CATHOLIC HEALTH
Australia

Catholic Health Australia

Senate Standing Committee on Finance and Public Administration: Inquiry into the Council of Australian Governments reforms relating to health and hospitals.

Submission: 26 May 2010

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About Catholic Health Australia

On any given day, one in ten of all Australians in a hospital or aged care bed are being cared for in one of the 21 public hospitals, 54 private hospitals, and 550 aged care facilities that are operated by different bodies of the Catholic Church. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Executive Summary

When the final report of the National Health and Hospital Reform Commission was presented to Government, there was anticipation that many of its recommendations would lead to vast improvements in the health of all Australians. Many health providers, of which the Catholic Church is one, lament that much of the Commission's reform vision has not been addressed by the Council of Australian Governments.

Catholic Health Australia (CHA) did not achieve all it sought from health reform. We do support the main decisions that were made, being changes to which government provides dominant funding of hospital services, local governance of hospital networks, and activity based funding for appropriate hospitals. Yet with so little known as to how the changes will work, it is too early for CHA to form a view as to how the reforms will contribute to improved patient care of better general health of all Australians.

Ideally, COAG would have agreed to establish a single funding body for health, be that the Commonwealth or a new COAG funding entity.

Ideally, COAG would have adopted the World Health Organisation (WHO) framework on the social determinants of health in order to prevent ill health in the community which would in turn reduce future health costs being incurred.

The proposed 4 hour emergency department turn around target, and the commitment that 95% of all patients seeking elective surgery will be treated within clinically appropriate times are programs that CHA endorses. They in themselves are not reform – they are programs. And their success will be determined by how they are implemented, which will require more doctors, more nurses, and more capacity in the hospital system than is currently in existence.

The COAG announcements do not make clear the future role for private hospitals. The CHA network of private hospitals operates one in four of all private hospital beds in Australia, so we take a particular interest in their future. Ideally, the Commonwealth will move to annunciate a clear role for private hospitals in Local Hospital Networks, whereby their ability to deliver hospital services to private patients at no direct cost to government is better recognised. Their ability to deliver public services at less than the cost of government owned public hospitals should also be recognised. The development of Activity Based Funding will enable this, but again, getting the system properly structured is crucial.

When considering aged care, CHA sees little in the COAG announcement that addresses the failures of the Howard Government's *Aged Care Act* 1997. We are now looking to the Productivity Commission to develop through its aged care inquiry a blue print for reform with a focus on:

- Giving consumers choice;
- Guaranteeing access by making aged care an entitlement to those assessed as needing it;
- Service provider sustainability, to ensure services exist to meet demand.

For the first time in this submission, CHA publishes the findings of its *GP Access Survey,* which assess the availability of medical care in residential aged care settings. The survey, conducted across 6,364 residential aged care beds, finds:

- 15% of aged care homes report a shortage of GPs, that results in compromised patient care;
- 57% of aged care homes report admitting aged care residents to hospitals because of problems in accessing GPs.

CHA argues the success of the COAG health proposals will be determined by the adequacy of their implementation. The participation of all parts of the health system in designing and overseeing an implementation plan is paramount. The non-government sector must be immediately engaged in the system design and implementation process of hospital reform. To ignore the non-government sector disenfranchise key agents for change.

Introduction

Health professionals and health policy advocates have put substantial effort into the public policy debate initiated by the Commonwealth Government aimed at seeking to improve the effectiveness of the nation's health and aged care system.

CHA, like many other health system participants and advocates, holds its own view on how the health system would ideally operate. Our view is informed by our almost two hundred years of health service operations in Australia, and our ability today to serve one in ten of all people on any given day who are in a hospital or residential aged care bed.

In our ideal health system, the focus on health would be on avoiding illness and hospital admission. Our ideal health system would understand that good health is determined by an infant's experience in the womb, by their early childhood experiences, by their educational attainment, their access to income and employment, their geographic location, their ethnicity, and their access to social supports at different points in their life cycle. All of these factors, known as the social determinants of health, are influenced by factors beyond the control of the health and ageing portfolios.

