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13 December 2002

Dr Andrew Southcott MP
Chairman
House of Representatives Standing Committee on Ageing
Parliament House
Canberra ACT 2600

Dear Dr Southcott

Thank you for the opportunity to make a submission to your inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years.

The attached submission touches on the broad range of issues that your inquiry will investigate, with particular focus on health and aged care.

We would be pleased to provide whatever advice and assistance we can to facilitate and inform your inquiry, including of course giving evidence at your public hearings.

Yours sincerely

John O'Dea
Director
Medical Practice Department

A Better Future for Health and Aged Care in Australia

Australian Medical Association submission to the House of Representatives Standing Committee on Ageing Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years

INTRODUCTION

The role of medical practitioners in providing quality health care to older Australians is a vital one to their well-being. As the peak body representing medical practitioners in Australia, the Australian Medical Association (AMA) has a proud history of being in the vanguard of social policy developments to recognise the important place of caring for older Australians.

Today, one in nine Australians is 'older'; in 2020, one in four of us will be 'older'.

As a society, one of our biggest challenges is getting people to focus on the human dimensions of ageing.

Change is needed if we are to keep pace with the needs of our older people. We, as decision and policy makers, have an opportunity to develop a model for seamless flexible care, if we think outside the current boundaries and work together.

The AMA is committed to working with other stakeholders including government to ensure that the needs of older people are recognised. They must then receive the care that they are entitled to expect in an accessible and timely manner within a quality framework preserving dignity and promoting wellness.

SUMMARY OF RECOMMENDATIONS

1. When an older person is no longer able to remain at home, a range of residential care options, which can cater for their physical, functional and psycho-social needs, should be available.

2. High level care in a residential aged care facility should be available to any person who is in need of such care irrespective of their financial position.

3. Application of standards for residential aged care facilities should enhance and improve delivery of resident care, promote efficiency and be practical. The associated documentation should promote face-to-face contact or services by staff and medical practitioners. Accreditation should encourage consolidation of good practice, quality improvement and a goal of best practice in medical and personal care.

4. Appropriately funded mechanisms of medical audit must be encouraged in residential facilities. These mechanisms should facilitate monitoring by medical practitioners of the services provided to residents. Regular discussion of patient care issues between the patient's general practitioner and the other providers of care should be encouraged.

5. Provision must be made for the appropriate remuneration of the involved medical

practitioners who should participate in relevant quality improvement programs in aged care facilities.

6. All staff employed in residential aged care facilities should be appropriately trained and be involved in continuing educational programs.

7. The care of people with dementia should be part of the expected skills set in all aged care facilities.

8. Challenging behaviour as a result of dementia or psychiatric illness require specialised staff and facilities to complement geriatric services. The staff and facilities should be able to provide appropriate assessment and management, whether the older person is at home, in hospital or in residential care. Adequate staff must be available to provide quality care.

9. Older persons must not be denied access to acute hospitals on the basis of their age or because of their co-morbidities.

10. Medical practitioners with expertise in aged care should be an integral part of each general hospital's services and be available for consultations and advice.

11. General hospitals should provide a designated geriatric medical service with beds for acute care, assessment and rehabilitation.

12. General hospitals should also provide appropriate multi-disciplinary out-patient services to address the complex syndromes of older age such as falls, dementia and incontinence.

13. Our architects must design 'smart' houses and residential aged care facilities which are adaptable and can have multiple uses, and utilise medical and communications technology which can help in the monitoring of an individual's health – e.g. with smart beds with autoanalyser programs. These new houses should be cheap to produce, modular, energy-efficient, and easily mass produced - but individual.

14. We need town planners and municipal authorities to allow flexibility so that such houses/buildings can be easily moved, can be grouped geographically close, but <u>not</u> too close together.

15. The Government will need to encourage better use of technology with rebates available for these services.

16. If an older person has need for acute care in hospital, they should then have access to transitional care if appropriate before either returning to the community or entering a residential aged care facility.

17. The expansion of the hospital in the home range of acute hospital substitution models, where the patient's GP can be responsible for creating and managing the care plan and ensuring continuity of care, provides a model for both appropriate and cost-effective care for many older people.

18. Consideration be given to reallocating bed licences, so that some residential facilities are specifically allocated for the young people. This means that younger people who at present

occupy beds in nursing homes with older people can be relocated to a facility that is occupied by younger people and where the focus is on their care and developmental needs.

19. There must be commitment from both Commonwealth and State Governments to work together to ensure younger people with disabilities live in appropriate and adequately funded accommodation.

20. Research and programs to prevent and alleviate elder abuse should be encouraged and supported.

21. To achieve innovative changes to the health system, Australia will need to train an increased number of medical practitioners who work in specialities associated with ageing.

22. The medical profession is sympathetic to the nursing profession's difficulties with aged care facilities, and supports its call for wage parity with other sectors of the nursing profession and recognition of aged care nursing as a speciality and a valued skill.

23. One AMA suggestion is for residential aged care facilities to appoint a GP Facility Adviser.

24. The AMA argues that GPs must be encouraged to provide care to older Australians, but the costs and complexities associated with visits to aged care facilities are huge hurdles. To achieve this objective, the Government must urgently address the funding, staffing and facility issues surrounding the provision of high quality medical care in residential aged care facilities.

25. Whichever funding model is decided upon, the issue of the changing demographics and the need for appropriate health care delivery must be addressed. Funding should be primarily for care services, but should include a capital component as part of a properly benchmarked care payment.

26. Resources should be made available by governments which will ensure the funding of research programs which focus on age related issues.

27. As a matter of urgency, research, especially clinical research into age-related issues, should be encouraged and supported.

28. This research should be multidisciplinary because of the complex inter-relationships between genetic, psycho-social, environmental and economic factors causing dysfunction from disease, disuse, and the effects of biological ageing.

29. Funding organisations need to positively discriminate in favour of gerontic research if we are to fully understand the emerging issues of our ageing society.

30. Undergraduate, postgraduate and continuing education of health care providers must address and emphasise the care and, in particular, health promotion among older people.

CHANGING DEMOGRAPHY

For the first time in human history, in Australia and many other similar countries, there are

increasingly large numbers of people living into their eighties and beyond.

In 1999 the Australian population aged 85 years and over was relatively small, at 241,000. It is projected to experience the highest growth rates of age cohorts within the population, doubling by 2021. It will reach some 1.3 million (or over 5% of the population) by 2051[1].

There are two growth rate 'peaks', with 6% growth in 2006 (associated with the post World War 1 baby boom) and a higher 7% growth in 2032 (associated with the post World War 2 baby boom).

There will be a particularly rapid increase in Australia's aged population. The aged (65 years and over) are projected to increase by about 140% from 1997 to 2031. The very old (80 years and over) will increase by around 200 per cent over the same period. An ageing population means increased usage of long-term aged care services.

There is an erroneous assumption that ageing is a process of escalating ill-health and disability so that old age is a key driver for the high costs of medical care in our community. Ageing itself is not the main mechanism driving increased health-care costs. Ageing is a normal process. It does not and need not, imply illness, impairment or disability. The relationship between age, morbidity and health-care costs is not straightforward.

Demographic change is just one factor. General inflation, together with developments in medical technology, pharmaco-therapy, health promotion and disease prevention measures, not to mention the greater expectations by the public at large, are also contributing factors. Acute medical and surgical conditions that prevail in younger populations continue to occur in older people. Chronic diseases, which impact on life expectancy and quality of life, are common in the over 75s, having already impacted on individuals in their younger years. These tend to complicate the care needs and management of our older citizens.

CHANGING PATTERNS OF ILLNESS/AGEING

Disabling conditions which particularly affect those aged 65 and over are related to physical conditions including osteo-arthritis, cardio-vascular diseases such as heart failure, ischaemic heart disease, neuro-degenerative diseases such as dementia and Parkinson's disease, and stroke and systemic diseases such as diabetes mellitus and inflammatory arthritis such as rheumatoid arthritis and systemic lupus erythematosus.

Depression and anxiety, the high prevalence metal health disorders are frequently seen and can be very disabling.

Another feature of illness and disability in old age is co-morbidity: the presence of more than one condition, and the combined effects of each condition. This becomes particularly significant in people over eighty years.

Dementia provides a striking example of the effect of very old age on individuals.

The prevalence of dementia doubles every five years over the age of sixty, from only 0.72%

[1] Trewin, D. (2000) *Population Projections, Australia, 1999 to 2101*, Australian Bureau of Statistics, 2000, pp. 12-13.

(60-64) to 23.60% (84+)[2]. Whether this increase continues over the age of 85 is not clear. Apart from dementia, there are other neurological conditions contributing to the increase in severe disability experienced by those people over eighty years of age.

Dementia and these other conditions may result in disorders of memory, cognition, behaviour, motor and sensory functions, mobility and balance. Such neurodegenerative diseases are often slowly progressive and while preventive and treatment strategies are emerging, they may not have the same profile as strategies in cardio-vascular disease, and find it difficult to obtain adequate funding.[3]

We can expect the systemic disorders to be overtaken by neurodegenerative diseases as the major cause of death in older people during the coming decades and also as the major cause of severe disability[4].

We must recognise that there is great diversity in the health and functional capacity of older people, and that not all old people are frail and ill. Indeed, younger old people (65 to 80) in Australia are generally independent, fit, able and well.

Predicting the future of illness, impairment, disability and death in the Australian community is of course difficult. It is made within our current knowledge of:

- the causes of disease and its progression,
- the limits of current medical technology and
- the current measures of the social, economic and behavioural determinants of the health status of future generations[5].

One view is that, as the incidence of disease is delayed to older age, ill-health and disability will occur for a shorter period of a person's life ('compression of morbidity').

An opposite view is that, while life spans have increased, chronic illness and disability may also have increased, resulting in longer periods of life spent in ill health.

There is also a view that any gains from preventing illness or death from one type of disease are reduced or cancelled by increasing illness or death from other diseases[6]. (A depressing thought!?)

Two particular issues that will bring about change to the health care system are:

- the ageing of the 'baby boomers' and
- the rise in the number of very old people (80 years or more).

Baby boomers are not afraid of change – it has followed them through their lives.

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[2] Jorm, AF and Korten AE (1988) A method for calculating projected increases in the number of dementia sufferers. *Australian and New Zealand Journal of Psychiatry*, 22, 183-189.
[3] *Dementia care in Victoria: a public health approach* (1997). Report of the Ministerial Task Force on Dementia Services in Victoria, Melbourne.
[4] *National Strategy for an Ageing Australia. An Older Australia, Challenges and Opportunities for all*. (2001) (amended 2002) Kevin Andrews, Minister for Ageing, Commonwealth of Australia. Page 48.
[5] Ibid, page 48.
[6] Ibid, page 46-7.

Social policy and legislative change over the past years has meant that this generation is more aware of its rights, and has higher expectations of future care, conditions and comfort.

This generation of educated health conscious consumers will demand care and accommodation in their later lives where quality and access of care and standards of living are not only available, but are met.

Need to target services

Life expectancy and disability are not uniform across population groups within Australia.

The health of populations living in rural and remote areas of Australia is worse than that of those living in capital cities and other metropolitan areas.

Indigenous Australians have higher rates of premature death from diseases of the circulatory system, cancer and external causes such as accidents, poisoning and violence, and the onset of chronic disease and ill health tends to occur earlier in these communities.

Socioeconomic disadvantage is also associated with poorer health including higher rates of premature death and increased likelihood of engaging in risk taking activities which contribute to ill health[7] such as smoking and alcohol abuse.

CHANGING PATTERNS OF NEED

Community care

The vast majority of older Australians live independently and in their own homes. Fewer than 1 in 10 people over the age of 70 live in a residential aged care facility.[8]

Many people are able to stay in their own home with the support of Home and Community Care (HACC) services, Community Aged Care Packages (CACPs) as well as the availability of respite care.

Recommendation 1:

When an older person is no longer able to remain at home, a range of residential care options, which can cater for their physical, functional and psycho-social needs, should be available.

Residential aged care

Older people are now only entering residential aged care facilities when support within the home is no longer adequate to meet their health care needs.

