Submission to Productivity Commission

Caring for Older Australians

From Dr Robert Hoffman

29th July 2010-07-29

The number of RACF residents and facilities are growing and will continue to grow.

RACF's in general find it hard to attract committed GP to provide GP services to RACF residents. This problem will only get worse.

Busy GP's find it hard to commit to RACF – and when they do – are able to provide regular routine services well. However, unexpected issues are often unable to be dealt with in a timely fashion – requiring the doctor to visit at the end of a day in the surgery. In the evening, a locum can be called. More often, the response of a RACF to this delay in a GP attendance is to send the patient to an ED via ambulance. This is done out of an abundance of caution.

I have come from a busy general practice and found that I have been increasingly providing services to RACF – so much so that I now do it full time. I seem to have stumbled upon a model of aged care that few seem to have. I serve about 200+ residents in 12 RACF mostly within a narrow geographical area in the north of Melbourne. My average age of resident would be well over 80 years old. They range from a psych-geriatric unit to hostels. I work closely with local resources provided by the local health networks, and have excellent contacts with relevant specialists.

The upside for me is...

- I enjoy it
- By focussing on aged care I am increasing my skills in this area – for example management issues around the behaviour problems of dementia.

The upside for the RACF is...

- They can be confident of seeing me with almost immediately after an urgent call – or within a few hours if not so pressing.
- Less likely to need to send residents to hospital.

The upside for the resident is...

- Less likely to be hospitalised.
- Probably see me more frequently that a "practice" GP. I aim to see all residents monthly, and those who are sick – more frequently.

One aspect that I find interesting, is that other GP's, who get to know me, are comfortable to my being a "daytime" locum – for when their residents become unwell.

I am looking to have a Nurse Practitioner join me at some stage – but they are few on the ground in this area. This is a pity – as Aged Care is well suited to a collaborative model of Doctor-Nurse Practitioner.

The problems I find are mainly bureaucratic and cultural.

Government incentives can be problematic. There is an incentive program to encourage GP's to visit RACF. It is worth some $5,000 per year maximally. As I am no longer part of an accredited practice, I don't qualify. In my case it does not affect my willingness to practice as I do – but it is worth commenting on.

Another bureaucratic concern: my practice profile will be quite outside the normal GP profile, fewer consults that a typical GP with more complex consultations.

Many GP feel that by focusing on one area, I have ceased to be a "proper" GP. A similar problem confronts doctors who focus on skin cancers, men's health or indeed any special interest group. This is a cultural problem that needs to be worked though in the FRACGP. However, I have been in General Practice since the mid 1980's – so I feel I have no need to justify myself. Younger GP's may find a different response.

I am putting my experience forward as another style of practice that will I am sure be more attractive to doctors as the need grows for GP's to work in RACF.