There would also be a strong primary health care system that was accessible to all and works in partnership with patients and providers in all settings to keep people healthy and to effectively manage their conditions when they do need treatment.

In our ideal hospital system, there would be a single government funder of hospitals that allocated funds to either private or public government or non-government owned hospitals on the basis of which hospital could best and most cost effectively meet community need.

Real and genuine tax payer funded incentives would be provided to encourage more than half the population to hold private health insurance as a means of freeing up the even greater burden that would fall on the tax payer to meet the cost of public hospital care if private health insurance levels fell to an unsustainable point. Those who because of socioeconomic disadvantage suffer most as a result of the failures of the current health system would be guaranteed better access and service when they needed it.

Importantly, in this ideal hospital and aged care system, all staff would be justly paid and have received access to quality education and training. The current shortfall in medical, nursing and care staff would have been overcome by programs to encourage people into the profession, expanded university and technical training supported by sufficient clinical training places, and the improvement of the current health workforce culture that regrettably drives many good people away from the health workforce because the pressures of a stretched system are for some just too much to bear.

CHA's ideal aged care system would be one in which older Australians have a real choice in where they receive care, and all Australians assessed as in need of aged care and support, regardless of their income, have access to high quality care as an entitlement. All providers of both residential and community aged care services would be paid by government, or by consumers with capacity to pay, an amount at least equal to the actual cost of providing care services.

The Council of Australian Government reforms relating to health and hospitals do not achieve all these aspirations of CHA. As a health advocate, CHA is pragmatic enough to appreciate that our aspirations for the health system may never have been likely to have been achieved through this recent round of changes to health administration.

There are components of the changes, however, that go someway to meeting CHA's hopes for health reform.

Access targets to guarantee patients presenting at public hospitals for emergency or elective surgery will be treated within clinically recommended times is a terrific advance. The success of this measure will be determined by

the ability of new resources, both financial and personnel, to be directed towards ensuring targets are met. Importantly systems will need to be designed to minimise opportunities for gaming and target manipulation.

The introduction of more nationally consistent, transparent reporting of performance by hospitals and Medicare Locals under the auspices of the new National Performance Authority is also welcome and has the potential to improve the services experienced by patients.

The Commonwealth taking sole responsibility for all aged care is a proposal CHA first put forward in November 2008. The Commonwealth taking responsibility for those parts of the Home and Community Care program that relate to people aged over 65 will enable in time a single integrated aged care program to evolve, which will stand in stark contrast to the current arrangement whereby Commonwealth funded providers deliver residential and some community care programs and State or Territory funded providers deliver other community care programs.

To some extent, the terms of reference for this Inquiry miss the point. Having not seen all of CHA's aspirations for health reform addressed in the COAG announcement, we would prefer to put our disappointment to one side and now focus on achieving the successful implementation of what has been proposed. CHA does not intend to oppose any of the COAG proposals. Instead, we've said there should now be a significant commitment towards the successful implementation, design and execution of the proposals. The non-government sector is key to this success, and we've offered to play our part in making the changes work.

This submission of CHA does not intend to assess the extent to which the measures announced by the Commonwealth will improve the overall operation of the Australian health care system. There is much detail still to be worked through at all levels of government as to how the arrangements will work. In an area as complex as health, the detail will be fundamental in determining the extent to which the reforms will lead to an improvement in the health system.

One of CHA's key considerations in assessing the impact of the reforms will be the impact they have on equity of access to health services, and ultimately greater equity of health outcomes. From CHA's perspective, it will not be sufficient to increase the efficiency of the health system if this also does not result in greater equity.

Equity could be best achieved by action on the social determinants of health. CHA argued to the National Health and Hospitals Reform Commission that any fundamental examination of the operation of the health system as part of the Australian health reform process should give serious consideration to:

- Implementing recommendations of the World Health Organisation's Commission on Social Determinants of Health;
- Legislating for improvement in the social determinants of health;
- Establishing a Health Access Ombudsman;
- Empowering policy makers outside health to play a role in addressing the social determinants of health; and
- Resourcing agencies supporting the disadvantaged to play a role in improving adverse social determinants of health.