[7] Ibid, page 38.
[8] '*Aged Care – make the choices that are right for you*' Aged and Community Care Division, Department of Health and Family Services, Commonwealth of Australia 1998.

This has resulted in the residential care system now catering for an increasingly frail population with the proportion of permanent residents receiving high level care shifting from 58% at 30 June 1998 to 62% at 30 June 2000.[9] This also has the effect of decreasing the need for low care in facilities while increasing the need for high care beds.

Recommendation 2:

High level care in a residential aged care facility should be available to any person who is in need of such care irrespective of their financial position.

Recommendation 3:

Application of standards for residential aged care facilities should enhance and improve delivery of resident care, promote efficiency and be practical. The associated documentation should promote face-to-face contact or services by staff and medical practitioners. Accreditation should encourage consolidation of good practice, quality improvement and a goal of best practice in medical and personal care.

Recommendation 4:

Appropriately funded mechanisms of medical audit must be encouraged in residential facilities. These mechanisms should facilitate monitoring by medical practitioners of the services provided to residents. Regular discussion of patient care issues between the patient's general practitioner and the other providers of care should be encouraged.

Recommendation 5:

Provision must be made for the appropriate remuneration of the involved medical practitioners who should participate in relevant quality improvement programs in aged care facilities.

Recommendation 6:

All staff employed in residential aged care facilities should be appropriately trained and be involved in continuing educational programs.

Dementia and Psychogeriatric Care

Recommendation 7:

The care of people with dementia should be part of the expected skills set in all aged care facilities.

Recommendation 8:

Challenging behaviour as a result of dementia or psychiatric illness require specialised staff and facilities to complement geriatric services. The staff and facilities should be able to provide appropriate assessment and management, whether the older person is at home, in

[9] Australian Institute of Health and Welfare Media Release 'Australia's aged care 1999-2000 18 May 2001.

hospital or in residential care. Adequate staff must be available to provide quality care.

Hospital Care

Recommendation 9:

Older persons must not be denied access to acute hospitals on the basis of their age or because of their co-morbidities.

Recommendation 10:

Medical practitioners with expertise in aged care should be an integral part of each general hospital's services and be available for consultations and advice.

Recommendation 11:

General hospitals should provide a designated geriatric medical service with beds for acute care, assessment and rehabilitation.

(See below under Transitional care).

Recommendation 12:

General hospitals should also provide appropriate multi-disciplinary out-patient services to address the complex syndromes of older age such as falls, dementia and incontinence.

At present, such services are provided haphazardly, depending on State and local priorities and expertise, e.g. the Victorian Government's network of Cognitive, Dementia and Memory Services (CDAMS). These services have the potential to improve health outcomes and avoid unnecessary hospital admissions.

APPROPRIATE ACCOMMODATION AND CARE OPTIONS FOR THE FUTURE

We must look to designing more appropriate housing where older people can still have their independence, but also have easy access to care – perhaps 'cluster' housing, close to shops and health care facilities, and with a resident carer.

When thinking of more appropriate housing and accommodation we must remember that just because people are ageing, it doesn't mean that they lose the ability to give and receive love.

At this time of their lives they need, more than ever, the love and support of other human beings.

Sometimes it may not be appropriate, but wherever possible we need to have appropriate accommodation so that partners can stay together rather than be in separate facilities, often some distance apart.

Linked to the wish by older people to stay in their own homes, is the need for seamless and flexible care. This means that older people should be able to receive an appropriate level of

care when they need it.

Looking ahead to 2042: some ideas for the future

We need to utilise, and be encouraged to use appropriate new technology.

The question needs to be considered as to whether residential aged care facilities costing some $100,000 per bed to build are socially viable into the future.

Recommendation 13:

Our architects must design 'smart' houses and residential aged care facilities which are adaptable and can have multiple uses, and utilise medical and communications technology which can help in the monitoring of an individual's health – e.g. with smart beds with autoanalyser programs. These new houses should be cheap to produce, modular, energy-efficient, and easily mass produced - but individual.

Retinal scanning autoanalysers are available now - unfortunately they are very expensive and there are no incentives for GPs to use them.

Recommendation 14:

We need town planners and municipal authorities to allow flexibility so that such houses/buildings can be easily moved, can be grouped geographically close, but not too close together.

If we are smart, a new technology industry will arise, one in which Australia can lead the world.

Doctors will need to be equipped to instantly, on the spot, investigate, diagnose and treat. GPs will be much more mobile, independent and self reliant.

Health teams will spend most of their time in the community. There will be a need for high-tech centres of excellence and research.

Recommendation 15:

The Government will need to encourage better use of technology with rebates available for these services.

Transitional care

Recommendation 16:

If an older person has need for acute care in hospital, they should then have access to transitional care if appropriate before either returning to the community or entering a residential aged care facility.

A care 'gap' is widening between hospital and residential settings that few countries are

addressing.

There is a definitional issue that the committee could help clarify, with various terms used to describe such transitional care (including sub-acute, rehabilitation, convalescent, and step-down), which can describe different models of care. There is as yet no commonly accepted definition for the concept.

Transitional care would cater for older people who no longer need acute care, but do need further recovery time before returning to their home or to a residential aged care facility. It would provide more appropriate care, accommodation and therapy than patients are receiving at present in acute care - and free up hospital beds for those patients who need acute care.

'Transitional services' involving rehabilitation and the resolution of common consequences of acute illness in the elderly such as delirium, incontinence, and falls require specialist geriatric medicine and rehabilitation input.

There are hurdles – State/Federal funding complications, a need for a higher nurse to patient ratio than in aged care facilities, more integrated medical services which would include GPs and specialists, and a defined and experienced multidisciplinary care team – but the hurdles are not insurmountable.

With a more seamless health and aged care system, people could move from hospital to transitional care then either back to their homes to be supported by community care or move into high or low facility care with funding following the patient seamlessly wherever they are.

Ageing Australians are an integral part of the community and a significant segment of consumers of the health care system. They need appropriate care just as much as any other Australian. It is not acceptable for elderly people to wait in hospital for significant periods where the accommodation and care is inappropriate.

Hospital in the home

Recommendation 17:

The expansion of the hospital in the home range of acute hospital substitution models, where the patient's GP can be responsible for creating and managing the care plan and ensuring continuity of care, provides a model for both appropriate and cost-effective care for many older people.

Younger people with disabilities

There are currently estimated to be over 6,000 people under the age of 65 living in residential aged care facilities throughout Australia due to lack of alternative accommodation for young people with a disabilities. There is an urgent need for alternative accommodation models to be developed for these young people with a focus on rehabilitation and quality of life. They should have access to accommodation options that not only meet their high support needs but also provide for social and personal development.

Recommendation 18:

Consideration be given to reallocating bed licences, so that some residential facilities are specifically allocated for the young people. This means that younger people who at present occupy beds in nursing homes with older people can be relocated to a facility that is occupied by younger people and where the focus is on their care and developmental needs.

Recommendation 19:

There must be commitment from both Commonwealth and State Governments to work together to ensure younger people with disabilities live in appropriate and adequately funded accommodation.

ELDER ABUSE

Elder abuse includes physical, psychological or financial abuse or neglect and may be intentional or unintentional. It violates basic legal and human rights. Older people should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

Some elder abuse is preventable if carers receive adequate information, education and support. Education and training programs on the recognition, intervention and management of elder abuse should be available to all involved health professionals.

Medical practitioners, especially general practitioners, have a pivotal role in the recognition, assessment, understanding and management of elder abuse and neglect.

Recommendation 20:

Research and programs to prevent and alleviate elder abuse should be encouraged and supported.

CHANGING PATTERNS OF CARE

If older people wish to stay in their homes longer, then the health system will have to move away from supporting episodic care to supporting continuity of care. Individual approaches to treatment will require a team approach that will be underpinned by evidence and outcomes, clinical pathways and guidelines.

Teams will need to comprise medical practitioners and health care professionals across the sector – GPs, specialists, community nurses, allied health care professionals, pharmacists and representatives from community agencies.

The use of the team approach will direct appropriate care where it is needed, and make for smooth transition from acute to sub-acute care and from community to facility care.

Communication structures would need to be in place, such as a patient-accessible electronic home care record system which would allow instant contact with a range of healthcare professionals, information sources and other health services in an electronic distributed

environment.[10]

Multidisciplinary teams and more integrated approaches to providing medical and health services have been introduced with the Co-ordinated Care Trials and Enhanced Primary Care programs.

These programs have been designed to assist people with chronic illnesses and complex care needs, and include care planning, case conferencing and health assessments.

Recommendation 21:

To achieve innovative changes to the health system, Australia will need to train an increased number of medical practitioners who work in specialities associated with ageing.

General Practitioner out of surgery visits

There will need to be changes in the organisation of medical practice. Doctors will need to reverse the current trend and move out of their surgeries and return to treating more people in their own homes and residential aged care facilities providing care where it will be needed.

However, there are several identified barriers to GPs providing out of surgery visits - more so when we discuss GPs attending patients in residential aged care facilities.

An analysis of Health Insurance Commission data indicates that despite the increase in the number of older Australians in care, and the increasing levels of dependence of those in residential care, the number of visits to residential facilities made by doctors between 1998 and 2000 declined by nearly 40,000.

Fewer GPs are visiting residential aged care facilities: see below under *Disincentives to providing aged care*.

Most providers of residential aged care facilities encourage the residents to retain their GP when they enter a facility. Continuity of care is an important aspect in patient care for a General Practice and the patient –they have a therapeutic relationship, know the patient's medical history and their psycho-social background, and the GP is part of the patient's support network. Growing numbers of residents are placed in accommodation at a distance from their previous General Practitioner and this continuity does not occur. Securing medical care for residents of residential aged care facilities is increasingly problematic with a dwindling number of GPs providing such care.

Disincentives to providing aged care

The AMA is concerned at the disincentives and barriers that currently exist which make it difficult for doctors to operate in the aged care sector. The AMA has prepared a discussion paper on *GP Services to Residential Aged Care Facilities* which outlines these disincentives, and some policy options for addressing them, in some detail. A copy is attached.

[10] Ibid.

These disincentives to care reflect a perceived lack of value by society of aged care residents, older Australians, and their carers.

With a national shortage of residential aged care facility beds, older people do not have the luxury of choosing the location of the facility where they are going to live. The relocation of some residential aged care facilities from inner suburban sites to the outer urban fringe means that patients have little choice but to move with the facilities away from their family, friends and GP.

These trends are exacerbating the amount of time spent in travelling by GPs. Securing medical care for residents of residential aged care facilities is increasingly problematic with a dwindling number of GPs providing such care.

GPs who travel to residential aged care facilities are not making a wise business decision, especially if they choose to 'bulk-bill' their patients.

A GP who takes over the care of a new patient from another GP in a residential aged care facility ideally would develop a Comprehensive Medical Assessment Care Plan. This involves what amounts to patient assessment, information collection and review and care plan development. The collection and clarification of historical data, including discussion with the patient and/or relatives or legal guardian (e.g. regarding end of life issues and enduring treatment directives) as appropriate, accessing a previous GP, phoning specialists and contacting a hospital – is often necessary. This is time consuming but extremely important for provision of care and prospective quality medical care.

The high dependency level of residents in aged care facilities and their associated complex and chronic health problems means that this process is not straightforward. Participation of the GP in this process involves substantial non face-to-face time attempting to develop a plan within a structure that is fragmented. Remuneration currently makes participation in such an exercise uneconomic, inefficient and carries with it high opportunity cost.

When the GP arrives at a residential aged care facility there are further barriers. The GP must ideally be accompanied by nursing staff when proceeding to see a patient. To ensure high quality care, doctors must work in collaboration with the nursing staff and clinical information must be exchanged at this level. Accessing already over-stretched nursing staff at a residential aged care facility can be quite problematic.

Recommendation 22:

The medical profession is sympathetic to the nursing profession's difficulties with aged care facilities, and supports its call for wage parity with other sectors of the nursing profession and recognition of aged care nursing as a speciality and a valued skill.

Realistic workloads, work practice and support comprise some of their requirement. With inadequate residential aged care facility workforce provision, the GPs' role working within a facility is considerably hampered and high clinical standards harder to achieve for residents/patients.

