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Mr Mike Woods
Deputy Chairman
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Productivity Commission Inquiry into Caring for Older Australians

Dear Mr Woods

I am pleased to provide the Productivity Commission with the Australian Medical Association (AMA) submission to the Commission's inquiry into Caring for Older Australians.

The geriatricians, old age psychiatrists, general practitioners, and rehabilitation and palliative care specialists that met with the Productivity Commission inquiry team in Canberra on 2 July 2010 were very appreciative of the opportunity to present their views on how to improve access to medical care for older Australians. The AMA hopes that the team found the extensive consultation with the doctors, who care for older Australians every day, informative and valuable to the inquiry.

The AMA submission to the inquiry is based on AMA policies and the key issues discussed during the consultation.

Yours sincerely

Dr Andrew Pesce
President

9 August 2010

ap:sc

AMA

AMA Submission to Productivity Commission Inquiry into Caring for Older Australians

Introduction

Demand for health care services to meet the needs of older Australians is growing rapidly. Future generations of older people are likely to have more complex health care needs and expect a higher quality and level of service. There will be an increasing preference by older Australians to live and be cared for at home wherever possible and for as long as possible.

One of the critical requirements for quality care for older Australians is timely patient access to a doctor. With the number of older people (65 to 84 years) expected to more than double from 2.6 million to 6.3 million, and the number of very old (85 and over) to more than quadruple from 0.4 million to 1.8 million, between 2010 and 2050, there is a clear imperative for the Australian Government to develop a sustainable service delivery framework to provide access to medical services for older people in the community and residential aged care. "Medical services" means services provided by a medical practitioner.

Improving access to medical services for older people who live in the community and residential aged care will reduce unnecessary hospital and emergency department admissions and improve the quality of care. The interface between the aged care sector and medical practitioners must be timely and functional. Adequate incentives must be developed, and access to nursing and allied health services must be improved, to support the medical workforce to provide medical care to older Australians living at home and in aged care facilities.

Community Care

For the many older Australians living at home, access to community care is essential to support them to maintain their health, well being and independence and to continue living in their own home when they might have otherwise needed to move into residential aged care. Access to regular medical care and supervision is an essential component of their care needs.

General practitioners (GPs) are the primary medical care providers for older people living in the community and form long-term relationships with their patients and their families. They play a crucial role in managing and coordinating care for an older person.

However current Medicare benefit arrangements do not reflect the time it takes to provide care to older people with chronic long-term conditions and do not cover the costs of delivering medical care outside of the doctor's surgery. As a result, home

visits no longer feature in general practitioner care as much as they once did. As older people seek to live independently in their own homes rather than move into residential aged care facilities, there will need to be greater support for providing medical care in the community setting.

Government funding arrangements must support models of medical care where the doctor goes to the patient, rather than the patient goes to the doctor. The Department of Veteran Affairs has a number of good service delivery models in place that could be translated more broadly into general practice.

The delivery of medical care to older people outside of the doctor's surgery, including models of care where the doctor delegates tasks to practice and/or specialised nurses, and/or other health practitioners within a team based model of care, will have an immediate impact on improving access to medical care.

For example, a practice or community nurse could regularly visit an older person living at home with a chronic condition and liaise with the doctor to ensure they have access to timely medical care, allowing them to maintain their health and independence and continue living at home.

In the case where an older person living at home becomes very unwell, a practice or community nurse could step up the number of visits and care provided to the older person in addition to a doctor's visit, and in consultation with the doctor. Such a model would improve the care of older people, prevent inappropriate hospital and emergency department admissions and free up acute care resources.

This could be better facilitated if the Medical Benefit Schedule (MBS) reflected:

1. the complexity and significant amount of clinically relevant non face-to-face time involved in providing medical care and medical supervision to older Australians who live in the community;
2. a team-based model, including expanded roles for practice nurses acting for and on behalf of the GP's; and
3. the true cost of providing services to older people who live either at home or in residential aged care.

There are some rural models offering seamless access to care i.e. Multi-purpose services; district nursing services. We need to explore the possibilities of adapting these models for use in urban areas.