Whilst the Commonwealth has stated that it accepts the "principles" enunciated by the World Health Organisation on the social determinants of health (as detailed in the table at Appendix 1), the approach being taken by governments at all levels in addressing the social determinants of health remains fragmented and piecemeal.

Below we outline our specific responses to the Inquiry's Terms of Reference. We would welcome the opportunity to appear before the Inquiry and speak to our views if it would help focus the Inquiry on:

- enabling the most effective implementation of the proposals put forward by COAG; and

- encouraging the Commonwealth to take the next necessary step of health reform by establishing a legislative agenda to address the social determinants of health.

Response to the Terms of Reference relating to health and hospital care

CHA makes the following comments against the specific terms of reference.

Terms of Reference (a) and (b)

CHA is not in a position to provide informed comment.

Term of Reference (c): Additional/new services

The budget papers indicate the following additional resources will be provided to public hospitals over the forward estimates period:

- recurrent funding for around 22 000 additional elective surgery procedures in 2013–14
- implementation of access targets for elective surgery:
  * $650 million over four years for facilitation and reward payments; and
  * $150 million over three years for capital funding
- additional funding for emergency departments to implement four-hour national access targets:
  * $500 million over four years for facilitation and reward payments
  * $250 million over four years for capital funding
- 1300 new sub-acute beds ($1.6 billion over four years) and
- flexible funding for emergency departments, elective surgery and sub-acute care through creation of a funding pool ($200 million over four years).

The above substantial additional funding is welcomed by CHA and will result in the provision of additional services. CHA is particularly pleased to see substantial additional funding directed to the provision of sub-acute beds (or equivalent services), which has been an area long neglected. The provision of additional sub acute services is one of the more effective ways to reduce pressure on acute hospitals and will assist many patients to be treated in a more appropriate setting.

CHA is not in a position to offer detailed commentary on the precise number of additional services these funds will provide. The Department of Health and Ageing and Treasury may be best placed to do so.

Term of Reference (e): – New statutory bodies

The names, roles and resourcing of the new statutory agencies including the Independent Hospital Pricing Authority, the National Performance Authority, the National Funding Authority are set out - at least in general terms - in the appendices to the National Health and Hospitals Network Agreement and in the budget papers.

CHA notes the recognition given to "the vital role played by non-government providers in providing health and public hospital services, including Catholic hospitals" at A17 in the National Health and Hospitals to Network Agreement.

Accordingly, it is important that Catholic hospitals and other non-government providers with expertise in providing services across both public and private sectors are given the opportunity to contribute to the design, establishment and subsequent governance of these new bodies.

Independent Hospital Pricing Authority

CHA supports the establishment of an independent statutory body to determine the "efficient price" for hospital services. Given that CHA member hospitals operate in both the public and private sectors, CHA seeks to contribute its members' experiences in both sectors by participating in the consultative arrangements that will underpin the Authority's establishment and subsequent governance.

In relation to the "efficient price", CHA would suggest that the actual price paid to a particular Local Hospital Network would need to be based on a nationally struck price that is able to be modified to take account of a range of factors that are known to impact on the cost of providing services - many of which are not within the immediate control of a hospital.

These factors include the size, scope and comprehensiveness of the range of services provided by the hospital, demographic and socio-economic characteristics of the patient cohort (in addition to the co-morbidities inherent in the DRG system) and remoteness of location from major metropolitan location.

Rural and regional hospitals in particular have additional costs in areas such as transport, recruitment and retention (including relocation of clinical staff); they have an inability to backfill during absences and have lower overall occupancy levels for a given level of infrastructure as compared to metropolitan facilities. The maintenance of "block funding" arrangements for small regional hospitals, where activity and types of episodes is highly variable and hard to predict, is appropriate.