An inequitable fee structure for doctors which penalises visiting more than 1 patient with a sliding scale of rebates is perverse. Further, the Medical Benefits Scheme rate of rebate

provided for GP services is in itself a major disincentive to work in this area. The Government's own *Relative Value Study* found that fees were grossly inadequate.

The Health Insurance Commission is now targeting the 16% of doctors who do visit residential aged care facilities. As they are a small group, their practice is no longer comparable to the 'peers' with whom they are grouped and benchmarked against. They by definition provide more services 'than their peers', prescribe more, have to submit 'Medicare direct-billing forms' unsigned by patients (old, infirm, disabled and demented). Such perverse action by the HIC has to be addressed.

The inequitable wages for nurses and other care staff compared to their level of competence, seniority, responsibility and commitment grossly undervalues them as carers and their patients as human beings.

The large number of non-face-to-face administrative tasks and red tape expected of GPs and care staff are a continual drain on time, resources and morale.

There is a lack of integration of medical services within the aged care system making the support available to residential aged care facilities and the GPs that visit there minimal and the provision of that care more problematic.

There is an absence in many residential facilities of consultation rooms with adequate facilities such as examination couches, bright lights (needed for viewing wounds), and plug-in computer facilities that would facilitate access to patient records and electronic prescribing.

Further, there is considerable unremunerated time which is spent by the doctor when not with the patient, on issues such as interviewing relatives, writing prescriptions, checking medication records and dosages, arranging pathology and radiology tests, ambulances and hospitalisation.

Recommendation 23:

One AMA suggestion is for residential aged care facilities to appoint a GP Facility Adviser.

There are a number of ways that this could be achieved. The AMA is keen to work with government and other stakeholders to advance this idea which provides for a co-ordinated approach by stakeholders in ensuring excellent communication and better results for residents and a more satisfying working environment.

There are at present no adequate incentives to encourage doctors to participate in care management planning for older Australians in residential care. For example medication management reviews for residents of residential aged care facilities make poor use of the GPs upon whose medication charts such reviews are undertaken.

Recommendation 24:

The AMA argues that GPs must be encouraged to provide care to older Australians, but the costs and complexities associated with visits to aged care facilities are huge hurdles. To achieve this objective, the Government must urgently address the funding, staffing and facility issues surrounding the provision of high quality medical care in residential aged care facilities.

Medicare items have yet to reflect both the clinical and non-face-to-face work needs of Medical Practitioners visiting residential aged care facilities.

The Enhanced Primary Care initiative, and the ability to utilise Health Assessment, Care Planning and Case Conferencing items by GPs that are needed within residential aged care facilities are small steps in the right direction. Ideas such as these need to be developed and presented to give much more support for all members of the health team.

GPs cannot work in isolation: the team must be encouraged to participate. Until a more equitable formula for the fee-for-service attendances has been devised, and a more appropriate environment in which to work within a facility has been developed, there will continue to be an exodus of doctors from working within residential aged care facilities.

Overall, the AMA is committed to ensuring that older Australians have access to the care services that they need and are entitled to, and to working with other stakeholders to ensure that the policy environment can provide that.

The residential aged care facility environment: RCS & accreditation

While doctors are legally and ethically responsible for the care management of their patients, the enormous amount of paperwork required within residential aged care facilities act as major disincentives for doctors to provide medical consultations and treatment within facilities. These barriers include:

- The adversarial approach of the Department of Health and Ageing's Resident Classification Scale (RCS) validation system which monitors and determines the care level classification (and thus funding level) of all residents in aged care. If patients' function and condition improve, the residential aged care facilities are actually penalised!

- The inspectorial approach of the Aged Care Standards and Accreditation Agency. There is enormous paperwork involved in residential aged care facilities' complying with the standards and expected outcomes set by the Agency, including in medical areas such as medical care, medication management, and restraint. Failure to comply can result in sanctions on the facilities, including closure.

Compliance with these two inspectorial regimes is duplicated and forms 2/13 of the identified areas with which residential aged care facilities have to comply. And yet doctors and their representatives are not included in a number of the important decision-making loops for these systems.

The problem of delivery of medical care to residents/patients of aged care facilities is part of the wider problem of delivery of medical care to an ageing population.

To address the challenging area of aged care, we must think outside the traditional boundaries to seek innovative ways to address the health care needs of the ageing population in the coming years. This inquiry could play a key role in this process.

The problem needs to be addressed now – not in five or ten years' time. Then it will be too late.

NEED FOR IMPROVED INTEGRATION OF CARE SERVICES

The key to a robust, efficient and effective health system for Australians of all ages is improved integration of care services among institutional, residential, specialist, GP and primary health care settings. The current situation of ineffective integration leaves patients exposed to unnecessary duplication of admission assessments, piecemeal health and aged care delivery, and reduced access to medical care.

The interface between acute care and aged care and the inter-dependence is finally being recognised as a pressing issue.

As a society, we need to develop and implement strategies to improve the continuity of care across programs and to address any cost-shifting measures that impede care. The role of doctors in the health and aged care environments, and specifically the aged care/acute care/GP care/community health care interface, is central and integral.

Australian Health Care Agreements

The current renegotiation of the Australian Health Care Agreements (AHCAs) provides an ideal opportunity whereby all Australian governments can work cooperatively with each other, and with stakeholders, to develop a better framework in which health and aged care services can be funded and delivered to all Australians.

The AMA welcomes the direction of the health policy reform agenda endorsed by the September 2002 meeting of the Australian Health Ministers' Conference (AHMC), particularly the recognition by all Commonwealth, State and Territory Health Ministers of the need to improve the interface between hospitals and primary and aged care services to achieve better outcomes.

The AMA regrets the apparent withdrawal from this spirit of cooperation at the AHMC meeting on 29 November 2002, and hopes that the cross-jurisdictional commitment to positive reform agenda for Australian health services can be revived.

Funding

An ever-present problem is the funding arrangements for health care, which cross both State and Commonwealth jurisdictions. Until the negative implications of cost-shifting changes to a more positive cooperative arrangement, the reality of seamless care will be out of reach.

With the demographic changes and a much-needed revision of health care provision, it is unlikely that aged care will be able to continue with its present financial arrangements and funding mechanisms.

Several methods of funding have been suggested in recent years – such as Pay-As-You-Go (PAYG) where current costs are paid from current revenue, forward funding (private insurance schemes) or Mixed Funding Models[11]. Consideration should also be given to basing funding on

[11] Webster J. *Financing Long-Term Aged Care.* A discussion paper prepared for the National Aged Care Alliance. 2001.p2

a social insurance levy for long-term care administered by the Health Insurance Commission, similar to the German model. The debate continues in regards to appropriate models.

Recommendation 25:

Whichever funding model is decided upon, the issue of the changing demographics and the need for appropriate health care delivery must be addressed. Funding should be primarily for care services, but should include a capital component as part of a properly benchmarked care payment.

The imperative is for aged care service funding to be viable, and based on a standard benchmark of care linking quality of care, quality of life, and the resources and skills mix needed to achieve such benchmarks. The Productivity Commission recommended in 1999 that aged care funding be based on benchmarks linked to the real cost of care.

We need to contribute to the broader health financing debate such as the agenda for change in the next five years which we hope will be fixed by the Australian Health Care Agreements.

This situation will become more critical as we approach 2010 and the cost pressures escalate significantly.

RESEARCH RELATED TO THE CARE OF OLDER PEOPLE

Improvements in care will result from properly designed, analysed and reported biological, clinical and public health research. Because of the complex nature of gerontic research, it rarely fits the rigid scientific parameters of funding organisations such as the National Health and Medical Research Council (NHMRC).

Recommendation 26:

Resources should be made available by governments which will ensure the funding of research programs which focus on age related issues.

Recommendation 27:

As a matter of urgency, research, especially clinical research into age-related issues, should be encouraged and supported.

Recommendation 28:

This research should be multidisciplinary because of the complex inter-relationships between genetic, psycho-social, environmental and economic factors causing dysfunction from disease, disuse, and the effects of biological ageing.

Recommendation 29:

Funding organisations need to positively discriminate in favour of gerontic research if we are to fully understand the emerging issues of our ageing society.

EDUCATION AND HEALTH PROMOTION

Disability in old age is often influenced by prior lifestyle. Health authorities, hospitals and community based services, should co-operate with general practitioners in developing programs to promote the optimal health of older people before disabilities develop. Programs should target high risk persons.

Recommendation 30:

Undergraduate, postgraduate and continuing education of health care providers must address and emphasise the care and, in particular, health promotion among older people.

LEGAL ISSUES IN THE CARE OF OLDER PERSONS

As with ethical considerations, the law should adequately and appropriately protect the interests of older persons at all levels of health care policy and services.

Areas that should be legally recognised and provided for include, but are not necessarily limited to, the following:

- respecting and understanding privacy legislation;
- enabling capable individuals to plan in advance their care and make their preferences known to their families, medical practitioners and care providers through 'Living Wills' or other forms of advance directive;
- empowering a previously designated or appointed proxy decision-maker to consent to health care for persons who are incapable of giving consent;
- ensuring that those individuals who are unable to consent to health care due to mental incapacity have timely, adequate access to needed health care;
- protecting vulnerable persons from those acting against their best interests or against their previously expressed wishes; and
- ensuring that individuals are protected against policies or practices that unjustifiably discriminate with respect to access to and receipt of quality health care services.

The higher the value people place on autonomy, the more likely they are to wish to write down their preferences about health care treatment. This can be in the form of a document variously called 'Advance Healthcare Directive', 'Anticipatory Direction', or 'Living Will'. Legislation and terminology about these vary among States and Territories. These documents deal with health and lifestyle matters before death, in situations where the person themselves, for instance, through dementia or loss of consciousness, is no longer able to indicate their preferences.

Health care providers need to be aware of the legal requirements governing themselves and the health care facilities/institutions within the jurisdictions in which they practise.

SOME BACKGROUND INFORMATION ON THE AMA AND AGED CARE: PARTNERSHIPS FOR CARE

The AMA has been involved with aged care issues for many years – certainly since 1962 when the AMA Federal Council first began meeting in its own right, separating from the British Medical Association.

During that year, the future of rehabilitation services and the keeping of clinical records of patients' histories in nursing homes were on the agenda.

By 1973, issues such as Government policy on admissions to nursing homes were being considered.

In 1984, the AMA responded to the Senate Select Committee on Private Hospitals and Nursing Homes, and since then the AMA has had input into Government aged care reform strategies – the mid-term review in 1990-1991, the second stage in 1993, and more recently the 1997 Aged Care Reforms.

The AMA Committee on Care of Older People is a full committee of the AMA's Federal Council.

AMA Advisory Group on Care of Older People

For some years, the AMA's Committee on Care of Older People has met with other stakeholders as the AMA Advisory Group on Care of Older People. This group preceded both the National Aged Care Alliance and the federal government's Aged Care Working Group as a forum bringing together players in the sector, and continues to work effectively as an ideas-sharing forum.

National Aged Care Alliance (NACA, or the Alliance)

The AMA is one of 8 sponsoring members of the National Aged Care Alliance, a representative body of 23 peak national organisations in aged care, including consumer groups, providers, unions and health professionals working together to determine a more positive future for the aged care sector. Using the Alliance as a coordinating, unifying, and ideas-generating mechanism, the partners in the Alliance have established consensus on a broad-ranging agenda in aged care.

Vision for community care

The AMA has joined with 8 other national non-government consumer and service provider representative organisations in releasing the *Vision for community care* discussion paper, with the purpose of improving community care programs in Australia.

National Aged Care Summit

The AMA hosted a National Aged Care Summit in association with the National Aged Care

Alliance just before the November 2001 federal election. This summit, *Challenges and Solutions: the future of aged care in Australia – 2008 and beyond*, consolidated aged care as one of only 2 policy issues actually debated in the election campaign.

The AMA is thus a key player in establishing aged care as a key issue of public policy.

Drawing on the outstanding success of the 2001 summit, the AMA is considering hosting another aged care summit in 2003 on *A Better Future for Health and Aged Care in Australia* to ensure that health and aged care stay as key issues on the political agenda.