Entry points to care

Right now there is no clarity about where and how an older person living in the community who needs a range of medical, health and community care should enter the system to receive that care. Patients who enter at different points can have a variety of different outcomes. AMA members report that access to community care services is often impenetrable for older people and health care professionals. Often community care is divorced from the rest of the health care system and lacks direction or coordination. Delayed access to community care increases the risk of unnecessary hospital and emergency department admissions and all too often, care for an older person is only arranged in a crisis situation.

Australia needs a solid plan for the future care needs of older Australians and mechanisms for connecting the person with the medical and health services they need when they need them. Entry points into community care must be clear, and coordinated service delivery models that streamline access to medical care and related services must be developed.

Aged care assessment

The current aged care assessment arrangements fall short on efficiency and responsiveness to the care needs of older people. The effectiveness of the aged care assessment process can be improved by including the patient's usual medical practitioner in the assessment arrangements.[1] Our members tell us aged care assessment currently makes little use of the information doctors can provide about their patients. Medical practitioners form long-term relationships with their patients and an older person's usual doctor can bring his or her background knowledge of the whole person and their current circumstances to the assessment process. This information would ensure the person's assessment results in them receiving the care that is most appropriate for them, be it community or residential aged care.

Respite care

Demand for respite services is likely to increase over the next ten years as the trend toward community care increases and the carer base diminishes. The need for respite care usually occurs when the carer has become unwell and/or is temporarily unable to provide care. In these situations it is often very difficult to access to respite care.

Approval for respite care depends on a formal Aged Care Assessment Team (ACAT) assessment. In some jurisdictions, difficulty in accessing an ACAT assessment means it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the patient to hospital in order to give the carer some relief. This causes great distress for patients and their carers, and risks delivering respite care that is inappropriate both in timing and in the nature of care given.

A streamlined process is required to improve access to respite care for people who have not yet been assessed by an ACAT or who have not yet entered the aged care system. GPs who work in aged care know their patient's circumstances and requirements. In these circumstances, access to respite care could be streamlined by allowing GPs to approve respite care for older people in need of urgent respite care in much the same way a doctor determines that hospital admission is necessary.

Transport

As more very old Australians continue to live in their own homes, their ability to access to services will need to be better supported through transport schemes that provide older Australians with access to medical and other health services that cannot be delivered to them.

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[1] AMA submission to the Senate Community Affairs Committee on the Aged Care Amendment (2008 Measures No.2) Bill 2008.

Residential aged care

Many residents are transferred into residential aged care facilities from hospital after a long and complex admission, and have multiple and complex health care needs that require ongoing medical care. In the future, residential aged care will need to develop the capacity to provide a range of services - residential, respite, sub-acute and transitional care – and have the flexibility to provide services as the health care needs of residents change.

Doctors are not traditionally counted as part of the aged care workforce. Yet access to ongoing medical care for people living in residential aged care facilities is fundamental to achieving good health and quality of life. Doctors report many obstacles to providing medical services to older people in residential aged care:

1. a lack of access to registered nurses with whom to coordinate care;
2. an increasing use by residential aged care facilities of agency staff who are not familiar with residents which compromises continuity of care;
3. poor access to properly equipped clinical treatment rooms which limits the medical treatment that can be provided in that setting;
4. an absence of information technology infrastructure to facilitate access to electronic patient records and medication management, including software appropriate to the needs of GP's;
5. a strong financial disincentive for the doctor to leave their surgery, with all its attendant costs, to provide services in residential aged care; and
6. a growing tendency to build aged care homes in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by doctors away from their surgeries.

In an AMA survey of 750 GPs in 2008[2] (Box 1), 15% of GPs said they intended to decrease the number of visits to residential aged care facilities over the next two years and 7% reported they would stop visiting altogether if the current barriers to the delivery of medical care were not addressed. Residential aged care providers have also reported difficulty in accessing GP services for residents in nursing homes.

While there are dedicated doctors who continue to bulk bill services to residents in aged care facilities and provide services in less than adequate care delivery environments, many of them are nearing retirement age. Demand for medical services in the sector will exceed supply unless policies and incentives are put in place to support doctors to deliver medical services to older Australians in residential aged care facilities.

An aged care accreditation standard for medical care

Aged care providers have an inherent responsibility to guarantee residents access to ongoing medical care and supervision. Yet there is no aged care accreditation standard which requires aged care providers to arrange medical care for their residents. In the absence of such a standard, there is no process for monitoring

[2] AMA Survey of GP Services to Residential Aged Care Facilities. May 2008.