National Performance Authority and Performance Targets and Monitoring

CHA agrees there needs to be greater transparency and accountability in the operation of health services including hospitals. We also support greater national consistency in reporting on performance.

In supporting the need for greater accountability and transparency, CHA is however mindful of the need to take great care in the design of the arrangements to ensure they contribute to an improvement of system performance. Poorly designed arrangements can detract from system performance by focusing managers on only those aspects that are reported and/or rewarded.

We need, for example, to learn from the recent experience of the Mid-Staffordshire National Health Service Trust in the United Kingdom, where it has been reported that between 400 and 1200 excess deaths, together with appalling lapses of patient care and hygiene, occurred between 2005 and 2009 as a result of the local board and hospital management focussing more on meeting performance and cost cutting targets than on actual patient care.

We support the establishment of an independent statutory authority to develop and administer national standards for hospital performance – and would seek to be represented in their development and subsequent governance. We also consider that the development of performance standards and monitoring framework needs:

- Clearly articulated goals and objectives;
- Strong clinician and expert input into design, implementation and ongoing evaluation based on Australian and overseas evidence – with pilot testing before rollout to minimise unintended consequences;
- A mix of process and outcome measures (which have been appropriately risk adjusted);
- Incentives to improve performance that will motivate existing best and poorest performers (as well as those in the middle);
- To be designed in a way that avoids unintended consequences (for example a focus on emergency department waiting time reductions that fail to pick up increased inappropriate early discharges that may result from attempts to meet such targets) ;
- strategies to minimise the incentives for inappropriate competition, cherry picking and gaming between LHNs from the introduction of an ABF funding model.

CHA also notes that the National Performance Authority will provide confidential advice to the Commonwealth and State governments in

relation to poorly performing LHNs (National Health and Hospitals Network Agreement A14(c)). CHA is concerned that patients and consumers will potentially not be informed about poor performance; we consider that transparency and appropriate risk-adjusted benchmarking is the best way to mitigate against the likelihood of underperformance.

Term of Reference (f): States not signed up

CHA has nothing to contribute to this discussion.

Terms of Reference (g) and (h): Local Hospital Networks and funding models

As a general principle, CHA supports the notion that decision-making within hospitals should take place at a level that is as close to the delivery of services as possible. This particularly applies to day to day operational and budget management. All CHA member hospitals operate under such a governance structure today, and have done so successfully for many years.

Having said this, CHA takes the view that it is important to ensure the right balance is struck between local decision-making and effective strategic level planning at a wider population level - particularly in the provision of very expensive and complex services such as organ transplant units.

Experience both in Australia and overseas suggests that finding the right balance between centralisation and decentralisation of planning and management of health services is very difficult – with no simple answers or magic bullets.

Under the National Health and Hospitals Network Agreement, State governments will primarily determine the numbers of LHNs and their boundaries within each jurisdiction.

The original proposal announced by the Prime Minister provided for the establishment of up to around 150 Local Hospital Networks – this number is also included in Budget paper Number 1 (6-46). This number would have resulted in each LHN serving a population base of around 150,000 people.

This is well short of the population bases of similar networks in overseas countries and many health policy commentators have expressed concern that networks of this size would fall short of providing a critical mass of services and would also lead to a considerable increase in bureaucracy - with each network having its own administrative underpinnings. There is much commentary in the literature to suggest a population base of at least twice the number originally envisaged would be more efficient, effective and importantly address equity concerns (see K Eagar, *The Rudd hospital plan — many pitfalls to avoid on the way to a better health system* MJA 2010; 192 (9): 515-516).

At this stage, it is not clear what approaches are being taken by each of the jurisdictions and the extent to which existing administrative arrangements and boundaries may change as a result of the implementation of the National Health and Hospitals Network Agreement.

CHA notes the lost opportunity, at this stage, to allow cross border LHNs which may have addressed some of the more difficult issues of cost and service dysfunction near the boundaries of State/Territory borders.

