The Royal Australasian
College of Physicians

Submission to:

Australian Government Productivity Commission

Caring for Older Australians Issues Paper

on behalf of

The Royal Australasian College of Physicians

August 2010

The Royal Australasian College of Physicians (RACP) would like to thank the Productivity Commission for the opportunity to respond to the Issues Paper on Caring for Older Australians. We congratulate the Australian Government in looking forward towards solutions for what is widely acknowledged as an important and complex issue.

Executive Summary

The Adult Medicine Division of the RACP along with it's fellows and trainees are the experts in multidisciplinary care and complex disease management in older Australians. This division is the training organisation that oversees training of specialists in the medical care of and advocacy for older patients including the training of Geriatricians. The division would like to endorse the submission of the Australian and New Zealand Society for Geriatric Medicine and enhance that with the following points:

- Health needs of older Australians will require an expansion of the health workforce across all disciplines.
- Additional resourcing of training positions and supervision will be required particularly in the specialist workforce.
- Access in a timely manner to assessment and care for older Australians after acute hospitalisation needs review and a more team-based approach.
- The distinction between high and low level care is artificial and in conflict with the principles of 'aging in place'.
- Negotiation of the multiple funded programs needs simplification and must be driven by patient need not by program structures, eligibility criteria or funding restrictions.
- Hospital design must focus on limiting the hazards of this environment to older patients.
- Dental care in the elderly needs affordable access.
- Attention needs to be given to ethnic diversity and cultural competence in the provision of care and care environments for older Australians.
- Greater emphasis must be placed on prevention to reduce the increasing burden of chronic disease.
- A more co-ordinated approach to chronic disease management.
- Reduced reliance on acute care hospital beds.

The Royal Australasian College of Physicians

The Royal Australasian College of Physicians (RACP) is a Fellowship of more than 13,000 specialist and generalist physicians and 4,000 trainees who practice in more than 25 medical specialties including rehabilitation medicine, public health medicine, cardiology, respiratory medicine, neurology, oncology, occupational and environmental medicine, palliative medicine, paediatrics, geriatric medicine, sexual health medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the well-being of patients. The College works to establish and achieve the highest standards of contemporary knowledge and skill in the practice of medicine and to promote the health and well being of the community. The College, in collaboration with affiliated specialty societies, is the provider of frameworks and standards of education for specialist physicians and trainees. The College is a key stakeholder in the Australian health system, advocating for improving the health and wellness of individuals and communities and reducing disparities across population groups.

The Adult Medicine Division of the RACP and its Fellows are the experts in multi-disciplinary care and disease management. For example, they are the leaders in the management of complex aged care, dementia and diabetes. The Adult Medicine Division also works to coordinate research and provide advocacy on particular issues of importance to the health of Australians and New Zealanders.

The Australian and New Zealand Society for Geriatric Medicine is one of the Specialty Societies within the RACP. The Society has also sent a submission to the Inquiry, and the RACP would like to take this opportunity to state our support for the position they have laid out. In addition, we would like to raise the following issues for the consideration of the Commission. There are many facets to the complex question of Care of Older Australians and the way in which Fellows and trainees of the RACP are intimately involved in their health. We hope that these comments are of some assistance.

The College would first like to emphasise the following statement. This should be a primary consideration of the Commission throughout the development of their proposals for the future aged care system

<u>One of the most important underlying principles is that we should be driven by a patient/a client/a person's needs, rather than by program structures, eligibility criteria or funding restrictions</u>.

Support for training of a workforce

Care for the health needs of older Australians will require expansion of the workforce in many areas. A balanced multidisciplinary team - from personal care workers, nurses at all levels, allied health professionals, general practitioners and specialist physicians - will be necessary to ensure such needs are met. In the specialist medical workforce there is not only a current and ever increasing need for geriatricians, but also the many other medical specialists who are also involved in the care of older people. Hence more training positions and supervisors are required in the majority of adult specialties.

There is also a need for us to enhance our specific training in aged care within these medical specialties, with further development of curriculum and appropriate training opportunities focused on older Australians. The American Geriatrics Society is an example of the development of competencies in aged care for health professionals and medical specialists [1].

One of the important roles of physicians is as leaders of the health care team, particularly in hospital settings, acting as advocates for aged care patients. More recognition and development of this role is needed.

Workforce substitution

It is well recognised that the demand for affordable and effective health care will continue to increase. However, the resources to meet this demand are limited. Not only is there a need for more health care professionals but the skills and competencies of medical and health professionals will also need to change to meet this demand.