Box 1. Key findings of an AMA survey of 750 GPs in 2008 were:

Three quarters (75.2%) of GPs surveyed visit RAC.
Average age of respondents undertaking visits was 52.5 years.
Average number of visits per month = 8 (8.36)
Average number patients seen per visit = 5 (4.77)
Patient contact time and non-contact time was roughly equivalent.
Three quarters (78.36%) indicated that they had either maintained or increased the number of visits they made to RAC over the last 5 years.
Over one-quarter of respondents had increased their visits because there was no-one else available (27.19%) or because of the ageing patient profile (25.35%).
Of the quarter (24.8%) of GPs that had decreased the number of visits made to RAC over the last 5 years, 22.73% cited inadequate patient rebates as the reason.
Three quarters (77.13%) of GPs indicated that they would either maintain or increase the number of visits over the next two years, or would visit current patients but not take on any new patients.
Increased patient rebates to compensate GPs for time spent away from surgery was listed as the first priority by both GPs who did and did not visit RAC to encourage GP visits to RAC.

Average number of visits to an RACF per month	8.36 visits
Average numbers of patients seen per visit	4.77 patients
Average face-to-face time with each patient	3.12 minutes
Average amount of non-contact time for each patient	13.2 minutes
Average time away from surgery while visiting an RACF	1 hour, 47 minutes

whether residents are receiving medical care, and there is no incentive for providers of residential aged care to facilitate attendance by GP's.

While the current accreditation standard for clinical care covers the expected outcomes for care provided by all health professionals, it does not guarantee that residents are medically supervised and have ongoing access to timely and high quality medical care. A specific aged care accreditation standard for medical care will ensure that access to medical care is monitored and scrutinised under aged care accreditation arrangements like other important quality, service and care requirements.

Arrangements to provide medical care to residents

Innovative service delivery and funding frameworks must be explored to support access to medical care in residential aged care. These could include retainer arrangements, extending the role of the practice nurse into aged care, and Medicare rebates that reflect the complexity of care.

Retainer arrangements

The National Health and Hospital Reform Commission (NHHRC) recognised the poor access to medical care in residential aged care and recommended "funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes".

Dedicated funding from Government would allow aged care providers to enter into arrangements with local doctors to provide ongoing medical services to residents. Payments under these arrangements would offset the lost business costs that medical practitioners incur while they are not providing services in their surgeries and would be over and above the MBS fee for service payments which would continue to be

claimed for each medical service provided to a resident in a residential aged care facility.

The AMA proposal for additional funding for access to medical services in residential aged care[3] facilities calls for:

- accreditation arrangements that more closely monitor and guarantee that aged care residents receive medical care and supervision on an ongoing basis;
- access to adequately equipped clinical treatment areas that afford patient privacy and information technology to enable access to medical records and to improve medication management;
- specific financial support to approved residential aged care providers to allow and encourage them to enter into local agreements with medical practitioners to ensure residents can access appropriate medical care;
- access to sufficient number of registered nurses to monitor, assess and care for residents and liaise with doctors; and
- MBS items that better reflect complexity and the significant amount of clinically relevant non face to face time involved in providing medical care and medical supervision to residents of aged care facilities.

Extending the role of general practice nurses

General practitioners support and desire appropriate expansion of the role of nurses within a team based model of care. The AMA supports a model of care that allows the doctor to delegate tasks related to the care of older people to the general practice nurse (or, on occasion, other team members with clinical training). We believe this model would have an immediate impact, enhancing the quality of clinical assessment of patients, expanding the role of GP's in acute interventions, and reducing avoidable referrals to the acute hospital sector.

It is worth noting that proposals for nurse practitioners will not in themselves ensure residents in aged care have access to the medical care they need. Nurse practitioners will not be providing medical care and residents will still require access to general practitioners and medical specialists under collaborative care arrangements. Furthermore, the barriers to the delivery of medical care in residential aged care facilities still exist and nurse practitioners will encounter the same barriers experienced by doctors in the delivery of care.