CHA generally supports the criteria set out in the National Health and Hospitals Network Agreement – namely for LHNs to include a mix of hospitals (in metropolitan areas), be based on natural geographic regions and to provide flexibility to establish some networks on a functional or other basis and including the ability to take account of the needs of rural and remote areas.

As Catholic hospitals – public and private - will be directly affected by the introduction of LHNs, they are seeking input into their establishment.
In a number of capital cities – Brisbane, Sydney and Melbourne - Catholic public hospitals provide extensive health services. It may be appropriate for these Catholic health services to become their own Local Hospital Networks. In other cases, Catholic public hospitals would form part of a wider LHN.

Catholic hospitals operate within a moral framework that precludes them from providing some services. Arrangements for the operation

of LHNs will need to respect and take into account the moral framework within which Catholic hospitals operate.

Catholic hospitals are also independent legal entities that operate within pre-existing governance arrangements, many underpinned by State statute. We would seek to work with governments to ensure clear and appropriate accountability arrangements are established between the Catholic hospitals and LHNs and respective governments. Whilst the nature of pre-existing arrangements between Catholic hospitals and state governments is variable and complex, generally the relationship is based on state government statute. These existing statutory positions may need to be examined to determine whether they may need to be varied to accommodate the establishment and participation in LHNs. Any changes to statutes that affect Catholic hospitals should only be made with their consent and full involvement.

Service Agreements with LHNs

Service agreements will be matters for determination between Local Hospital Networks and State Governments.

In developing service agreements between State governments and LHNs and to ensure structural efficiency, equity of access and the maintenance of safe and high quality services, it will be important that the following matters are addressed and responsibility appropriately clarified:

- Target activity levels and distribution of services across networks;
- Location of state wide services including high cost and complex services;
- The alignment of demand management strategies across networks;
- Relationships with primary care organisations and providers;
- Relationships with community care services such as nursing and transitional care providers;
- Population health promotion – including within LHN boundaries;
- Reporting and accountability for equity of access and equity of health outcomes.

LHNs and private hospitals

With 40% of total hospital episodes (including 60% of surgery) now taking place in the private sector, more consideration needs to be given to the role and contribution that private hospitals (both not-for-profit and for-profit) can make in serving the health needs of populations within LHNs. This consideration should extend beyond private hospitals merely providing an overflow where public hospitals cannot meet waiting time targets and should include a focus on identifying and utilising the sector within an LHN that can provide the most effective and efficient services.

The implementation of the LHN framework can allow for LHNs to proactively engage with the private sector to enable a longer-term role for the private hospitals to contribute to capacity - particularly in areas where it is relatively more efficient to do so (an example being elective surgery) .

Activity Based Funding and the development of the "efficient price"

CHA welcomes the move to activity based funding (ABF) based on an "efficient price" as a means of increasing hospital efficiency. ABF needs to be introduced in conjunction with measures designed to ensure that incentives to increase hospital throughput do not compromise safety and quality and do not result in artificially induced hospital demand.

In considering the move to activity based funding, clarity is sought in the following areas:

- How will volume targets/caps imposed on the Local Hospital Networks by the state government fit in with the access guarantees for elective surgery and emergency departments?
- What happens if increases in demand beyond the control of the LHNs may preclude access to the reward and facilitation funding?
- Will hospitals/LHNs be able to undertake additional activity beyond that which is set out in the service agreements and still be funded including by the Commonwealth 60%?
- What penalties/incentives will be provided by state government in relation to volume targets?
- How will state governments pay for their share of hospital costs – will it be on the basis of activity based funding (ie payment of 40% of the efficient price plus any additional costs not covered by the 100% of the efficient cost)?
- Will hospitals be forced to provide services that are non-economic given the rate of the efficient price and their own specific cost structures?
- Will they be free to provide additional services in areas where they can generate surpluses?
- Will LHN hospitals seek to compete with the private sector?
- How will teaching and research infrastructure costs be costed and funded?

