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Draft Report: Caring for Older Australians

Dear Mr Woods

The AMA is pleased to make a submission in response to the Productivity Commission's Draft Report: Caring for Older Australians (the draft report) released on 21 January 2011.

The AMA is extremely disappointed that the draft report makes almost no reference to the provision of clinical care to older Australians generally, and access to medical care specifically, both of which are a critical consideration in caring for older people.

Provision of health care requires more emphasis in the final report. Residents of aged care are frail and have complex conditions that require medical management. It is vital that aged care homes are in a position to facilitate access to medical care.

The aged care workforce

In the same way that medical practitioners are an integral part of the hospital workforce, medical practitioners and other health practitioners comprising the GP-led team are an integral part of the aged care workforce, particularly in residential aged care. They are central (not peripheral) to the provision of quality care to older people across all care settings.

Any review of the aged care system and its ability to care for older Australians must incorporate specific recommendations around preserving a person's access to quality medical care when they enter the aged care system. The final report must consider the programs and incentives that are needed so that doctors and other health professionals are able to provide quality and timely health care to older Australians living in residential aged care and in the community. Further, forward planning must include incentives to attract students, trainees, and young graduates into aged care practice.

The doctor-patient relationship must be preserved for older Australians at the time in their lives when they need it most.

As the Commission has noted under the heading *Improving the attractiveness of aged care and the quality of care* "most of the solutions lie with aged care providers, as they have the principle responsibility for ensuring that they provide an attractive workplace." (page 362). The AMA has drafted a proposed aged care accreditation standard for access to medical care. The attached document illustrates how we see this standard working in practice.

The AMA views with concern the Commission's statement "that widened scopes of practice will become increasingly important as broader health workforce shortages become more acute" (page 369). At this time, the AMA cannot identify any evidence that demonstrates that widened scopes of practice for workers, such as nurse practitioners, improves the quality and efficiency of care if that care is provided independently. The Federal Government has recognised this in the Medicare and Pharmaceutical benefits arrangements by requiring nurse practitioners to have collaborative care arrangements with medical practitioners. It is crucial to qualify the Commission's statement with an acknowledgement that all health care provided to residents of aged care facilities must be coordinated by a medical practitioner familiar with the patient and taking ultimate responsibility for that care.

Access to medical care is directly related to points two and three in the Inquiry's terms of reference. We would like the final report to reflect more content from the AMA's former submission as well as the points listed below.

Support for medical practitioners to provide care in the community

Home visits

Joyce and Piterman (2008) report that "there has been a clear decline in GP home visits over the past decade. This is problematic in the context of a large and growing population of older Australians. Strategies are needed to better support this function in general practice, and/or ensure that alternative providers are meeting the need for these services."[1] The AMA agrees. The Bettering the Evaluation and Care of Health (BEACH) report suggested there had been 690,000 fewer home visits nationally by GPs in 2009–10 compared to 10 years earlier.[2]

With an increasing preference for older people to continue to receive care in their own homes for as long as possible, the provision of medical care to vulnerable, older people will become a logistical challenge. Caring for older people in their own homes is an expensive proposition for many private medical practitioners. Joyce et al found that the time consuming nature of home visits, the relatively poor remuneration, a large part time workforce and concerns about personal safety may all contribute to declining home visits. The Commission's preference for ageing at home should be

[1] Joyce, C & Piterman, L. Trends in GP home visits. Australian Family Physician. Vol 37, (12) 1039-1042.

[2] General practice activity in Australia 2000-01 to 2009-10: 10 year data tables. BEACH. December 2010. p28.

modified to take into account the time cost of accessing a person in his or her own home, and the workforce implications for medical and other health practitioners.

There must be more fulsome consideration of how private medical practice is to be appropriately supported to provide this care. The final report should include more consideration of the funding arrangements needed to support the non face-to-face time spent by medical practitioners in managing care for older Australians in community and in residential aged care settings. Policies and strategies should be aimed at maximising quality and continuity of care and the effective use of health resources.

Assessment and care coordination

The AMA notes the draft report recommends a single aged care gateway and agrees there should be a range of options for completing lower level assessments for basic support and care services, including through face-to-face consultations, over the phone or via the internet. We believe general practitioner assessment of people for access to low level residential and other aged care services such as respite care is appropriate. General practitioners will usually have the most comprehensive and constant knowledge of the person's change in physical circumstances. As put forward in the AMA's previous submission:

> "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."
> AMA Submission, 9 August 2010, page 3.