The purpose would include work on developing a long-term vision for aged care, including the concept of a continuum of care between aged, acute, and community care; and funding options for quality aged care, including disincentives to quality care in aged care, (e.g. from our perspective for GPs to provide services in residential aged care facilities), and ways to overcome these disincentives.

We would welcome the participation of committee members and staff.

CHALLENGES FOR THE FUTURE

The AMA is committed to ensuring that older Australians into the future have access to the care services that they need and are entitled to, and to working with other stakeholders to ensure that the policy environment can provide that. This parliamentary inquiry can play an important role in considering and tackling the policy questions that must be addressed in order to achieve this goal.

AMA Federal Secretariat
December 2002

DISCUSSION PAPER

GP SERVICES

TO

RESIDENTIAL AGED CARE

FACILITIES

Attachment to the AMA submission to the House of Representatives Standing Committee on Ageing Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years:
A Better Future for Health and Aged Care in Australia

INDEX

INTRODUCTION

For quite some time there have been large barriers facing General Practitioners who attend patients in residential aged care facilities. These barriers have led to a situation where fewer GPs are prepared to visit facilities, causing a critical shortage of GP services within some facilities.
In attempting to provide quality care to patients in residential aged care facilities, disincentives such as travelling time, lack of structured patient environment and the large quantum of non face-to-face services all add to difficulties doctors experience. If standards of care are to be sustained within the facilities, new models of GP services and remuneration need to be considered and implemented.

This paper sets out the reasons for the decline in services by GPs to facilities and draws on data to show the inequitable fee structure for visits. It looks at other influences on medical care in facilities and then proposes elements which can be considered in the development of new models of primary care medical services in residential aged care facilities which will ensure and sustain a high standard of care.

BACKGROUND

The demand for beds in aged care facilities is rapidly growing as the population in the over 65 age group is escalating. In 1998, the number of people aged over 65 years was 2.3 million. This figure will increase to 4 million in 2021 and to 5.7 million in 2041[12].

As at 30 June 2000, there were 3,005 occupied aged care homes in Australia providing a total of 141,162 places, an increase in absolute terms of only 511 places since 30 June 1999. During the reporting period there was a 96% occupancy rate.[13] A break-down of this occupancy rate (as at January/June 2000) is:

- former nursing homes 97.28%,
- former hostels 95.40%,
- new aged care homes 93.68%[14].

Occupancy levels have been retained, and increased for low care homes. Overall, the number of residential places has declined in relation to the number of older people. This has resulted because the introduction of new places into the system throughout the past decade has been insufficient to meet the benchmark ratio for hostel (and now low care) places, while the provision of nursing home places gradually declined towards the Government's 'benchmark' of 40 beds per 1,000 population aged 70 years and older.[15]

As will be seen later in this paper, there is also the contributing factor of the increase in the dependency levels of residents in both high care and low care over

[12] Professor Len Gray. Two Year Review of Aged Care Reforms, Canberra 2001 p1.
[13] Australian Institute of Health and Welfare (AIHW) 2001. Residential aged care in Australia 1999-00 A statistical overview, Canberra, AIHW (Aged Care Statistics Series no. 9)
[14] Professor Len Gray. Two Year Review of Aged Care Reforms, Canberra 2001 p27
[15] Professor Len Gray. Two Year Review of Aged Care Reforms, Canberra 2001 p30

the past several years. Also, available residential care places have been targetted to a progressively more dependent group of people because of the Government's policy of providing more home based care so that people can stay in the community longer.[16]

These statistics highlight the importance of, and the need for effective and efficient GP services in residential aged care facilities. Every resident is entitled to quality medical care. *Every medical practitioner is entitled to appropriate working conditions and remuneration enabling them to deliver timely quality care.*

"Bedblockers"

In a derogatory and demeaning way, hospitals, both public and private, often speak of older patients as "bed blockers". This results when they remain in hospital when no bed is available at a residential aged care facility, or when they are well enough to be discharged, but not well enough to look after themselves within their own homes.

The AMA has proposed, as a solution to 'bed blockers', the allocation of beds in residential aged care facilities whereby patients can move from hospital acute care to residential aged care facilities for "transitional" or "rehabilitative" care.

Another proposal is that medical guidelines be developed in collaboration with General Practitioners, Divisions of General Practice, Geriatricians, nurses involved in aged care facilities, with medical specialists and nursing representatives from acute care facilities, so that acute care needs of residents can be met within the facility. This concept of 'Hospital in the Residential Aged Care Facility' could parallel the 'Hospital in the Home' model. Although these proposals are beyond the scope of this paper they will impact on the role of medical practitioners within facilities and should not be discounted when considering models for primary care medical services in facilities[17].

A recent interim report on "Medical Professionals Perceptions of Public Hospital System" by Elkers and Quint stated that hospital administrators and specialists/consultants claimed that GPs should be prepared to take a broader role in the provision of primary and preventative care to patients which would decrease the demand on public hospital services.

Services to residential aged care facilities

There is both anecdotal and statistical evidence of an overall reduction in the number of medical practitioners willing to provide visiting medical services to the residents of aged care facilities. In addition there is also statistical evidence that, while utilisation of the MBS Level A item (and to a lesser extent Level B item) is dropping, there is an increase in the usage of Level C and D items[18].

[16] Australian Institute of Health and Welfare (AIHW) 2001. Residential aged care in Australia 1999-00 A statistical overview, Canberra, AIHW (Aged Care Statistics Series no. 9)
[17] Wenck, B, Stephan, J, Besley C. Discussion Paper "Acute Care in the Aged Care Residential Sector", an unpublished paper prepared for the Queensland Health Clinical Panel on Ageing, 2001.
[18] ref: Hansard p29140, 6 August 2001

The HIC statistics in the following table show the total number of services per year, for which a Medicare Benefit was claimed, for each of the Residential aged care facility consultation items:

MBS Item For RACF	Year ending 31 Dec 96	Year ending 31 Dec 97	Year ending 31 Dec 98	Year ending 31 Dec 99	Year ending 31 Dec 00
20 (level A)	91,527	85,338	79,325	68,613	61,901
35 (level B)	1,374,891	1,368,966	1,385,387	1,357,275	1,347,923
43 (level C)	67,377	74,057	82,339	88,799	97,640
51 (level D)	8,203	9,246	10,519	10,719	11,837
Total	**1,541,998**	**1,537,607**	**1,557,570**	**1,525,406**	**1,519,301**

From the above information, it can be seen that the number of Level A's has decreased markedly and the total number of services generally has decreased over the last five years.

This reflects the increasingly high incidence of sicker patients, complex multiple disease and resultant more complex medical requirements. Dependency levels, which continued to rise among both nursing home and hostel populations up to the time of the Aged Care Reforms in 1997, have continued this trend with the amalgamation of the two systems.

Between 30 June 1998 and 30 June 2000 high care residents (RCS 1 to 4) rose from 57.8% to 61.8% while those classified as low care (RCS 5 to 8) fell from 42.2% to 38.3%. A more detailed breakdown showing the dependency of permanent residents as at 30 June 1998 (over a six month period), June 1999 and at 30 June 2000 which is taken from *AIHW Residential Aged Care in Australia 1998, 1998-1999 and 1999-2000* is shown below.

	RCS1	RCS2	RCS3	RCS4	RCS5	RCS6	RCS7	RCS8	Total
Jan-June 1998	8,868 6.9%	32,279 24.9%	26,250 20.3%	7,398 5.7%	9,910 7.7%	12,576 9.7%	26,287 20.3%	5,835 4.5%	129,403 100%
1998/ 1999	15,971 12.4%	33,279 25.9%	22,995 17.9%	5,875 4.6%	11,072 8.6%	13,036 10.1%	22,383 17.4%	3,944 3.1%	128,555 100%
1999 2000	18,786 14.4%	33,835 26%	21,781 16.7%	6,081 4.7%	11,538 8.9%	13,399 10.3%	21,869 16.8%	3,027 2.3%	130,316 100%

Statistics for this kind of comparison are only available from January 1998 because of the changes brought about by the Aged Care Reforms 1997. A key feature of the reforms was the introduction of a single instrument, the Resident Classification Scale (RCS). The RCS was introduced with the specific intention that it would give greater recognition to the resources required to care for people with cognitive impairment and associated behavioural care needs and that funding could then be better aligned with assessed care needs – unfortunately there is no correlation!
Taking into account the above data it is interesting to note that the number of residents in aged care facilities in 1998 were 129,403 and the number of attendances by GPs to the facilities were 1,557,570. In 2000 the number of

residents increased to 130,316 while the number of attendances by GPs to the facilities dropped to 1,519,301.

It should also be noted that the Health Insurance Commission has "considered it necessary" to question some GPs in relation to their increased number of visits being undertaken to residential aged care residents/patients. It can only be assumed that there are fewer GPs visiting residential aged care facilities, and, because of the increased acuity, seeing these patients more frequently.

Fee structure

The fee structure for visits to residential aged care facilities is exactly the same as that for home visits or consultations at a hospital or institution and is based on a sliding scale of payment for the number of people seen at the one visit..
At all levels (A, B, C and D) the derived fee is made up of the fee for attendance at consulting rooms plus $19.15 which is then divided by the number of patients seen, up to a maximum of six patients. However, for seven or more patients, the fee for the attendance is at the same level as in consulting rooms, but only plus *$1.30 per patient. An example, based on a Level B consultation is shown below:*

Item No 23 (level B)	No of Patients	Loading	Schedule Fee (Derived) Item 35
$27.00	1	$19.15	$46.15
$27.00	2	$ 9.57	$36.60
$27.00	3	$ 6.38	$33.40
$27.00	4	$ 4.78	$31.80
$27.00	5	$ 3.63	$30.85
$27.00	6	$ 3.19	$30.20
$27.00	7	$ 1.30	$28.30
$27.00	8 (7 or more)	$ 1.30	$28.30
$27.00	9	$ 1.30	$28.30

It is far more likely that a GP will be seeing multiple patients during a visit to a residential aged care facility than during a home visit. Therefore, the average benefit received by a GP 'per patient' is much less for residential aged care facilities than for consultations on home visits or to hospitals.
In the actual doctor/patient billing process, HIC regulations require that the form is signed and a copy given to the patient in the case of bulk billing.
However the actual MBS item number (eg 35/1 to 35/7), where the schedule (derived) fee is based on the number of patients seen, is often not known at the beginning of a "round" or may alter when extra patients are seen – or not seen. Any change in the number of patients seen will, of course, mean that a different derived fee will be applicable. A legal and workable process should be developed which will address this problem so that patients/residents or their family receives an accurate and legible copy of the relevant form.
The following table, drawn from HIC data for the calendar year ending 31 December 2000 illustrates this disparity when it shows that the average benefit per service for home visit Level B is $36.21 compared with a residential aged care facility level B of $28.78. For level A, the disparity is $8.13, Level C $4.48 and Level D $3.25.

Item Number	Total Number of Services	Total Benefit Paid	Average Benefit per Service
4 (Home visit Level A)	10,751	$233,465	$21.72
20 (RACF visit Level A)	61,901	$841,009	$13.59
Disparity per service			**$8.13**
24 (Home visit Level B)	1,517,384	$54,944,462	$36.21
35(RACF visit Level B)	1,347,923	$38,792,025	$28.78
Disparity per service			**$7.43**
37 (Home visit Level C)	259,118	$14,314,890	$55.24
43 (RACF visit Level C)	97,640	$4,955,909	$50.76
Disparity per service			**$4.48**
47 (Home visit Level D)	42,107	$3,138,132	$74.53
51 (RACF visit Level D)	11,837	$843,784	$71.28
Disparity per service			**$3.25**

Enhanced Primary Care Items

The Enhanced Primary Care (EPC) items in the MBS were introduced into the MBS in November 1999. These new items – health assessments, multidisciplinary care plans and case conferences - allow primary care providers, especially general practitioners, to focus on preventive care for older Australians and to provide improved coordination of care for people with chronic illness and multidisciplinary care needs. On 1 November 2000 additions were made to the EPC MBS items which included a limited use of some of the items in residential aged care facilities.