Term of Reference (j) Mental Health

CHA is disappointed that the COAG proposals and funding agreements have not substantially addressed the provision of mental health services despite the National Health and Hospitals Reform Commission devoting an entire chapter to mental health services. CHA notes that the COAG will revisit the provision of mental health services during 2011 and calls on first ministers to substantially address the provision and resourcing of mental health services as part of that process.

Term of Reference (k)- Other issues

Dental Health

CHA is disappointed that the announced reforms have not addressed the shortfall in public dental health services. This is a major equity issue, and one that is long over due for action.

Role of the Commonwealth – primary care organisations

The Commonwealth has announced its intention to take full responsibility for funding primary care services. These services will be organised and funded through a network of primary care organisations – to be known as Medicare Locals.

As many of these services are currently provided by hospitals, there is a risk of increased fragmentation and blame and accountability shifting unless there is a close alignment and integration between Medicare Locals and LHNs. The funding models developed will be critical in ensuring the new arrangements lead to a more, rather than less, integrated system.

CHA notes the scope and definition of those services will need to be negotiated with the States and Territories. The significant variation between States and Territories in the reported numbers of “non-admitted patient services” provided by public hospitals (based on Australian Institute of Health and Welfare data showing 21 million episodes in NSW and only 7 million in Victoria in 2007-08) suggests there are significant definitional issues to be worked through before a nationally consistent approach can be determined.

Response to the Terms of Reference relating to residential and community aged care

Term of Reference (c): Estimates of additional GP treatments in aged care facilities

It is difficult to provide informed comment on the Government's estimates of additional attendances without basic data, data that can be anticipated will be provided to the Inquiry by the Department of Health and Ageing.

CHA observes, however, that incentives alone are unlikely to fully address GP access issues in aged care homes where there is an overall shortage of GPs in the first place.

A recent survey by CHA of its members[1], which is attached at Appendix 2, suggests that the main issues concerning the way GPs interact with their aged care home and their residents revolve to a significant degree around a shortage of GPs and GP unwillingness or inability to engage fully with residential care due to time pressures. The most common issues raised include home visits difficult to arrange; timeliness of visits; reluctance to take on new or difficult patients; poor or inadequate documentation; inadequate after hours and emergency access; rushed consultations; and poor communication and information sharing.

On the other hand, a characteristic of homes that had no issues with their GP interactions was that they were being serviced by fewer GPs, even though they were more likely to be located in metropolitan areas where the ratio of GPs per head of population is higher. Such homes were also more likely to have visiting GPs who participate in care plan reviews, medication reviews and comprehensive health care assessments , but also more likely to have provided GP support services such as visiting rooms and IT capability.

Against this background, CHA welcomes the increase in the value of incentives for GPs who visit aged care homes regularly, with larger patient loads.

[1] Survey of GP Access in Residential Aged Care (Catholic Health Australia , April 2010)

The measure is particularly important in relation to the increase from $1,500 to $3,500 for at least 140 attendances, which on average represents GPs caring for about 12 residents. In addition to the survey findings, feedback from our members is that GPs who care for a significant number of residents also are more likely to be the ones who assist the aged care home with ongoing improvement in clinical systems (including medication management), who help out in difficult circumstances when required, and who may act as a de-facto Medical Director for the aged care service.

These GPs should be recognised, rewarded and retained. In this regard, there may be a case for a further incentive tier of $5,000-$6,000 for those GPs who make a major commitment to serving residents in residential aged care services, with at least 240 attendances per annum.

Term of Reference (f): Arrangements for States not signed up

CHA notes that Victoria and Western Australia have chosen not to embrace the aged care reforms included in the National Health and Hospitals Reform package, and in particular have not agreed to the Commonwealth assuming full policy and funding responsibility for all aged care.

CHA would urge that the failure of these States to embrace the aged care reforms should not be allowed to jeopardize the creation of an integrated national aged care system for the rest of the nation as a result of the Commonwealth assuming full responsibility for aged care.