We support the Commission's proposal to promote team based care. This can be readily achieved by enhancing the existing Medicare funding arrangements for collaborative team based care led by the general practitioner.

The primary health care management plan could drive:

- access to a broader range and greater number of allied health services;
- facilitate better co-ordination of care with the workers employed by the aged care facilities;
- place a greater emphasis on the role of formal and informal carers i.e. family member who receives carer's allowance by recognising them as a provider of care that the medical practitioner must also co-ordinate and collaborate with.

Medical practitioners are an integral part of supporting carers to achieving quality outcomes for older people. However, as this work is not currently recognised in the Medicare benefits arrangements, it largely goes unremunerated for the dedicated medical practitioners who provide collaborative team based care. This may not be sustainable into the future. The Commission may consider revising its draft

recommendation 8.5 to reflect the fact that the model of multidisciplinary health care teams already exists. What is needed is the right funding arrangements to support it.

Similarly, we ask the Commission to consider, as part of recommendation 8.3, funding options for medical services provided during the palliative care phase, including the ongoing arrangements to assist family members after the patient has deceased.

Funding access to medical services in residential aged care

The AMA provided the Commission with a copy of its policy on *Additional funding for access to medical services for residents of aged care facilities 2008*, which includes a funding option for "an additional service payment paid by the RACF on behalf of its residents for each service that is provided to a resident of the facility over and above the MBS payment for that service". It is well known that Medicare rebates are inadequate to cover the costs of providing medical care to residents in aged care homes, and do not reimburse the non face-to-face time required to provide that care. This is a significant deterrent to providing care, particularly for younger doctors who do not find providing medical services to aged care attractive in the current environment. There is no reason to expect that other healthcare providers e.g. nurse practitioners, will not encounter similar financial barriers.

Under this inquiry there is an opportunity to improve funding arrangements for medical services to residents in aged care homes, recognising that the Medicare rebate for medical services does not cover the cost of providing care. The Commission should consider the extent to which aged care providers can assist residents to access medical care by collecting co-payment for medical services. This could be through a small increase in the accommodation bonds and/or retention amounts.

The AMA looks forward to attending the public hearings on 28 March 2011 to discuss these, and other aspects included in our earlier submission, with the Commission in more detail.

Yours sincerely

Dr Andrew Pesce
President

21 March 2011

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Attachment

AMA proposal for accreditation standard for aged care providers

Drafted according to Aged Care Standards and Accreditation Agency Ltd proforma

Expected outcome – Access to medical care

This expected outcome requires that:
Residents' have access to, and their medical care needs are met by, qualified medical practitioners.

The focus of this expected outcome is 'results for residents'.

Results

- Management demonstrates that policies and procedures are in place to ensure residents' medical care needs are identified and that arrangements are made to permit medical practitioners to provide care in a timely and efficient manner.
- Identified medical care needs are carried out in the manner prescribed by the medical practitioner.

Processes

Consider:

How does the home ensure that residents have ongoing access to qualified medical practitioners?
How does the home ensure it provides an environment for the efficient provision of medical care. For example, does the home provide:

<u>At no cost to aged care home</u>

- a car parking space
- 24-hour access through the main entry
- access to staff facilities such as toilets and dining room
- access to a suitable consulting room with examination couch
- ready access to clinical files, preferably computerized
- ready access to patients
- nurse available, suitably trained, with current clinical knowledge of the patient
- timely reliable information transfers (e.g. faxed medication sheets, but preferably electronic data transfers) to support telephone consultations
- a process for identifying the medical needs of residents and contacting medical practitioners to arrange consultation/s

<u>At low cost to aged care home</u>

- provision of medical practice software suitable for the clinical purposes of general practitioners and medical specialists
- basic clinical equipment, such as auriscope, ear syringe, suture equipment, vaginal specula, proctoscopes and ECG machines
- imprest pharmacy supplies

At significant cost to aged care home

- retainers[3] for medical practitioners who enter into service arrangements[4] with homes - but would be no cost to aged care home or government if resident bonds and retention amounts increased to cover retainer across all residents.

[3] Retainer is in addition to MBS rebates for medical services provided to individual residents.

[4] agreements would vary to provide flexibility, but would cover for example the days and times of usual attendance, the number and/or names of residents covered by the agreement, arrangements for after-hours care, participation in Medication Advisory Committees etc.