Predicting the number of future health workers is difficult at best. However, while the numbers of health workers needed may be hard to determine, it is generally agreed that there will be a shortage.

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[1] http://specialists.americangeriatrics.org/statement.pdf

Workforce Substitution is considered a possible solution to the current and predicted health workforce shortages. Workforce substitution occurs when members of the health profession take on roles and responsibilities that have previously been considered to be under the control of other health professionals. There are two types of workforce substitution.

One is the creation of new independent workers and the other is to extend the responsibilities of existing health workers. Workforce substitution is one way of ensuring the retention of the health workforce through the development of new career paths. An example of this is the UK Skills Escalator, which enables health workers to transition from one health area into another. Workforce substitution has been found to be effective in both the United States of America and the United Kingdom. It has been especially effective for specific population groups such as those from socio-economically disadvantaged backgrounds, the aged and people living in rural areas.

The most common form of workforce substitution in Australia is the Nurse Practitioner. However, a number of other roles are also being developed. These include the Hospitalist in NSW and in Queensland these are the Primary Care Paramedic, Rural and Isolated Practice Endorsed Nurse and Sexual and Reproductive Health Endorsed Nurse. Queensland is also trialling Physician Assistants.

In some ways workforce substitution already happens in the provision of health services for Aboriginal people by Aboriginal Health Workers.

There are a number of benefits associated with workforce substitution. It has the potential to:

- enable doctors to deal with more chronic or 'serious' conditions and health issues
- be helpful in rural and remote areas, especially if the worker has a broad range of health knowledge and skills
- help alleviate shortages of professionals in specific areas
- reduce training needs as the person would only be trained in specific areas and needs, unlike a doctor who has to have a broad knowledge and skills
- free doctors from doing tasks, which some consider that doctors are 'overqualified' for and allowing a less qualified person to do the task

The RACP supports the expansion of the role of health care professionals, into workforce substitution roles. Where possible this will be in collaborative teams that include a physician who

takes responsibility for the quality of care provided. The roles of the team members will be based on their clinical competencies.

The College makes the following recommendations in the interests of progressing a workforce substitution policy:

- Conduct a national evaluation of workforce substitution that is already occurring and its effectiveness, efficiency, quality, safety and acceptability.
- Conduct research to determine the best models of workforce substitution for Australia and New Zealand.
- Work with Colleges, States, Territories and health professionals, across all disciplines, to determine appropriate remuneration levels for current and future workforce roles.
- Work with Colleges and Universities to integrate training and understanding of any new roles into existing education streams.
- Review relevant legislation to recognise the new roles and to enable them to fulfil their responsibilities.
- Increase access to the Medical Benefits Schedule to a broader range of health professionals.
- Work with the Colleges and Universities and fund appropriate education and training programs for new workforce substitution roles.
- In conjunction with the Colleges encourage debate and discussion about the various workforce substitution roles and their involvement in the health system.
- Balance the interests of those that are graduating from medical schools with the health care needs of the Australian and New Zealand community.

Access to ongoing care

As many RACP Fellows work in hospital environments, appropriate and timely access to ongoing care for patients is a major concern. While it is acknowledged that timely assessment is a high priority for the current Aged Care Assessment Program, this remains a significant cause of delay in discharge. The process is complex and sometimes unpredictable. The College believes that a review of the assessment program in hospital would be useful, including the role of geriatrician led assessment teams, working in conjunction with the local ACAT.

The distinction between high and low level care is increasingly artificial, especially for patients whose care needs are assessed in hospital. This has a historical basis which is not sustainable given that Ageing in Place has shifted the balance between allocation of high and low level care places. It does not match with the population who reside in aged care, many of whom are

reallocated to high level care after being initially assessed as low level care, and who have incurred the accommodation band. This needs to be reviewed.

The distinction between Residential Aged Care funded programs such as CACPs and EACH packages, in comparison to HACC funded programs is blurred in terms of actual care provided, but creates complex assessment barriers. Despite numerous publications and other sources of information, the experience of negotiating the Aged Care system for sick older patients and distressed relatives remains confusing and difficult. The financial issues in timely access to residential care are also considerable, particularly for an older person who does not have a family member or other person who is able to negotiate for them. As the Commission notes, there is an increasing number of older people who have a very limited support network and accessing residential aged care and other aged care services is particularly difficult for these people.

