, who usually also act as escorts and physical enablers. Formal recognition and funding of community-based transport resources will facilitate access to medical specialists.

This is especially so for RACF patients, where the transport requirement might be disabled taxi or ambulance and the escort might be nursing-trained and salaried. The cost of those resources is most commonly paid at the patient's expense. This creates an additional barrier to access.

There is as little incentive for specialists to depart from office-based practice as there is for GP's. Whatever incentives are available to encourage GP's to increase RACF practice should also be available for at least those specialists which aged persons need most, viz geriatricians, dentists,

and ophthalmologists. In my experience, major enhancements to RACF practice can be made by availability of a visiting general surgeon, but I do not anticipate that surgical specialists will find RACF practice attractive under any circumstances.

The medical specialist who is potentially most use to a GP in RACF practice is a psychogeriatrician or psychiatrist with special interest in aged care. This is a workforce shortage that, in my opinion, is most acute, and must be accommodated in future workforce planning.

4. NURSING STANDARDS AND STAFF RATIOS

There is an increasing trend, driven by financial imperatives, to reduce the staff/patient ratios.

There is also an increasing trend to employ nurses whose skills and experience are inadequate for the task. While most nurses in the aged care sector are highly dedicated to their task, not all are adequately trained or fully qualified to perform the duties assigned to them.

The training, experience, and skills of RACF staff is variable, but there is an ever-increasing trend towards fewer Registered Nurses (RN's), more Endorsed Enrolled Nurses (EEN's, who are usually accredited to administer medications), more Enrolled Nurses (EN's), and sadly an increasing trend to rely on untrained Personal Carers (PC's) and volunteers. There is an increasing trend to assign skilled duties to staff unqualified to perform those duties.

There are three main reasons for this trend:

- aged care work has an undeserved reputation for being hard work and is traditionally unpopular with nursing staff
- there is a global nursing workforce shortage
- RN's in the aged care sector are paid under different awards from RN's in the acute sector and are typically paid about $300 per week less than RN's performing similar duties in the acute sector.

4.1. NURSES' PAY SCALES.

The third factor is one which must be addressed by the Productivity Commission. Today's RACF admission is a patient who commonly transferred direct from the acute sector, has an average age around 85 years, and suffers from complex and chronic multiple pathology, with a typical life expectancy of less than one year. The type of patient and medical dependency encountered in RACF's today is comparable to the nursing demands encountered in an acute medical ward. If the nursing demands and responsibilities are comparable, then the wage structure should be comparable, if not the same.

The undesirable sequelae of low pay scales include:

- nurses with higher skill levels and experience are more likely to choose work in the acute sector than in the aged care sector, thus focusing the nursing workforce shortage onto the RACF sector
- RACF's have a high degree of reliance on agency nurses.

Anecdotally, I believe that many of the nurses who accept the lower pay scales of the aged care sector do so motivated by genuine dedication to the patients and the sector. It is reprehensible that RACF operators and their government funders exploit such a culture of genuine care.

4.2. AGENCY NURSES

Agency nurses require special consideration. They do not know the patients. Like GP's who infrequently attend RACF, they are unfamiliar with the work environment, including documentation and protocols.

Importantly, it has been my experience that agency nurses are overly ready to transfer RACF patients to hospitals. Since many RACF patients have medical conditions comparable to patients in the acute sector, some nurses have a low threshold for referral to emergency departments. Many of those referrals are inappropriate:

- the patient's condition might be an expected progression of existing conditions
- the patient's treatment plan might be based on a palliative approach, with no intent to transfer to the acute sector
- the patient's condition might mean that referral to the acute sector is futile
- agency nurses tend to transfer patients to the acute sector without prior contact with the UTD or any other medical assessment and advice.

4.3. RACF NURSES AND ACUTE HOSPITAL ADMISSIONS

It has been my experience that those nurses are reluctant to continue to provide high levels of care to sicker patients in RACF, the reasons including:

- the pay scales do impact on the quality of nurses in RACF
- RACF have a high reliance on agency nurses
- diminishing staff/patient ratios discourage nurses from continuing care of sick patients in the RACF environment.