In the context of nurse practitioners employed by residential aged care providers, an accreditation standard for access to medical care would ensure that the aged care provider has secured the services of medical practitioners with whom the nurse practitioners can practice collaboratively, as per the proposed Medicare and Pharmaceutical Benefits arrangements.[4]

Medicare rebates that reflect the complexity of care

There is a disconnect between the Medicare rebate and the true cost of providing the service in residential aged care. While many doctors are still bulk billing residents, this will become unsustainable.

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[3] AMA policy paper. Additional funding for access to medical services for residents of aged care facilities. 2008.

[4] Letter from AMA to Office of Aged Care Quality and Compliance, Department of Health and Ageing re Appropriate models of practice for nurse practitioners in aged care. 2 February 2010.

Medicare rebates for medical services in residential aged care need to reflect the complexity and amount of clinically relevant non-face to face time in providing medical care to residents. Medicare Benefits Schedule items must reflect innovations that exist in other areas of the MBS by expanding the scope of tasks practice nurses can perform on behalf of doctors in the residential aged care setting.

Investing in more aged care places and better facilities

Federal Government investment in the residential aged care sector must ensure the sector can provide the level and quality of infrastructure and services to meet the needs of an ageing population. This includes funding to expand the number of places to meet demand and to upgrade facilities to the condition the community expects and values for older Australians. For instance, facilities must be able to provide adequately equipped clinical treatment areas that afford patient privacy. The development of clinical treatment rooms could be a condition for providers receiving capital grant money.

Aged care facilities must also have the information technology in place for medical practitioners to access patient information and manage patient care electronically.

An appropriately resourced and skilled aged care workforce

Of significant concern is the difficulty in attracting and maintaining an appropriately skilled aged care workforce, and in particular registered nurses. Over the last five years, the number of registered and enrolled nurses working in residential aged care has decreased while the use of agency staff and personal carers has increased. This places additional pressure on the nursing staff working in the sector to provide quality nursing care to residents. A lack of wage parity with the acute care sector for nurses who work in aged care is one of the main reasons nurses are not attracted to working in residential aged care.

Having sufficient numbers of registered nurses in aged care will help ensure that residents' health is properly monitored and that they receive adequate medical and nursing care. Residents who require medical attention will be quickly identified, and nursing care will be of the same quality provided in the acute care setting. This level of nursing care is appropriate to the needs of people who do need to enter residential aged care, and is desperately lacking today.

Teaching nurses homes

The provision of appropriate and accredited clinical training places in residential aged care would add to the overall breadth and depth of medical training and improve the quality of care of residents. It would encourage younger doctors to visit residential aged care, and educate the next generation of doctors about caring for the aged as part of routine medical practice. This concept is consistent with the principles of expanded training settings being explored elsewhere in the health education environment.

The Teaching Nursing Homes initiative announced in the 2010-11 Federal Budget is a step in the right direction in as much as it will provide the Australian aged care sector with 'centres of excellence' in education, training, research and development. The target group for this initiative must include medical, nursing and allied health professionals, and personal care workers, ancillary support workers and carers, both volunteer and paid.

Sub-acute/Rehabilitation care

Following an acute episode, timely access to specialist sub-acute services (Geriatric Medicine, Rehabilitation and Palliative Care) that minimise disability and subsequent handicap gives older people the best chance of recovery and provides them with the best opportunity to either return home or to access a low care residential aged care place if necessary.

While recovery from illness and minimisation of impairment and handicap takes time, that amount of time can be minimised with access to an appropriate mix of multi-disciplinary specialist care such as geriatric medicine and rehabilitation services. Waiting in an acute care bed for placement in an aged care facility should not be the standard default clinical pathway for older Australians who have experienced an acute episode.

The AMA Priority Investment Plan 2009[5] calls for an immediate increase in restorative services and sub-acute beds for rehabilitation and convalescence so that there are appropriate services for people who leave hospital but need further care:

Funding efficient sub-acute care services will allow older people with a complex illness to access an appropriate treatment environment that allows full recovery without forcing a premature decision to go to the residential aged care sector. Similarly, early risk assessment by a medical practitioner during an acute admission and access to appropriate, hospital guided medical care and management can also prevent older people who return to live in the community from being inappropriately readmitted to hospital emergency departments and/or an acute care bed after an acute care episode.