GPs are now able to contribute, if invited, to a resident's RCS care plan, and to organise and coordinate, or participate in multidisciplinary case conferences for residents in facilities. It was hoped that, by introducing these items into residential aged care facilities, GPs would be encouraged to involve themselves more fully in the delivery of care in the facilities. However, to date, little use has been made of the items. Only 175 GPs have used the three time tiered items (15, 30 and 45 minutes) for case conferencing in residential aged care facilities from 1 November 2000 to April 2001.

GP Memorandum of Understanding

Any proposed new GP fee structure must also be considered in the context of the GP Memorandum of Understanding especially in regard to the cap and the redistribution of funds and the targetting of initiatives where fee-for-service has been replaced by blended payments such as PIP.

Clearly any changes will require additional new funds if real gains are to be made in aged care.

GP SERVICES TO RESIDENTIAL AGED CARE FACILITIES

Visits by GPs to residents/patients at residential aged care facilities can either be on a regular basis, or on an "as needs" basis. In the first instance a GP can have an arrangement whereby the facility's residents/patients are routinely visited, say, every four weeks. In the second instance, a GP may visit the resident/patient when the facility has telephoned with a specific urgent request.

Integrating Medical Care in the residential aged care facility

Any new models must have a framework which integrates medical, nursing, pharmacy and allied health care.

To be eligible to enter a residential aged care facility care recipients are assessed by Aged Care Assessment Teams (ACATs) who determine if the care levels required are high level care (levels 1-4) or low level care (levels 5-8), but not the specific care level.
On entering a facility, the new resident undergoes, over a period of at least 21 days, an appraisal process. This appraisal process is necessary for two reasons:

- firstly, the completion and the development of a "care plan" and,
- secondly, the "care plan" justifies and assigns the Resident Classification Scale (RCS) level.

The RCS "score" assigns the in-coming resident to one of the eight levels of Commonwealth funding subsidy. The RCS score is completed by the approved provider or someone acting on their behalf and results from a set of questions about a care recipient's clinical needs, ability to do various daily tasks, major areas of personal care need, communication or sensory assistance and the care recipient's need for social or emotional support.

The RCS is purely a funding tool; casemix for aged care facilities.

A facility's care plan comprises a statement of the resident's problems determined during assessment, with resident centred goals and strategies to help residents achieve and maintain those goals. A GP can now contribute, if invited by the facility, to a facility's resident's care plan with billing using an EPC MBS item.

In high care, the care plan is finalised by nursing staff, but in low care there are often no trained nurses involved.

One way to begin an integrating process for medical practitioners and facilities would be to have input in the appraisal process when the patient enters the facility - either from home or from hospital.

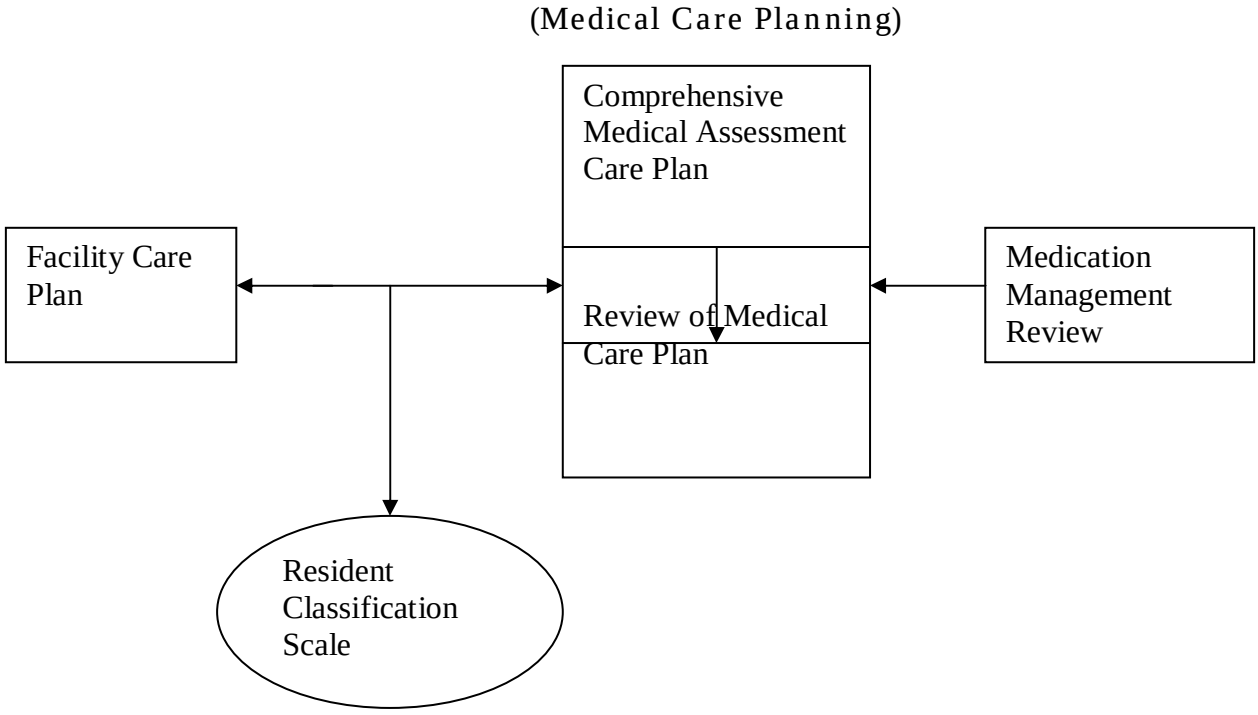
Often a GP attending a residential facility cares for patients that have previously been under the care of a GP who is no longer able to provide care in their new environment. The GP caring for the new patient in the residential facility needs to review available information, collect necessary historical data that is not in their file, do a comprehensive assessment and formulate a medical care plan for the new patient – "A Comprehensive Medical Assessment Care Plan".

This proposed Comprehensive Medical Assessment Care Plan incorporates elements of the current EPC Community Health Assessment and the medical portion of a multidisciplinary Care Plan. Most patients entering residential care have complex and chronic problems with which the GP takes a long time to become familiar. The current schedule of fees does not encourage such large amounts of non-patient time mitigating against doctors undertaking a comprehensive review. Currently admitted patients are also in need of a Comprehensive Medical Assessment Care Plan. This activity should be specifically remunerated with a new EPC MBS item.

The Comprehensive Medical Assessment Care Plan will need to be done over a period of two to three weeks. The collection and clarification of historical data – discussion with the patient and/or relatives or legal guardian as appropriate, accessing a previous GP, phoning specialists and contacting a hospital – is often necessary. This is time consuming but extremely important for provision of continuity of care and prospective quality medical care.

Current arrangements within residential aged care facilities of medication management are fragmented. Medication reviews by pharmacists are usually undertaken with little, if any contact with prescribers, the GPs. New models of care delivery are required to support a collaborative model, similar to the new Domiciliary Medication Management Review (DMMR) arrangements. A Medication Management Review should be an integral part of the collaborative model.

Information from the Comprehensive Medical Assessment Care Plan and subsequent Review Medical Care Plan could feed into the facility's care plan/RCS process and link into a Residential Medication Management Review, resulting in better organised, more appropriate and coordinated care for the resident/patient.



This integrated approach will require changes and additions to the EPC MBS items. At present, there is no GP initiated care plan item or Medication Management Review item for residential aged care facilities. In fact, GPs are specifically and deliberately excluded. The present item, which invited doctor participation in an aged care facility's care plan, will be redundant. Additional MBS items will be needed for:

- Comprehensive Medical Assessment Care Plans,
- Review Medical Care Plans, and
- Medication Management Review.

In the USA a "Resident Assessment Instrument"-related casemix funding model has been developed to meet the need for staffing level determination, as well as providing funding incentives for quality assurance[19].

Barriers to visiting residential aged care facilities

Many GPs are finding that the barriers to providing care to residents in aged care facilities mean that it is not financially cost-effective and viable to continue to care for a patient once they enter a facility.

Factors affecting the capacity for general practitioners to visit residential aged care facilities range from conditions within the facility to GP remuneration. The most common barriers are:

- the unsatisfactory levels of remuneration, especially when other competing demands on their time and expertise are better remunerated (and no way near as frustrating);
- the amount of time spent in travelling;
- the time spent waiting for nursing staff before it is possible to see a patient, and then finding the patient (or vice versa);
- the lack of appropriate examination facilities such as a room set aside to see patients, and basic equipment eg bright light needed for viewing wounds, performing rectal or vaginal examinations, let alone *ever* trying to perform any procedure.
- the lack of IT facilities at the facility which would improve efficiency of prescribing and administrative tasks;
- the large number of non-face-to-face tasks expected of GPs by the facility staff which are not covered by fee-for-service and are performed when the doctor is NOT at the residential aged care facility;
- the considerable unremunerated time which can be spent on issues such as: writing scripts, faxing drug and treatment orders, checking medication records and dosages; making, answering and responding to numerous urgent telephone queries from aged care facility staff, arranging urgent pathology tests (eg micro-urine), arranging locums, hospitalisation, ambulances; and interviewing relatives.

[19] Scherer, S. Policy Proposal: Medical Care. Unpublished paper prepared for National Aged Care Alliance, 2001 (page 4, see references).

- the increased paperwork undertaken by GPs which is required by the facility to fulfil requirements demanded by the accreditation process.
- the lack of consultation between staff and other health care professionals and GPs, and lack of integration of GP services in the facility system.
- the frequent phone calls received at the surgery subsequent to visits to residential aged care facilities, from facility staff to clarify and confirm patient/resident treatment.
- the lack of specialists willing to visit residential aged care facilities, which results in unrealistic and unfair expectations being placed on GPs to undertake an extended 'specialist' role. This often dissuades, especially younger GPs, from being involved in the care of patients in facilities.

Other Perceived Problems and Barriers

Most providers encourage the residents to retain their GP when they enter the facility, although in reality this will depend on the proximity of the facility to the doctor's surgery. Because of the shortage of residential aged care facility beds, patients rarely have the luxury of choosing the location of the facility where they are going to live. However, once they move out of their familiar community, they lose their usual doctor and so they often lose their medical history, especially including psycho-social knowledge and ultimately their medical advocate (and friend).

A developing problem is the relocation of some residential aged care facilities from inner suburban sites to the outer urban fringe. As patients from these inner suburban facilities move with the facilities, and mostly they have no choice, they move away from their family, friends and GP. Also they will also be moving to outer fringe suburbs where the population is younger and the focus and expertise of the health care system is geared more to younger people.

A logical flow on problem is that of the provision of emergency medical services. It is seldom that a doctor can immediately leave their practice when a call is received regarding a patient at a residential aged care facility during routine consulting hours. Also residential aged care facilities are usually not serviced by GPs after hours. At times when a doctor cannot attend an urgent call, a locum may attend, or, as in the 'after hours' context, the only alternative for many facilities is the use of ambulance transport to the hospital Accident and Emergency. Many outer urban fringe areas do not have access to locum services. Residents will either not be seen, sent off to Accident and Emergency, or GPs will find this all just too arduous and refuse to service aged care facilities.

The Commonwealth Department of Health and Ageing recently advertised for applications from organisations or consortiums for grant funding to improve access, efficiency and quality of after hours primary medical care services across Australia. It may be that medical care in residential care could link into such a program. Unfortunately, as we have described, problems of urgent (emergency) visiting are not confined solely to after-hours.

Staffing

Staff members in residential aged care facilities play an integral and essential role in the delivery of quality care to older people. With the increasing dependency levels of people entering residential care, facilities need to be properly staffed to be able to fulfill their duty of care and manage the complex medical care needs.

At present there is no set staffing or skill mix level within facilities. While nurses and carers are committed to working in aged care, they find the workload, lack of wage parity, and their inability to achieve desired resident outcomes a deterrent to remaining in the industry. Consequently morale is low and it is difficult to retain, let alone recruit skilled nursing staff. Even agency staff members, employed when permanent staff members are absent, are often not available.

To be able to provide high quality care, in fact any care, doctors must work in collaboration with the nursing staff. The medical profession is sympathetic to the nursing profession's difficulties, and supports its call for wage parity and more realistic workloads. Until this happens, the GP's role working within a facility is considerably hampered and high clinical standards of care harder to achieve for our residents/patients.