Term of Reference (i)- (i) and (iii): 2500 new aged care beds to be generated by zero real interest loans

CHA appreciates the extension of the Zero Real Interest Loans Scheme on more favourable terms. However, the Zero Real Interest Loan Scheme is targeted to selected regions and is only a partial response to the inadequacy of the current capital funding arrangements to sustain the expansion and renewal of residential

services, especially the high care services that will be needed as the population ages.

CHA notes the Access Economics research [2] which demonstrates that, with revenue streams based on current accommodation payments for residential high care ($26.88 per bed day), construction of a new residential high care home would not proceed even with a construction cost per bed as low as $138,000 as the present value of revenues is less than the estimates of all the costs, making the internal rate of return (IRR) less than the weighted cost of capital (WACC).

Based on an average construction cost of $187,000 per unit to build an aged care home to contemporary standards, the required accommodation payment per day was estimated by Access Economics at $40.32 per bed day.

A consequence of this situation has been under-allocation of residential high care places in recent Aged Care Approval Rounds, and the handing back of allocated places (bed licences). Those developments that have proceeded have relied on the cross subsidy of low care and Extra Service bonds, and in some cases entry contributions from retirement village units.

As a reflection of this dependency on bonds, the median bond held increased by 29% in 2008-09 to $200,000, and Extra service places grew by 36% in 2008-09. [3]

Recent advice from CHA members is that the situation has been exacerbated in those regions where the Department of Health and Ageing considers that the Extra Service high care provision ratio has been reached. As a result, a number of applications for high care places that would otherwise have come forward have not proceeded.

Because of the long lead times involved with new service development and renewal, a slow down in building activity will inevitably result in a shortage of supply of suitable residential services in the medium term which will be difficult to reverse quickly.

Further, extension of the Zero Real Interest Scheme also continues the complex regime for capital funding, including as it does a mix of accommodation supplements, capital grants and zero real interest loans. It is hard to see how fair and equitable treatment of providers is achieved through such complex arrangements.

In summary, the extension of this highly targeted Scheme for two years does not address the long term sustainability of capital funding arrangements for the sector overall.

The current dependency on residential low care bonds also poses a structural barrier to reforms that would give older people more options to receive care for longer in their own homes. A proportion of those expected to favour this option would most likely be people who would otherwise be eligible to pay a bond.

CHA notes that these and related issues are likely to fall within the Terms of Reference of the Productivity Commission's public inquiry into aged care. CHA is hopeful that the extension of the Scheme for two years only is a signal that the capital funding issue will be addressed substantively upon receipt of the Productivity Commission's report.

<u>Term of Reference (i)- (ii) and (iii): Long Stay Older Patients (LSOP)</u>

This measure provides up to 2,000 time limited flexible aged care places under the Innovative Pool provisions of the *Aged Care Act 1997* to be made available to the States and Territories as compensation for the cost of older people in public hospitals who have been assessed (by ACATs) as eligible for aged care subsidies.

The measure is consistent with the decision that the Commonwealth is to assume full policy and funding responsibility for all aged care.

CHA understands that the places will be allocated from within the provision ratio target of 113 aged care places per 1,000 people aged 70 and over. If this is the case, and given the

[2] Economic Evaluation of Capital Financing of High Care (Access Economics, March 2009)

[3] Report on the Operations of the Aged Care Act 1997 2008-09

advice that the Government is on track to reach this target in 2011[4], it is probable that the LSOP places will be allocated at the partial expense of the expansion of residential and community care places. Moreover, it is not clear that that the number of older people inappropriately accommodated in public hospitals will decline while the provision cap of 113 places per 1,000 people aged 70 and over remains in place, unless waiting lists in the community increase.

CHA has argued in other places, most recently in its initial submission to the Productivity Commission's public inquiry into aged care, that access to aged care and subsidies should become an entitlement based on assessed care needs and capacity to pay, with eligible people and their families having a choice of care setting and provider.[5]

Until this policy is achieved and there is an expansion in overall aged care places, it is likely that older people will continue to be inappropriately and expensively accommodated in public hospitals.