It is important to note that providing access to sub-acute care must not be confused with providing access to transitional care places (or care awaiting placement). Sub-acute care is very different and cannot be provided at the same cost as residential aged care. Well-resourced sub-acute care provides older people with access to specialist medical, nursing and allied health professionals to ensure that older people who suffer an acute illness get the best chance of returning home in the shortest possible time. Conversely, sub-acute care can also be used to stop or slow the deterioration of a person's condition before they require admission to acute care.

Private health insurers must also accept responsibility for this type of care for their members.

[5] AMA Priority Investment Plan. 16 September 2009.

End of life care

Having a conversation about how a person wishes to be cared for at his or her end of life is a difficult social issue. Our health care system must give older people the opportunity to die a proper and dignified death. Our community needs to be educated about the reality of death and dying. Similarly, health care professionals need to be up skilled and supported to provide quality end of life care. The health care professional discussion with their patient about end of life issues and palliative care should be properly remunerated, as it is a clinically relevant professional service. Advanced care planning will ensure more appropriate end of life care is provided to older people, particularly in the aged care sector.

The AMA Position Statement on the Role of the Medical Practitioner in Advance Care Planning[6] endorses the key role of the doctor in providing guidance, advice and in discussing treatment issues related to incapacitating conditions and/or future health care options with patients, as part of the therapeutic relationship. Given that there are currently jurisdictional differences in the law pertaining to advance care documents, the AMA has called for all States and Territories to enact consistent legislation that establishes advance directives as legally enforceable.

Older Indigenous Australians

The delivery of medical and aged care services to older Indigenous Australians must be holistic and culturally appropriate across a range of services and health care settings. Older Indigenous Australians should be able to access community and residential aged care services within their own communities, and should have the opportunity and flexibility to decide what care they need and how that care should be delivered to them.

Funding

The AMA acknowledges the difficult task the Commission has to offer funding models that are sustainable. However, we urge the Commission to consider that the asset base of the future generations of older people may not match that of the current generation of older people.

The residential aged care sector

A number of independent reviews have reported that current funding for aged care threatens the viability of the aged care sector and is inadequate to provide the services required, meet increased costs such as wages, and implement the expansion needed to meet future demand. In particular, development of high care facilities is no longer deemed to be viable under current capital arrangements.

Frail and elderly Australians deserve a level of investment that allows them to maintain their health and their dignity in their new environment. Funding issues for

[6] AMA Position Statement. The Role of the Medical Practitioner in Advance Care Planning. 2006.

the residential aged care sector must be resolved. It is difficult to see how the provision of residential aged care high care will be sustainable unless bonds are introduced. Funding models must be sustainable and take into account the fact that the asset base of the current generation of older people might not be the same as that of future generations of older people.

Medical and health care services

Funding must be directed to ensure older Australians, their families and carers, have access to medical and health care when they need it. A funding model whereby funding follows the person rather than being allocated to an agency to distribute may result in more timely access to more appropriate care, and provide greater equity of access and flexibility in how that care is delivered. This model could be particularly appropriate for indigenous Australians. Consideration should include the practical application of models of consumer directed care in the Australian context.

eHealth

The health care of the patient is best served, and is delivered most safely, when the medical practitioner has access to the full health record. This is particularly important in unplanned transfers between the aged care sector and the acute sector. The multidisciplinary nature of care that older people need – general practice, acute, emergency and sub-acute care – will be improved by the application of an electronic medical record. In particular, electronic discharge summaries and electronic medication management systems have the capacity to improve communication between health care professionals and across care settings, to improve continuity of care and reduce the potential for adverse events. The Federal Government must build the overarching infrastructure to connect patient information electronically.

Reforming the care arrangements for older Australians

The AMA offers the following key considerations for reforming the care arrangements for older Australians:

- Access to medical assessment and diagnosis is fundamental to planning for a person's care needs;
- The care needs of older Australians must be managed and coordinated, to ensure they access the services they require;
- Much of those care needs will have to be provided where the person is, rather than the person going to where the care is provided;
- Funding arrangements will need to reflect the costs of mobile service providers and the complexity of care required for the very old;
- There will need to be transparency of the suite of care that is available and the funding arrangements for that care;
- Advanced care planning must be in the suite of care;
- The suite of care must be supported by eHealth measures; and
- Residential aged care services providers will need to offer a range of services and be flexible to step up and step down care as residents' needs change.