Corporatisation

A further issue that requires consideration is the effect of the developing and rapidly expanding corporatisation of medical practices – an activity that has focussed on three principal areas, stock market floats of new companies, aggressive acquisition of general practices by entrepreneurs and the formation of vertically integrated companies.

While the speed and extent of this change has been dramatic and unexpected, there are core concerns including ethical values, clinical autonomy and standards of care. Consideration must be given to the potential effects of these developments on the delivery of aged care medical services, especially when taking into account long term planning.

It is possible that there will be some positive effects from corporatisation or practice amalgamations especially if, in larger practices, there is the opportunity for GPs dedicated to and better trained in geriatric medicine to provide a more effective and cost efficient service.

However it is highly unlikely that altruism will drive corporate behaviour as it has driven doctors so far. It is much more likely that hard nosed Corporates will carefully look at all areas of practice as to their profitability, in their own right and this will certainly include residential aged care facilities. Only if these criteria of profitability are met will Corporates consider having GPs, let alone dedicated GPs, to service this increasing marketplace.

RECOMMENDATIONS

There needs to be a reassessment as to what level of rebates and conditions are going to be required to retain and hopefully attract GPs back, so as to maintain optimum medical services within residential aged care facilities. The existing rebates and the associated formula can be at best described as "inadequate" and there is little or no integration or coordination of medical, nursing, allied health and pharmacy care.

The following recommendations for primary care medical services within residential aged care facilities have been developed for consideration:

1. *Revive the current model by the provision of an adequate and appropriate MBS fee structure.*

It is essential that the large amount of non-face-to-face time be acknowledged and added in to any determined or existing MBS fee formula. At present there is the inadequate derived MBS fee with its regressive sliding scale (see page 8).
Remuneration using this sliding scale is inappropriate when the ratio of face-to-face to non face-to-face work for each visit is approximately 60:40. This sliding scale does not take into consideration difficulty factors such as the environment and time spent accessing both staff and patients – difficulties which do not exist in home or hospital visits. Consideration must be given to the introduction of a different formula with loading factors added for non face-to-face work and a difficulty component.

2. *Encourage GPs to attend residential aged care facilities by an extension of integrated models of care under the EPC initiative where GPs can:*
   - *Complete a Comprehensive Medical Assessment Care Plan*
   - *Review Medical Care Plans*
   - *Perform Medication Management Reviews.*

The Comprehensive Medical Assessment Care Plan and Review Medical Care Plans would feed into the facility care plan and give medical input to the RCS, link into a Residential Medication Management Review, and so, for the first time, enable a direct correlation between funding and care.

It is noted that the Medication Management Review Implementation Steering Group (MMRISG) is looking at Residential Medication Management Review (RMMR). Australian Pharmaceutical Advisory Council (APAC) is looking at both medication specific services and guidelines in the broader framework of care that is required for any meaningful improvement in medication management.

EPC items for attendance at a facility's Medication Management Committee or ideally, as in the APAC best practice model[20], at a Division of General Practice

[20] Australian Pharmaceutical Advisory Council. *Integrated best practice model for medication management in residential aged care facilities.* Commonwealth of Australia 1997

auspiced Regional Medication Advisory Committee[21] would go a long way to solving problems of polypharmacy, iatrogenic disease and burgeoning PBS costs in the elderly.

3(a) GPs could attend residential aged care facilities within a GP Facility Adviser arrangement to allow further flexibility in terms of remuneration arrangements in some circumstances, such as large facilities and public facilities.

All residents/patients have the right to be treated by their usual GP, or a GP of their choice within a residential aged care facility. However where a resident/patient's GP is not accessible, facilities now often use a panel of doctors, selected by the nursing staff/provider, to deliver care to the residents. This assures certainty with ongoing familiarity and integration into the facility's care system. At present remuneration remains fee-for-service.

However, no matter what arrangements are used, residents/patients must retain their right to their practitioner of choice.

3(b) GP Facility Adviser arrangements could be used for GPs to sit on Medical Advisory Committees, Credentialling Committees and Medication Advisory Committees similar to those presently run in private hospitals.
To ensure quality patient care, it is essential that GPs are involved in Committees which provide discussion on an integrated basis with across-professionals such as doctors, facility staff and pharmacists. Committees such as Medical Advisory Committees and Medication Advisory Committees provide an opportunity for such discussion to take place.

4. As part of the accreditation process, there should be mandating of provision by the residential aged care facilities of:
IT, in consultation with the General Practice Computing Group, and
facilities for consultation and examination.

These facilities could be used for taking histories, writing scripts and undertaking procedures and would have advantages for all parties and save considerable time. It would facilitate a "consultation by appointment" process, where appropriate, especially in low care facilities. It would also facilitate technological integration, more effective care, far more dignified care and be attractive to visiting medical practitioners.

In considering these four recommendations, it might well be that a combination of them could be used in the development of a series of models and that these models would not only be additive, but could also run in parallel giving a range of possibilities for varying circumstances.
As alluded to in the Introduction (page 5) future planning of aged care should include consideration of models of care such as transitional care, whereby patients can move from hospital acute care to residential aged care facilities for rehabilitative care, and Hospital in the Residential Aged Care Facility, where acute care needs of residents can be met within the facility. These models,

[21] Segal, G. *Role and Activities of a Regional Medication Advisory Committee for Residential Aged Care Facilities.* Unpublished paper prepared for Greater South Eastern Division of General Practice, 2000.

however, are beyond the scope of this paper and would demand a total change of practice and philosophy of State/Commonwealth funding processes.

CONCLUSION

It is essential that the outcome of the consideration of these issues be the drafting of new and appropriate MBS items for residential aged care facilities and that serious consideration be given to its importance as an issue separate from the GP Memorandum of Understanding. *Separate and new funding for these important problems in aged care is essential.*
Facilities should be appropriately funded to enable them to purchase the medical advice they need and to invest in an appropriate medical infrastructure.
Accreditation should encourage quality improvement and best practice in medical and health care. Unless there is reform in the whole system merely reviewing a section, for example Residential Medication Management Review (RMMR) will be ineffective.

Finally it should be remembered that the problem of delivery of medical care to residents/patients of aged care facilities is still part of the wider problem of delivery of medical care to an ageing population. In view of the increasing demands on an already overburdened system, the total needs of the older population must still be properly addressed. Access to a high standard of clinical care is a right and must never be denied on the basis of age, disability or perceived societal usefulness.

There is no place for policies and practices that discriminate in terms of access to quality health care service at any age.

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DISCUSSION PAPER

GP SERVICES

TO

RESIDENTIAL AGED CARE

FACILITIES

Attachment to the AMA submission to the House of Representatives Standing Committee on Ageing Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years:
A Better Future for Health and Aged Care in Australia

INDEX

INTRODUCTION

For quite some time there have been large barriers facing General Practitioners who attend patients in residential aged care facilities. These barriers have led to a situation where fewer GPs are prepared to visit facilities, causing a critical shortage of GP services within some facilities.

In attempting to provide quality care to patients in residential aged care facilities, disincentives such as travelling time, lack of structured patient environment and the large quantum of non face-to-face services all add to difficulties doctors experience. If standards of care are to be sustained within the facilities, new models of GP services and remuneration need to be considered and implemented.

This paper sets out the reasons for the decline in services by GPs to facilities and draws on data to show the inequitable fee structure for visits. It looks at other influences on medical care in facilities and then proposes elements which can be considered in the development of new models of primary care medical services in residential aged care facilities which will ensure and sustain a high standard of care.

BACKGROUND

The demand for beds in aged care facilities is rapidly growing as the population in the over 65 age group is escalating. In 1998, the number of people aged over 65 years was 2.3 million. This figure will increase to 4 million in 2021 and to 5.7 million in 2041[22].

As at 30 June 2000, there were 3,005 occupied aged care homes in Australia providing a total of 141,162 places, an increase in absolute terms of only 511 places since 30 June 1999. During the reporting period there was a 96% occupancy rate.[23] A break-down of this occupancy rate (as at January/June 2000) is:

- former nursing homes 97.28%,
- former hostels 95.40%,

[22] Professor Len Gray. Two Year Review of Aged Care Reforms, Canberra 2001 p1.
[23] Australian Institute of Health and Welfare (AIHW) 2001. Residential aged care in Australia 1999-00 A statistical overview, Canberra, AIHW (Aged Care Statistics Series no. 9)

- new aged care homes 93.68%[24].

Occupancy levels have been retained, and increased for low care homes. Overall, the number of residential places has declined in relation to the number of older people. This has resulted because the introduction of new places into the system throughout the past decade has been insufficient to meet the benchmark ratio for hostel (and now low care) places, while the provision of nursing home places gradually declined towards the Government's 'benchmark' of 40 beds per 1,000 population aged 70 years and older.[25]

As will be seen later in this paper, there is also the contributing factor of the increase in the dependency levels of residents in both high care and low care over the past several years. Also, available residential care places have been targetted to a progressively more dependent group of people because of the Government's policy of providing more home based care so that people can stay in the community longer.[26]

These statistics highlight the importance of, and the need for effective and efficient GP services in residential aged care facilities. Every resident is entitled to quality medical care. *Every medical practitioner is entitled to appropriate working conditions and remuneration enabling them to deliver timely quality care.*

"Bedblockers"

In a derogatory and demeaning way, hospitals, both public and private, often speak of older patients as "bed blockers". This results when they remain in hospital when no bed is available at a residential aged care facility, or when they are well enough to be discharged, but not well enough to look after themselves within their own homes.

The AMA has proposed, as a solution to 'bed blockers', the allocation of beds in residential aged care facilities whereby patients can move from hospital acute care to residential aged care facilities for "transitional" or "rehabilitative" care.

Another proposal is that medical guidelines be developed in collaboration with General Practitioners, Divisions of General Practice, Geriatricians, nurses involved in aged care facilities, with medical specialists and nursing representatives from acute care facilities, so that acute care needs of residents can be met within the facility. This concept of 'Hospital in the Residential Aged Care Facility' could parallel the 'Hospital in the Home' model. Although these proposals are beyond the scope of this paper they will impact on the role of medical practitioners within facilities and should not be discounted when

[24] Professor Len Gray. Two Year Review of Aged Care Reforms, Canberra 2001 p27
[25] Professor Len Gray. Two Year Review of Aged Care Reforms, Canberra 2001 p30
[26] Australian Institute of Health and Welfare (AIHW) 2001. Residential aged care in Australia 1999-00 A statistical overview, Canberra, AIHW (Aged Care Statistics Series no. 9)

considering models for primary care medical services in facilities[27].

A recent interim report on "Medical Professionals Perceptions of Public Hospital System" by Elkers and Quint stated that hospital administrators and specialists/consultants claimed that GPs should be prepared to take a broader role in the provision of primary and preventative care to patients which would decrease the demand on public hospital services.

Services to residential aged care facilities

There is both anecdotal and statistical evidence of an overall reduction in the number of medical practitioners willing to provide visiting medical services to the residents of aged care facilities. In addition there is also statistical evidence that, while utilisation of the MBS Level A item (and to a lesser extent Level B item) is dropping, there is an increase in the usage of Level C and D items[28].

The HIC statistics in the following table show the total number of services per year, for which a Medicare Benefit was claimed, for each of the Residential aged care facility consultation items:

MBS Item For RACF	Year ending 31 Dec 96	Year ending 31 Dec 97	Year ending 31 Dec 98	Year ending 31 Dec 99	Year ending 31 Dec 00
20 (level A)	91,527	85,338	79,325	68,613	61,901
35 (level B)	1,374,891	1,368,966	1,385,387	1,357,275	1,347,923
43 (level C)	67,377	74,057	82,339	88,799	97,640
51 (level D)	8,203	9,246	10,519	10,719	11,837
Total	**1,541,998**	**1,537,607**	**1,557,570**	**1,525,406**	**1,519,301**

From the above information, it can be seen that the number of Level A's has decreased markedly and the total number of services generally has decreased over the last five years.

This reflects the increasingly high incidence of sicker patients, complex multiple disease and resultant more complex medical requirements. Dependency levels, which continued to rise among both nursing home and hostel populations up to the time of the Aged Care Reforms in 1997, have continued this trend with the amalgamation of the two systems.

