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Senate Inquiry into Aged Care

Submission from
Dr Peter Winterton

Thankyou for seeking submissions on this important subject from the Australian community.
My credentials for making a submission are based on over 25 years in general medical practice in Mt Hawthorn and having been involved in this time in a considerable amount of aged care service provision.

- Current arrangements in aged care provision are too complicated. Service provision supervision in this important field of community care has become an industry itself. The rules keep on changing so much so that no reasonable person can keep apace with the changing regulations. Aged care facilities are so concerned about complying with the rules that the service providers ie. The carers spend more time documenting what they should do than looking after their residents. Vast amounts of meaningless paper work are generated which is of little or no material benefit to the resident/patient. As an example a patient with a severe stroke is documented as having a communication and mobility disorder. The reality is that the patient is aphasic and has a dense hemiplegia and can't walk or talk and needs assistance with basic tasks no matter what euphemistic classification is imposed on the patient.
- Current facilities available to young persons with major disability are few and far between. With the improved medical outcomes that are now common in severe spinal and head injury this category of patient will increase and thus provision must be made for this type of patient in the future.
- Current facilities for people with age and mental health problems are not adequate. Mental health has become de-institutionalised. This means that there are now more elderly folk with a present or past mental health problem in need of care. Some current aged care facilities find these patients too difficult to cope with and thus provide sub-optimal care.
- Aged care and community packages are a good idea but they do not adequately recognise or understand that elderly people and carers of any age are not able to provide 24 hour care for their partners even with the best of intention. If community packages were to be more

effective then the level of care provision and the opportunity for the principal carer to have time out needs to be better factored in. I have seen this in action with the care of my late father and am seeing it at present with the care of my father in law.

- The provision of medical services to aged care facilities is not viewed well by medical practitioners because of the time and bureaucratic demands. An example of extra useless paper work. I have a patient who develops a urinary tract infection (which is common). The sister at the aged care facility rings me and asks for my opinion and directions. I prescribe antibiotics over the phone. I will then be asked to fax a script to the pharmacy or the nursing home. I perform all of this without remuneration and at expense to me in time and fax costs whilst I am in the middle of a consultation with a patient in front of me. The whole exercise is unrewarding.
- The EPC items of the MBS that were introduced in the 1998-99 budget in order to improve aged care to older and chronically ill Australians is so demanding of time and paper that many busy general practitioners have not and will not embrace them in their current form. Chronic disease management on a day to day basis is a major component of a General Practitioner's workload and is increasing due to a number of factors.
    - The super specialisation of medicine, thus the GP is what the general physician used to be: the co-ordinator of care.
    - The improved outcomes of modern medicine resulting in more complex medical problems needing increased knowledge and time to manage them.
    - The deterioration the public hospital system resulting in the General Practitioner caring the responsibility.

  If EPC items are to be of any use the process needs simplification and removal of a lot of the useless hoops that General Practitioners are expected to hop through.

- Staffing in aged care facilities needs to be reviewed. Currently only Nursing Homes have trained nursing staff. These are becoming increasingly difficult to find and keep. Hostels in the main have untrained staff. These staff have to make decisions well beyond their training and expertise, puts residents well being at risk and places an increased demand on medical practitioners to support these staff.
- With acute hospitals in crisis the back up for doctors for providing aged care services to nursing homes and hostels has diminished in

recent years. Patients are often returned from an acute hospital little better than when they were sent in, if one can find a bed for them.

- The current distinction between hostel and nursing home is damaging to patients. Patients are not being allowed to age in the same place and often will have to shift twice in old age. This is not in patient's best interests. There should be seamless care in the same facility as much as possible. The current system does not promote this idea. Financial considerations drive Nursing Homes from not wanting high care hostel patients because they get reclassified as low care nursing home type patients which does not reward the institution, so these people find themselves in no mans land. Nursing Homes now see themselves as terminal care stations; the sicker the patient and the quicker they die and re-fill the bed the better it is for their bottom line.
- The regulations and costs perplex relatives. Eg asset tests, income tests, deeming rules etc. All of this is on top of the realisation that the person who needs care is their loved one and this person is no longer what they used to be. The whole situation is demanding, frustrating and very painful. Aged care provision is real; it needs to be debated such as in this forum and at an earlier stage in people's lives. Aging is a part of living, not that unspeakable event that can be pushed into the background for a future government to cope with.