Hospital Design

Hospitals remain a hazardous environment for older people, who are at high risk of falls, delirium, infection and loss of function. As older people will comprise an ever increasing proportion of hospitalised patients, more attention is needed in the area of hospital design to try to minimise the hazards. This is also a concern in respects to access to health care in the community.

Dental Care

There is an urgent need for improved and affordable access to dental care for older people. The days of full dental clearances and dentures are over, but maintenance and restorative dental services have not caught up. This poses a significant health risk for infection and compromised nutrition and should be urgently addressed.

Recognition of Ethnic Diversity

The challenge of ethnic diversity is noted in the Issues paper. This should be recognised in both the workforce and the older population. Improved workforce training in this area is required and should include the skills of cultural competence. Residential care building design should be flexible enough to accommodate the varied needs of ethnic groups and to change over time; for example, as migration patterns change, some facilities established by specific ethnic communities may have a dwindling number of residents from those communities.

Prevention and Public Health Promotion

Chronic disease is increasing in the Australian population, partly as a consequence of the ageing of the population and significantly as a result of low and uncoordinated investment in health promotion and disease prevention and in specialist health care for older people. Indigenous

people are particularly subject to high levels of chronic disease with resulting reduced life expectancy.

Much of this disease burden is preventable, and is linked to the prevalence of modifiable ‘lifestyle factors'. A reduction in the general population of these factors, identified as tobacco use, risky consumption of alcohol, poor nutrition and lack of exercise, will have a positive impact on mortality, morbidity, disability adjusted life years (DALYs), and therefore on the associated costs and burden on health systems. There must be a greater focus on prevention in order to assuage the high levels of chronic disease which will continue to impact on Australia’s older population.

There are numerous evidence based programs and policy changes which can be made to contribute to the reduction of this disease burden, which will only be emphasized by an ageing population. Such measures, which should be co-ordinated by a national body, such as the proposed National Prevention Agency, should include:

- effective prevention and reduction of health impacts caused by smoking, unhealthy alcohol consumption and obesity requires removal of direct and indirect financial barriers to pharmacological and psychological treatments for addiction and addictive behaviours;
- investment in active cessation of smoking is essential, including through regulation to limit the addition of addictive additives in tobacco, to implement generic packaging, and to restrict lower cost cigarette imports;
- reduction in alcohol consumption should be targeted through introduction of a volumetric approach to taxation for alcohol;
- prevention and reduction of obesity requires reform in payments arrangements to promote coordinated general practice, specialist and allied health care of at-risk population groups. It also requires population-wide measures to reduce the cultural acceptance of unhealthy eating, such as better food labeling through the implementation of front-of-pack traffic light labeling, a reduction of junk food advertising, reforms to the physical environment to facilitate exercise (including aids to cycling and public safety concerns), and measures to increase. Stricter healthy eating policies should also be implemented in hospital and care facilities to ensure healthy nutrition meals are the norm.

Managing Chronic Disease

Specialist physicians are central to the provision of appropriate, coordinated health care for older people; for those with chronic and complex conditions and for people with mental and physical illnesses.

Significant investment should be made to:

- increase the training of general physicians to augment the capacity of health services to meet the increasing need for diagnosis, treatment and management of complex and chronic conditions across acute, sub-acute and ambulatory care settings, and to provide for the needs of specific population groups;
- ensure nationally consistent access to sub-acute care for those with chronic and complex conditions and mental illness. In particular, inpatient and community based rehabilitation services are lacking throughout most of Australia and this reduces health outcomes for people requiring sub-acute care following injury or illness, including acute mental illness episodes;
- coordinate and co-locate acute and sub-acute care services to integrate care for individuals, including those with severe and persistent mental illness, and to maximize efficient use of clinical and other health resources;
- improving services to meet the particular health needs of indigenous people through expanded specialist training places and trainee support in indigenous health services and communities.

Reduce reliance on acute care hospital beds

Consideration should be given to the need to 'free-up' and reduce Australia's reliance on acute care hospital beds. This will need to include the expansion of community and ambulatory care services.

- increasing the availability of sub-acute health services for older people, people with complex and chronic conditions or injury and disability, and those with severe and persistent mental illness;
- reforming funding to provide a logical and coherent structure of payments for health services based on complexity of health need and treatment and to provide episode of care payments promoting coordination and integration of care between health professionals and across all health care settings;
- increasing availability of and access to post-acute and ambulatory health services providing community-based care;
- reforming funding and increasing investment in out-of-hospital community specialist care, especially in:
    - Geriatric care
    - Palliative care
    - General medicine
    - Mental health