The outcome is a high rate of inappropriate referrals to the acute sector, with consequent excessive consumption of resources, including ambulance transport resources.

If one accepts a ballpark estimate that at least one third of referrals from the RACF sector to emergency departments could have been avoided by encouraging nurses in RACF's to exercise better clinical judgement and to accept responsibility for the clinical conditions for which they were trained, and if GP's were consulted more closely before transfers from RACF to emergency departments, a substantial unnecessary workload could be eliminated from the input side of emergency room work.

5. E-HEALTH AND EFFICIENCIES.

In 1.2 above, I referred to the provision of computers for GP use in RACF. Since computers are now accepted as a benchmark of quality GP practice, both for efficiency of work effort and for enhanced quality and safety of care, this issue needs no further expansion.

However, one issue of e-health does call for expansion in this context, the question of e-prescribing.

Most RACF's contract with a pharmacy to supply prescribed pharmaceuticals to all (or, recognizing the ethics of patient choice, most) of their residents. The most common protocol is:

- the GP to writes a medication order in the form adopted by a particular RACF
- the medication order is communicated to the community pharmacy
- the community pharmacy dispenses and packs the medication in a form and a generic familiar to the nursing staff of the RACF
- the pharmacy issues medication documentation in a format familiar to the nursing staff of the RACF
- the pharmacist sends a request to the GP for a prescription, whether PBS or otherwise
- the GP writes the prescription, usually at an office location remote from the RACF, and transmits the paper prescription to the pharmacy by a mutually negotiated means
- the pharmacy issues requests for new prescriptions as the need arises when scripts are due, but with a high error rate in practice and often with poor timing especially for renewed prescriptions for authority items or scheduled drugs such as opioids.

It has been my experience, which anecdotally is universal across the country, that renewal of prescriptions is a major time-consuming activity for GP's who have substantial numbers of RACF patients. I estimate that elimination of this one task would effectively save the equivalent of more than 100 FTE GP's across the nation. [If I have an average of 130 patients in RACF, and my prescription writing consumes at least 3 hours every week, 147,000 RACF patients across the country implies about 110 40-hour weeks of GP time.]

Provision of electronic prescribing with direct transmission to community pharmacies would:

- create significant GP workforce efficiency
- create significant pharmacist workforce efficiency
- reduce the financial and dissatisfaction disincentives for GP's to adopt RACF
- enhance security of medication supplies to RACF patients
- reduce errors and enhance safety in RACF medication supplies.

An alternative to e-prescribing is chart-based prescribing, wherein the medication order displaces the need for a PBS prescription. This has hazards of its own, particularly the risk that medication orders will not be sufficiently reviewed by the prescribing GP and/or that pharmacies can continue supply when the clinical need has passed. However, as an efficiency measure, chart-based prescribing should be recommended as an interim measure until such time as e-prescribing has been refined and is widely adopted.

6. SPECIFIC ISSUES.

6.1. INDIGENOUS AGED CARE.

Although the gap in life expectancy between indigenous and non-indigenous Australians is widely accepted to be 17 years, anecdotally it appears that there is a greater gap in the age of admission to an aged care facility. The average age of admission of a white urban Australian to an aged care facility is 85 years. The average age of admission of an indigenous patient to a rural equivalent appears to be under 65 years, a gap of at least 20 years.

Logistically, more indigenous Australians are admitted to RACF situated far from their homes. Family visits are much more difficult, especially in rural areas where the distances are measured always in hundreds of kilometers. To offset this, it is my experience that indigenous Australians in remote areas are much more likely to be admitted to a non-residential day respite facility in their homelands than to be admitted to a RACF in a distant location. It is surprisingly difficult to ascertain how many day respite centres exist, but it seems that a majority of small remote communities have, under local indigenous management, come to a local solution. This is the outcome of an excellent National Respite Carers' programme which should be encouraged and expanded.

