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Committee Secretary  
Senate Select Committee on Health  
PO Box 6100  
Parliament House  
Canberra ACT 2600

19 September 2014

**Submission to the Senate Select Committee on Health**

Dear Sir/Madam,

Thank you for the opportunity to make a submission to the Senate Select Committee on Health with regard to its inquiry into health policy, administration and expenditure.

Benetas is a provider of aged care services. Benetas operates as one of the largest not-for-profit aged care providers in Victoria, employing over 1,400 staff and 400 volunteers to support over 4,000 older people, and their carers and families, to live fulfilling lives through our aged care homes and community services across metropolitan and regional Victoria. Benetas offers a range of aged care services including residential care via 13 residential aged care facilities, in-home care, respite care and housing services. Benetas also provides specialised care and expertise in dementia, palliative and culturally appropriate care for people from non-English speaking backgrounds.

Benetas has an active advocacy and research agenda, and has a focus on translational research that can be used to improve aged care services and models of care. Findings are shared with the industry and government at all levels to help inform policy directions and aims to ultimately improve the ageing experience of all older Australians and their families. See [www.benetas.com.au](http://www.benetas.com.au)

This submission by Benetas addresses the following terms of reference:

- **b.** the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- **d.** the interaction between elements of the health system, including between aged care and health care;
- **f.** the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- **g.** health workforce planning.

Sandra Hills  
CEO Benetas



**This response addresses term of reference b; the impact of additional costs on access to affordable healthcare.**

Older people consistently identify access to affordable and quality health care services as an area of concern. Chronic disease and poorer health status preferentially affects those on the lowest incomes and those that live in areas of concentrated disadvantage.

There is good evidence that at least ten per cent of people delay or avoid visits to the doctor or do not buy prescribed medications medicines because they cannot afford them<sup>1</sup>. Out-of-pocket costs amounted 16.8% of total health expenditure in Australia in 2008-09<sup>2</sup>.

For older people, especially those with multiple chronic medical conditions, seeking medical care to maintain their health and reduce acute health problems that may result in hospital admissions should be encouraged. For those on limited incomes (like those who rely on the Age Pension) any form of co-payment is a significant barrier to accessing timely medical care. Timely access to primary health care should be encouraged, especially for vulnerable older people, as early care will reduce the subsequent level of admissions for acute hospital care.

There are also particular problems with the proposed co-payment for consultation with a General Practitioner (GP) for residents in Residential Aged Care Facilities (RACF).

Only about twenty per cent of Australia's GPs currently make visits trips RACFs. However, those who do will now face losing \$11 per patient consultation if they do not collect the proposed new co-payment from each patient as they will miss out the new low-gap incentive if they do not enforce the proposed co-payment policy. GPs who visit their patients in RACFs are already paid significantly less in the RACF setting than they receive by seeing other patients at their clinic.

The practicalities of such a proposal are problematic for RACF staff too. Many people who live in RACFs have some degree of dementia and multiple co-morbidities. Under the co-payment proposal RACF staff will have to arrange for the client to have \$7 available to pay the GP who will then have to issue a receipt so that the payment can be acquitted against the client's financial records. Such a proposal is cumbersome and unworkable for the both RACF and the attending GP.

These burdensome arrangements and likely reductions in consultation payments will provide a further disincentive for GPs to see patients in RACFs and should be reconsidered.

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<sup>1</sup> 2013 National Health Performance Authority Healthy Communities: Australians' experiences with access to health care in 2011–12, accessible at [http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Report-Download-Healthy Communities-Australians-experiences-with-access-to-health-care-in-2011%E2%80%9312/\\$FILE/NHPA\\_HC\\_Report\\_Patient\\_Exp\\_June\\_2013.pdf](http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Report-Download-Healthy%20Communities-Australians-experiences-with-access-to-health-care-in-2011%E2%80%9312/$FILE/NHPA_HC_Report_Patient_Exp_June_2013.pdf)

<sup>2</sup> AIHW (2010) Australian Institute of Health and Welfare 2010. Health expenditure Australia 2008–09. Health and welfare expenditure series no. 42. Cat.no. HWE 51. Canberra: AIHW. Table 3.7, p.30.



**This response addresses term of reference d; the interaction between elements of the health system, including between aged care and health care.**

Aged care recipients in residential and community settings often have complex health care needs and health service access for aged care recipients can be challenging. Older people often have complex care needs requiring multiple services as they age, and as a result, the demand for health and home support services for older people will increase.

The aged care system is complex and fragmented with multiple funding streams and points of entry. This complexity contributes to confusion for older people and their carers when trying to access care and information. Access to referral pathways and the full range of aged care services available is multifaceted, with both consumers and service providers reporting difficulty understanding the system.

General practice is usually the first access point for older people with health and support needs in the community. In 2012-13 people living in many areas serviced by Benetas, on average, visited a GP 4.8 times with the number of visits increasing with age<sup>3</sup>. Residents in residential aged care facilities (RACFs) saw a GP on average 13.4 times a year<sup>4</sup>.

The *Living Longer Living Better* (LLLb) reforms (2013) are currently being implemented, and while funded agencies are well informed about these changes, general practice and other private health professionals and services are generally not included in communication and networking processes. Private services do not form part of the reformed "aged care system" and are generally not included in systems and processes. This has the potential for care duplication and confusion, and impacts upon older people's access to services.