Between 30 June 1998 and 30 June 2000 high care residents (RCS 1 to 4) rose from 57.8% to 61.8% while those classified as low care (RCS 5 to 8) fell from 42.2% to 38.3%. A more detailed breakdown showing the dependency of permanent residents as at 30 June 1998 (over a six month period), June 1999 and at 30 June 2000 which is taken from *AIHW Residential Aged Care in Australia 1998, 1998-1999 and 1999-2000* is shown below.

[27] Wenck, B, Stephan, J, Besley C. Discussion Paper "Acute Care in the Aged Care Residential Sector", an unpublished paper prepared for the Queensland Health Clinical Panel on Ageing, 2001.
[28] ref: Hansard p29140, 6 August 2001

	RCS1	RCS2	RCS3	RCS4	RCS5	RCS6	RCS7	RCS8	Total
Jan-June 1998	8,868 6.9%	32,279 24.9%	26,250 20.3%	7,398 5.7%	9,910 7.7%	12,576 9.7%	26,287 20.3%	5,835 4.5%	129,403 100%
1998/ 1999	15,971 12.4%	33,279 25.9%	22,995 17.9%	5,875 4.6%	11,072 8.6%	13,036 10.1%	22,383 17.4%	3,944 3.1%	128,555 100%
1999 2000	18,786 14.4%	33,835 26%	21,781 16.7%	6,081 4.7%	11,538 8.9%	13,399 10.3%	21,869 16.8%	3,027 2.3%	130,316 100%

Statistics for this kind of comparison are only available from January 1998 because of the changes brought about by the Aged Care Reforms 1997. A key feature of the reforms was the introduction of a single instrument, the Resident Classification Scale (RCS). The RCS was introduced with the specific intention that it would give greater recognition to the resources required to care for people with cognitive impairment and associated behavioural care needs and that funding could then be better aligned with assessed care needs – unfortunately there is no correlation!

Taking into account the above data it is interesting to note that the number of residents in aged care facilities in 1998 were 129,403 and the number of attendances by GPs to the facilities were 1,557,570. In 2000 the number of residents increased to 130,316 while the number of attendances by GPs to the facilities dropped to 1,519,301.

It should also be noted that the Health Insurance Commission has "considered it necessary" to question some GPs in relation to their increased number of visits being undertaken to residential aged care residents/patients. It can only be assumed that there are fewer GPs visiting residential aged care facilities, and, because of the increased acuity, seeing these patients more frequently.

Fee structure

The fee structure for visits to residential aged care facilities is exactly the same as that for home visits or consultations at a hospital or institution and is based on a sliding scale of payment for the number of people seen at the one visit..

At all levels (A, B, C and D) the derived fee is made up of the fee for

attendance at consulting rooms plus $19.15 which is then divided by the number of patients seen, up to a maximum of six patients. However, for seven or more patients, the fee for the attendance is at the same level as in consulting rooms, but only plus $1.30 per patient. An example, based on a Level B consultation is shown below:

Item No 23 (level B)	No of Patients	Loading	Schedule Fee (Derived) Item 35
$27.00	1	$19.15	$46.15
$27.00	2	$ 9.57	$36.60
$27.00	3	$ 6.38	$33.40
$27.00	4	$ 4.78	$31.80
$27.00	5	$ 3.63	$30.85
$27.00	6	$ 3.19	$30.20
$27.00	7	$ 1.30	$28.30
$27.00	8 (7 or more)	$ 1.30	$28.30
$27.00	9	$ 1.30	$28.30

It is far more likely that a GP will be seeing multiple patients during a visit to a residential aged care facility than during a home visit. Therefore, the average benefit received by a GP 'per patient' is much less for residential aged care facilities than for consultations on home visits or to hospitals.

In the actual doctor/patient billing process, HIC regulations require that the form is signed and a copy given to the patient in the case of bulk billing.

However the actual MBS item number (eg 35/1 to 35/7), where the schedule (derived) fee is based on the number of patients seen, is often not known at the beginning of a "round" or may alter when extra patients are seen – or not seen. Any change in the number of patients seen will, of course, mean that a different derived fee will be applicable. A legal and workable process should be developed which will address this problem so that patients/residents or their family receives an accurate and legible copy of the relevant form.

The following table, drawn from HIC data for the calendar year ending 31 December 2000 illustrates this disparity when it shows that the average benefit per service for home visit Level B is $36.21 compared with a residential aged care facility level B of $28.78. For level A, the disparity is $8.13, Level C $4.48 and Level D $3.25.

Item Number	Total Number of Services	Total Benefit Paid	Average Benefit per Service
4 (Home visit Level A)	10,751	$233,465	$21.72
20 (RACF visit Level A)	61,901	$841,009	$13.59
Disparity per service			**$8.13**
24 (Home visit Level B)	1,517,384	$54,944,462	$36.21
35(RACF visit Level B)	1,347,923	$38,792,025	$28.78
Disparity per service			**$7.43**
37 (Home visit Level C)	259,118	$14,314,890	$55.24
43 (RACF visit Level C)	97,640	$4,955,909	$50.76
Disparity per service			**$4.48**
47 (Home visit Level D)	42,107	$3,138,132	$74.53
51 (RACF visit Level D)	11,837	$843,784	$71.28
Disparity per service			**$3.25**

Enhanced Primary Care Items

The Enhanced Primary Care (EPC) items in the MBS were introduced into the MBS in November 1999. These new items – health assessments, multidisciplinary care plans and case conferences - allow primary care providers, especially general practitioners, to focus on preventive care for older Australians and to provide improved coordination of care for people with chronic illness and multidisciplinary care needs. On 1 November 2000 additions were made to the EPC MBS items which included a limited use of some of the items in residential aged care facilities.

GPs are now able to contribute, if invited, to a resident's RCS care plan, and to organise and coordinate, or participate in multidisciplinary case conferences for residents in facilities. It was hoped that, by introducing these items into residential aged care facilities, GPs would be encouraged to involve themselves more fully in the delivery of care in the facilities. However, to date, little use has been made of the items. Only 175 GPs have used the three time tiered items (15, 30 and 45 minutes) for case conferencing in residential aged care facilities from 1 November 2000 to April 2001.

GP Memorandum of Understanding

Any proposed new GP fee structure must also be considered in the context of the GP Memorandum of Understanding especially in regard to the cap and the redistribution

of funds and the targetting of initiatives where fee-for-service has been replaced by blended payments such as PIP.

Clearly any changes will require additional new funds if real gains are to be made in aged care.

GP SERVICES TO RESIDENTIAL AGED CARE FACILITIES

Visits by GPs to residents/patients at residential aged care facilities can either be on a regular basis, or on an "as needs" basis. In the first instance a GP can have an arrangement whereby the facility's residents/patients are routinely visited, say, every four weeks. In the second instance, a GP may visit the resident/patient when the facility has telephoned with a specific urgent request.

Integrating Medical Care in the residential aged care facility

Any new models must have a framework which integrates medical, nursing, pharmacy and allied health care.

To be eligible to enter a residential aged care facility care recipients are assessed by Aged Care Assessment Teams (ACATs) who determine if the care levels required are high level care (levels 1-4) or low level care (levels 5-8), but not the specific care level.

On entering a facility, the new resident undergoes, over a period of at least 21 days, an appraisal process. This appraisal process is necessary for two reasons:

- firstly, the completion and the development of a "care plan" and,
- secondly, the "care plan" justifies and assigns the Resident Classification Scale (RCS) level.

The RCS "score" assigns the in-coming resident to one of the eight levels of Commonwealth funding subsidy. The RCS score is completed by the approved provider or someone acting on their behalf and results from a set of questions about a care recipient's clinical needs, ability to do various daily tasks, major areas of personal care need, communication or sensory assistance and the care recipient's need for social or emotional support.

The RCS is purely a funding tool; casemix for aged care facilities.

A facility's care plan comprises a statement of the resident's problems determined during assessment, with resident centred goals and strategies to help residents achieve and maintain those goals. A GP can now contribute, if invited by the facility, to a facility's resident's care plan with billing using an EPC MBS item.

In high care, the care plan is finalised by nursing staff, but in low care there are often no trained nurses involved.

One way to begin an integrating process for medical practitioners and facilities would be to have input in the appraisal process when the patient enters the facility - either from home or from hospital.

Often a GP attending a residential facility cares for patients that have

previously been under the care of a GP who is no longer able to provide care in their new environment. The GP caring for the new patient in the residential facility needs to review available information, collect necessary historical data that is not in their file, do a comprehensive assessment and formulate a medical care plan for the new patient – "A Comprehensive Medical Assessment Care Plan".

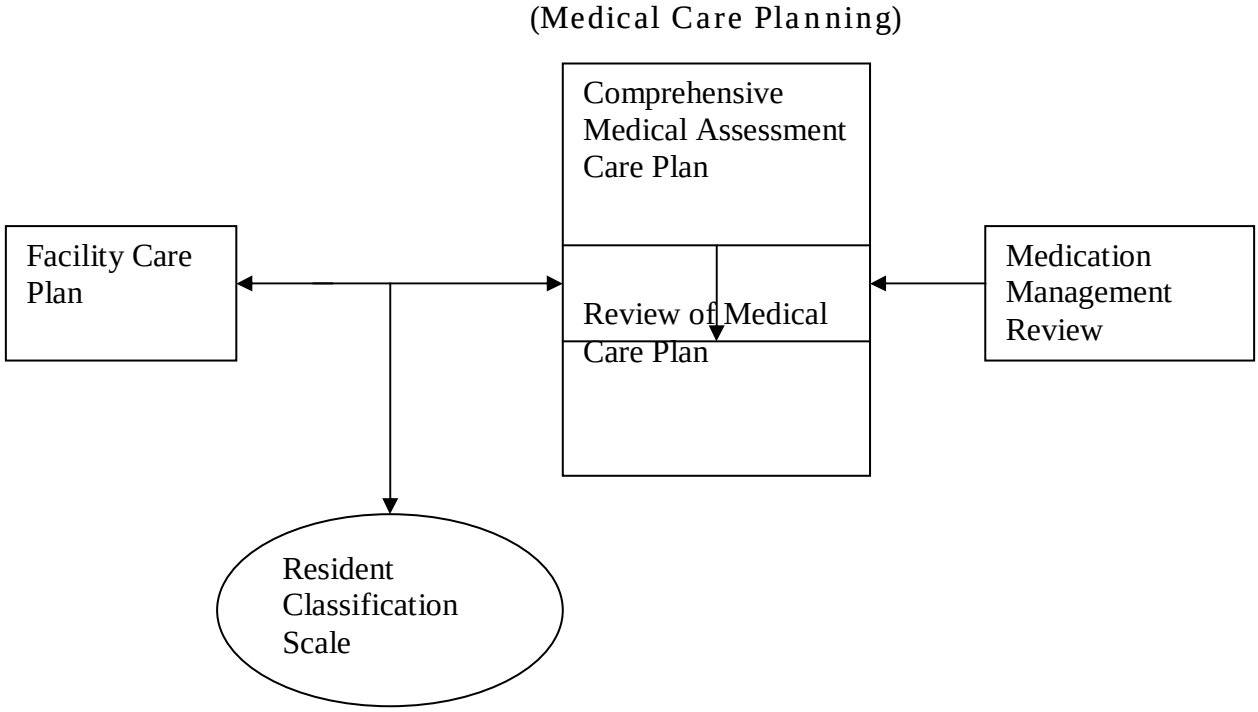
This proposed Comprehensive Medical Assessment Care Plan incorporates elements of the current EPC Community Health Assessment and the medical portion of a multidisciplinary Care Plan. Most patients entering residential care have complex and chronic problems with which the GP takes a long time to become familiar. The current schedule of fees does not encourage such large amounts of non-patient time mitigating against doctors undertaking a comprehensive review. Currently admitted patients are also in need of a Comprehensive Medical Assessment Care Plan. This activity should be specifically remunerated with a new EPC MBS item.

The Comprehensive Medical Assessment Care Plan will need to be done over a period of two to three weeks. The collection and clarification of historical data – discussion with the patient and/or relatives or legal guardian as appropriate, accessing a previous GP, phoning specialists and contacting a hospital – is often necessary. This is time consuming but extremely important for provision of continuity of care and prospective quality medical care.