Culturally, indigenous Australians admitted to a RACF are more disadvantaged than white Australians admitted to a RACF. There is no single aboriginal nation; there are around 200 skin groups or language groups across Australia. Aboriginals admitted to a RACF are very likely to find themselves being cared for by nursing staff, even if they are aboriginals themselves, who cannot speak their language. They might even find themselves being nursed by aboriginal health workers who, in traditional culture, should be in an avoidance relationship with them. A locally planned and managed culturally sensitive facility should be developed wherever possible. It is most likely that this is practicable only by an expansion of the day respite centres that already exist in many small remote communities.

6.1.1. ETHNIC COMMUNITIES

As a corollary to the discussion of indigenous aged care, there are very few RACF in Australia thay accommodate ethnic groups.

Older patients often lapse into their mother tongues and, apart from the language issue, usually feel more comfortable spending their declining days in facilities which specifically reflect their ethnic or linguistic or cultural backgrounds. In a multicultural Australia, this factor must not be forgotten, even if the solution is economically non-viable.

6.2. YOUNG PEOPLE IN AGED CARE.

There are many young people (e.g. under 65 years) who reside in RACF even though that environment is ill-equipped to accommodate them. They are there because there is no other facility able to meet their needs. Young chronically disabled patients are much less populous than aged people, and in most of non-urban Australia there is insufficient population density of young disabled to justify building a dedicated facility.

The young disabled are likely to survive for many years in supported nursing accommodation. The average length of stay for an aged person admitted to a RACF is less than a year. The young disabled seek and need resources such as lifestyle and rehabilitation. RACF provide lifestyle

resources unsuited to younger patients and are geared towards palliation, not towards rehabilitation.

6.3. ACAT ASSESSMENTS

Assessment by an Aged Care Assessment Team is a necessary pre-requisite for application for subsidized admission to a RACF. At present, the waiting time for routine outpatient assessments by ACAT is measured in weeks to months. There is a further delay from the time of ACAT assessment to the time of admission, which is determined by bed availability.

In urgent cases, such a long delay is unacceptable. Urgent cases include those in which the patient has been coping adequately in the community but there has been a change in circumstances. The changed circumstances might be brought on by an acute medical event, or by unexpected loss of an existing support structure. The changed circumstances might be short-term (such as the illness of a carer) or long-term.

ACAT assessments are commonly performed on patients in acute hospitals, typically where a patient has been admitted from the community after a fall or illness which has altered their circumstances in such a way that they are likely to be decompensated to a degree that they are unlikely to return to the community. Hospital assessments are usually performed at short notice and are necessary to reduce occupation of acute beds by patients whose needs are for long-term care.

GP's believe that they should be granted the function of an ACAT assessor, at least for RACF admissions which are expected to be short-term. GP's usually have extensive knowledge of the patient's functional capacity and the durability of existing carer support. The patient's usual treating GP is most likely to be the GP caring for the patient during a short-term admission.

I propose that GP's should be granted the power to determine an ACAT-like assessment for brief RACF admissions up to 4 weeks. If events evolve to indicate that the admission is likely to evolve into a long-term admission, the existing ACAT resource can be mobilized at leisure to re-assess the patient and issue a long-term ACAT assessment.

6.4. TRANSITION ISSUES.

It is a universal finding that patients never want to go into residential care. Ideally, patients would transition progressively from home to independent retirement village to supported individual accommodation to low-care to high-care RACF. It is my opinion that most patients wait until very late before accepting each successive step and eventual admission to RACF, often under emergency conditions. Aged persons have reduced intellectual flexibility, often take the next step into higher levels of care after their reserve capacity to adapt to the change has been exceeded, and it is my opinion that they should be encouraged to accept the transition in accommodation. I believe that this will only be achieved on a population in the long term by a change of culture to acknowledge the need to change before the next level of dependency is reached.

While I strongly support the principle that all should be encouraged to exercise the highest levels of autonomy, it is my impression that most patients wait too late before relinquishing any independence.

I believe that many patients defer accepting assistance because of a traditional view of substandard nursing homes, a view which some modern nursing homes have failed to dispel.

Dr Wayne Herdy