There is a complex mix of publicly funded, privately purchased and blended funding services available to support older people, with flexible referral processes. The key referral points are general practice, Aged Care Assessment Service, local government and hospitals, although older people also self-refer into services. Health professionals report that it is difficult to get information about the range and number of services an older person is accessing at any one time and there is often duplication or gaps in services.

Private allied health professionals and private nursing and home care agencies report feeling disconnected from the general aged care service system and involvement in and awareness of national initiatives is needed. Hospital discharge coordinators report they are often unaware of services a person is accessing prior to admission.

Advance Care Planning (ACP) initiatives are very important for clients receiving aged care services. There is recognition that primary care is the most appropriate place for developing ACPs. There is neither a consistent approach for notifying services/staff of the existence of an ACP, nor a common approach to advance care planning. For example the Victorian Department of Health has an ACP policy and supports ACP in major health services but this initiative does not include general practice.

These anomalies demonstrate the need for better coordination of initiatives and information dissemination that transcends sectors and is sustainable outside short term funding cycles.

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<sup>3</sup> National Health Performance Authority (NHPA). (2014). Average number of GP attendances per person age standardised 2012-13. Available at: <http://www.myhealthycommunities.gov.au/national/mbs0002>

<sup>4</sup> National Health Performance Authority (NHPA). (2014). Average number of GP attendances in residential aged-care facilities per patient who received at least one GP attendance in a facility. Available at: <http://www.myhealthycommunities.gov.au/national/mbs0003>



There are significant areas of the interaction and intersection between the health system and the aged care system where the clinical and personal needs of older people can be better met. An important service model is Hospital outreach/inreach services.

These services are very valuable in providing clinical care for people living in RACF who develop more serious medical problems that would otherwise require transfer to an Emergency Department via ambulance. These services are especially valuable for frail aged people of those with dementia where admission to hospital is likely to have a deleterious effect on them, even if their medical condition is well managed after admission. However, the availability of these services is patchy, especially outside of major capital cities and the clinical composition of these teams and the services they offer vary widely. The best of these services are exemplars of cost effective, client centred and clinically appropriate care. Expansion of and support for these services would offer real gains for older people requiring a level of medical care beyond primary care.

**This response addresses term of reference f; the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services.**

We assume that this term of reference wishes to examine better integration of clinical services that are funded by Medicare.

A number of trials of telehealth services are underway. The preliminary findings of these studies are that telehealth has the potential to health overcome some barriers to health care for people living in RACFs, especially in rural and remote areas where access to distant specialist medical consultations is difficult.

Telehealth appears to be a useful tool for particular types of medical consultations for suitable patients. However, at present there is no Medical Benefits Schedule (MBS) item number for GPs to conduct a telehealth consultation for their patients in RACFs. Given the known barriers to access to GPs for people living in RACFs, this is a structural financial barrier that, if removed, would improve access to primary health care for many clients in RACFs and enable GPs to effectively and efficiently provide their valuable services.

The arrangements for utilising MBS items for billing for services provided by Nurse Practitioners (NP) are also cumbersome. There are a number of restrictions pertaining to the MBS and NPs which constrain their ability to fully practice in the RACF setting, especially outside normal business hours when GPs are often unavailable.

For example, an eligible nurse practitioner cannot provide Medicare rebateable services such as issuing of repeat prescriptions, updating patient notes or consultations with RACF staff over the telephone. Consideration should be given to removing these constraints to enable NPs to provide flexible, affordable services to patients living in RACFs.



**This response addresses term of reference g; health workforce planning**

The nursing workforce is an ageing workforce, and the ageing of the nursing workforce is even more acute in the aged care sector than most other areas of nursing. Aged care nursing is not seen as a desirable area of nursing practice; it is poorly remunerated compared to other areas of nursing practice and funding for care provision is both limited and time consuming to document. Aged care nursing is complex: clients have many physical, clinical, psychological, social and spiritual needs, and relationships between clients and their families often require careful tending.

In addition, the composition and skill set of the RACF workforce has changed over the years. There are now many more staff providing client care who have limited training and few, if any, clinical skills. This has resulted in a greater clinical decision making burden being carried by fewer nurses.

The *Living Longer Living Better* (LLLBB) reforms will also affect the demands on nurses working in aged care. From 1 July 2014 only clients that were previously defined as 'high care' will be eligible to live in a RACF. This will mean that over a relatively short time, the clients that are cared for by nurses in RACF will all have much greater needs than was the case previously.

Consequently it is likely that as aged care nurses retire from aged care nursing that it will be difficult to find replacement staff, exacerbating the problems of relatively high staff turnover in aged care.

Like nurses that work in aged care, GPs that do see their patients in RACFs tend to be older. As a consequence of the LLLBB reforms, these doctors will soon be managing a greater number of patients in RACFs with even more complex needs than is currently the case, while the problems of remuneration and other barriers to providing care will remain. Sooner or later these ageing doctors will retire from practice or cease to visit RACFs. As with aged care nurses, it is likely that it will become increasingly difficult to get GPs to care for people living in RACFs.

The problems of an ageing health workforce and the reluctance of many younger nurses and medical practitioners to work in aged care is a large and looming problem for people living in RACF and aged care providers. These problems are often magnified in rural and remote areas which tend to have relatively old populations and are relatively poorly serviced with GPs. Better implementation of more flexible models of care (see response to term of reference f above) may alleviate some aspects of this problem, but are unlikely to provide more than a partial solution.