Current arrangements within residential aged care facilities of medication management are fragmented. Medication reviews by pharmacists are

usually undertaken with little, if any contact with prescribers, the GPs. New models of care delivery are required to support a collaborative model, similar to the new Domiciliary Medication Management Review (DMMR) arrangements. A Medication Management Review should be an integral part of the collaborative model.

Information from the Comprehensive Medical Assessment Care Plan and subsequent Review Medical Care Plan could feed into the facility's care plan/RCS process and link into a Residential Medication Management Review, resulting in better organised, more appropriate and coordinated care for the resident/patient.



This integrated approach will require changes and additions to the EPC MBS items. At present, there is no GP initiated care plan item or Medication Management Review item for residential aged care facilities. In fact, GPs are specifically and deliberately excluded. The present item, which invited doctor participation in an aged care facility's care plan, will be redundant. Additional MBS items will be needed for:

- Comprehensive Medical Assessment Care Plans,

- Review Medical Care Plans, and
- Medication Management Review.

In the USA a "Resident Assessment Instrument"-related casemix funding model has been developed to meet the need for staffing level determination, as well as providing funding incentives for quality assurance[29].

Barriers to visiting residential aged care facilities
Many GPs are finding that the barriers to providing care to residents in aged care facilities mean that it is not financially cost-effective and viable to continue to care for a patient once they enter a facility.

Factors affecting the capacity for general practitioners to visit residential aged care facilities range from conditions within the facility to GP remuneration. The most common barriers are:

- the unsatisfactory levels of remuneration, especially when other competing demands on their time and expertise are better remunerated (and no way near as frustrating);
- the amount of time spent in travelling;
- the time spent waiting for nursing staff before it is possible to see a patient, and then finding the patient (or vice versa);
- the lack of appropriate examination facilities such as a room set aside to see patients, and basic equipment eg bright light needed for viewing wounds, performing rectal or vaginal examinations, let alone *ever* trying to perform any procedure.
- the lack of IT facilities at the facility which would improve efficiency of prescribing and administrative tasks;
- the large number of non-face-to-face tasks expected of GPs by the facility staff which are not covered by fee-for-service and are performed when the doctor is NOT at the residential aged care facility;
- the considerable unremunerated time which can be spent on issues such as: writing scripts, faxing drug and treatment orders, checking medication records and dosages; making, answering and responding to numerous urgent telephone queries from aged care facility staff, arranging urgent pathology tests (eg micro-urine), arranging locums, hospitalisation, ambulances; and interviewing relatives.
- the increased paperwork undertaken by GPs which is required by the facility to fulfil requirements demanded by the accreditation process.
- the lack of consultation between staff and other health care professionals and GPs, and lack of integration of GP services in the facility system.
- the frequent phone calls received at the surgery subsequent to visits to residential aged care facilities, from facility staff to clarify and confirm patient/resident treatment.

[29] Scherer, S. Policy Proposal: Medical Care. Unpublished paper prepared for National Aged Care Alliance, 2001 (page 4, see references).

- the lack of specialists willing to visit residential aged care facilities, which results in unrealistic and unfair expectations being placed on GPs to undertake an extended 'specialist' role. This often dissuades, especially younger GPs, from being involved in the care of patients in facilities.

Other Perceived Problems and Barriers

Most providers encourage the residents to retain their GP when they enter the facility, although in reality this will depend on the proximity of the facility to the doctor's surgery. Because of the shortage of residential aged care facility beds, patients rarely have the luxury of choosing the location of the facility where they are going to live. However, once they move out of their familiar community, they lose their usual doctor and so they often lose their medical history, especially including psycho-social knowledge and ultimately their medical advocate (and friend).

A developing problem is the relocation of some residential aged care facilities from inner suburban sites to the outer urban fringe. As patients from these inner suburban facilities move with the facilities, and mostly they have no choice, they move away from their family, friends and GP. Also they will also be moving to outer fringe suburbs where the population is younger and the focus and expertise of the health care system is geared more to younger people.

A logical flow on problem is that of the provision of emergency medical services. It is seldom that a doctor can immediately leave their practice when a call is received regarding a patient at a residential aged care facility during routine consulting hours. Also residential aged care facilities are usually not serviced by GPs after hours. At times when a doctor cannot attend an urgent call, a locum may attend, or, as in the 'after hours' context, the only alternative for many facilities is the use of ambulance transport to the hospital Accident and Emergency. Many outer urban fringe areas do not have access to locum services. Residents will either not be seen, sent off to Accident and Emergency, or GPs will find this all just too arduous and refuse to service aged care facilities.

The Commonwealth Department of Health and Ageing recently advertised for applications from organisations or consortiums for grant funding to improve access, efficiency and quality of after hours primary medical care

services across Australia. It may be that medical care in residential care could link into such a program. Unfortunately, as we have described, problems of urgent (emergency) visiting are not confined solely to after-hours.

Staffing

Staff members in residential aged care facilities play an integral and essential role in the delivery of quality care to older people. With the increasing dependency levels of people entering residential care, facilities need to be properly staffed to be able to fulfill their duty of care and manage the complex medical care needs.

At present there is no set staffing or skill mix level within facilities. While nurses and carers are committed to working in aged care, they find the workload, lack of wage parity, and their inability to achieve desired resident outcomes a deterrent to remaining in the industry. Consequently morale is low and it is difficult to retain, let alone recruit skilled nursing staff. Even agency staff members, employed when permanent staff members are absent, are often not available.

To be able to provide high quality care, in fact any care, doctors must work in collaboration with the nursing staff. The medical profession is sympathetic to the nursing profession's difficulties, and supports its call for wage parity and more realistic workloads. Until this happens, the GP's role working within a facility is considerably hampered and high clinical standards of care harder to achieve for our residents/patients.

Corporatisation

A further issue that requires consideration is the effect of the developing and rapidly expanding corporatisation of medical practices – an activity that has focussed on three principal areas, stock market floats of new companies, aggressive acquisition of general practices by entrepreneurs and the formation of vertically integrated companies.

While the speed and extent of this change has been dramatic and unexpected, there are core concerns including ethical values, clinical autonomy and standards of care. Consideration must be given to the potential effects of these

developments on the delivery of aged care medical services, especially when taking into account long term planning.

It is possible that there will be some positive effects from corporatisation or practice amalgamations especially if, in larger practices, there is the opportunity for GPs dedicated to and better trained in geriatric medicine to provide a more effective and cost efficient service.

However it is highly unlikely that altruism will drive corporate behaviour as it has driven doctors so far. It is much more likely that hard nosed Corporates will carefully look at all areas of practice as to their profitability, in their own right and this will certainly include residential aged care facilities. Only if these criteria of profitability are met will Corporates consider having GPs, let alone dedicated GPs, to service this increasing marketplace.

RECOMMENDATIONS

There needs to be a reassessment as to what level of rebates and conditions are going to be required to retain and hopefully attract GPs back, so as to maintain optimum medical services within residential aged care facilities. The existing rebates and the associated formula can be at best described as "inadequate" and there is little or no integration or coordination of medical, nursing, allied health and pharmacy care.

The following recommendations for primary care medical services within residential aged care facilities have been developed for consideration:

1. *Revive the current model by the provision of an adequate and appropriate MBS fee structure.*

It is essential that the large amount of non-face-to-face time be acknowledged and added in to any determined or existing MBS fee formula. At present there is the inadequate derived MBS fee with its regressive sliding scale (see page 8).

Remuneration using this sliding scale is inappropriate when the ratio of face-to-face to non face-to-face work for each visit is approximately 60:40. This sliding scale does not take into consideration difficulty factors such as the environment and time spent accessing both staff and patients – difficulties which do not exist in home or hospital visits. Consideration must be given to the introduction of a different formula with loading factors added for non face-to-face work and a difficulty component.

3. *Encourage GPs to attend residential aged care facilities by an extension of integrated models of care under the EPC initiative where GPs can:*
   - *Complete a Comprehensive Medical Assessment Care Plan*

- *Review Medical Care Plans*
- *Perform Medication Management Reviews.*

The Comprehensive Medical Assessment Care Plan and Review Medical Care Plans would feed into the facility care plan and give medical input to the RCS, link into a Residential Medication Management Review, and so, for the first time, enable a direct correlation between funding and care.

It is noted that the Medication Management Review Implementation Steering Group (MMRISG) is looking at Residential Medication Management Review (RMMR). Australian Pharmaceutical Advisory Council (APAC) is looking at both medication specific services and guidelines in the broader framework of care that is required for any meaningful improvement in medication management.

EPC items for attendance at a facility's Medication Management Committee or ideally, as in the APAC best practice model[30], at a Division of General Practice auspiced Regional Medication Advisory Committee[31] would go a long way to solving problems of polypharmacy, iatrogenic disease and burgeoning PBS costs in the elderly.

3(a) GPs could attend residential aged care facilities within a GP Facility Adviser arrangement to allow further flexibility in terms of remuneration arrangements in some circumstances, such as large facilities and public facilities.

All residents/patients have the right to be treated by their usual GP, or a GP of their choice within a residential aged care facility. However where a resident/patient's GP is not accessible, facilities now often use a panel of doctors, selected by the nursing staff/provider, to deliver care to the residents. This assures certainty with ongoing familiarity and integration into the facility's care system. At present remuneration remains fee-for-service.

However, no matter what arrangements are used, residents/patients must retain their right to their practitioner of choice.

3(b) GP Facility Adviser arrangements could be used for GPs to sit on Medical Advisory Committees, Credentialling Committees and Medication Advisory Committees similar to those presently run in private hospitals.

To ensure quality patient care, it is essential that GPs are involved in Committees which provide discussion on an integrated basis with across-professionals such as doctors, facility staff and pharmacists. Committees

[30] Australian Pharmaceutical Advisory Council. *Integrated best practice model for medication management in residential aged care facilities.* Commonwealth of Australia 1997

[31] Segal, G. *Role and Activities of a Regional Medication Advisory Committee for Residential Aged Care Facilities.* Unpublished paper prepared for Greater South Eastern Division of General Practice, 2000.

such as Medical Advisory Committees and Medication Advisory Committees provide an opportunity for such discussion to take place.

4. As part of the accreditation process, there should be mandating of provision by the residential aged care facilities of:

(a) IT, in consultation with the General Practice Computing Group, and

(b) facilities for consultation and examination.

These facilities could be used for taking histories, writing scripts and undertaking procedures and would have advantages for all parties and save considerable time. It would facilitate a "consultation by appointment" process, where appropriate, especially in low care facilities. It would also facilitate technological integration, more effective care, far more dignified care and be attractive to visiting medical practitioners.

In considering these four recommendations, it might well be that a combination of them could be used in the development of a series of models and that these models would not only be additive, but could also run in parallel giving a range of possibilities for varying circumstances.

As alluded to in the Introduction (page 5) future planning of aged care should include consideration of models of care such as transitional care, whereby patients can move from hospital acute care to residential aged care facilities for rehabilitative care, and Hospital in the Residential Aged Care Facility, where acute care needs of residents can be met within the facility. These models, however, are beyond the scope of this paper and would demand a total change of practice and philosophy of State/Commonwealth funding processes.

CONCLUSION

It is essential that the outcome of the consideration of these issues be the drafting of new and appropriate MBS items for residential aged care facilities and that serious consideration be given to its importance as an issue separate from the GP Memorandum of Understanding. *Separate and new funding for these important problems in aged care is essential.*

Facilities should be appropriately funded to enable them to purchase the

medical advice they need and to invest in an appropriate medical infrastructure. Accreditation should encourage quality improvement and best practice in medical and health care. Unless there is reform in the whole system merely reviewing a section, for example Residential Medication Management Review (RMMR) will be ineffective.

Finally it should be remembered that the problem of delivery of medical care to residents/patients of aged care facilities is still part of the wider problem of delivery of medical care to an ageing population. In view of the increasing demands on an already overburdened system, the total needs of the older population must still be properly addressed. Access to a high standard of clinical care is a right and must never be denied on the basis of age, disability or perceived societal usefulness.

There is no place for policies and practices that discriminate in terms of access to quality health care service at any age.