Again, CHA notes that the Terms of Reference of the Productivity Commission's public inquiry into aged care will present the opportunity for this and related matters to be addressed.

Terms of Reference (i) (iv): Commonwealth policy and funding responsibility for all aged care

CHA welcomes the assumption of full policy and funding responsibility for all aged care by the Commonwealth as it will facilitate policy integration for all aged care. Locating responsibility with one level of Government will allow policy integration around matters such as consumer choice and access, assessment and eligibility, subsidy levels and fees policies and accountability, reporting and quality assurance.

Greater integration would also allow reduced duplication in administration, and more simple arrangements for consumers to access care and to transition across services as needs and circumstances change.

Clarification that full responsibility for aged care rests with the Commonwealth also creates greater certainty and less complexity for the Productivity Commission in undertaking its review of aged care. In particular, to fulfil the Government's request that the Productivity commission develops detailed options for redesigning Australia's residential and community aged care arrangements, including the services currently delivered by the Home and Community Care Program.

Together with the Commonwealth assuming majority funding responsibility for public hospitals, full Commonwealth responsibility for aged care and primary care should also create a financial incentive for the Commonwealth to support aged care services which would reduce the pressure of older people on public hospital services.

In assuming full responsibility for all aged care for people aged 65 and over, CHA notes that the Commonwealth would also assume full funding responsibility for specialist disability services delivered under the National Disability Agreement for all people aged 65 and over. On the other hand, the States and Territories would be responsible for funding care services for younger people - such as people with disabilities - where ever they are receiving care.

CHA supports the use of age as a practical means for apportioning funding responsibility, but considers that the setting for the receipt of care should remain neutral as to funding source. The setting should be that which is most appropriate for each individual in order to ensure continuity of care as needs change, including as a result of ageing. CHA also considers that the new funding arrangements must cater for the needs of groups such as MS suffers and people with early onset dementia whose care needs can emerge well before 65 years of age.

[4] Health and Ageing Portfolio Budget Statement 2010-11

[5] Initial Submission to the Productivity Commission Inquiry into Aged Care, *Caring for Older Australians (*Catholic Health Australia, April 2010)

Appendix 1 - World Health Organisation Social Determinants of Health framework

Table 1: WHO Framework for determinants of health

Society	**Socioeconomic**	**Health Behaviours**	**Biomedical**	
Culture	Education	Smoking	Blood pressure	
Resources	Employment	Physical activity	Blood cholesterol	
Systems	Income and wealth	Alcohol consumption	Body weight	
Policies	Family, neighbourhood	Use of illicit drugs	Glucose regulation	
Affluence	Access to services	Dietary behaviour	Immune status	An individual's and a population's health
Social cohesion	Housing	Sexual behaviour		
Media	Knowledge	Vaccination status		
Natural environment	Attitude	Psychological factors		
Built environment	Beliefs	Safety factors		
Individual physical and psychological makeup (genetics, ageing, life course, intergenerational influencers)				

Catholic Health Australia

Survey of Access to General Practice Services in Residential Aged Care

April 2010

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

1. Background

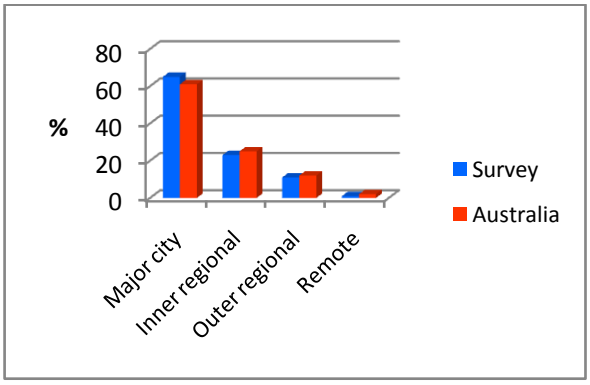
The purpose of the survey was to obtain better information on the interactions between Catholic aged care homes and General Practice from an aged care provider perspective, for use in national policy deliberations.

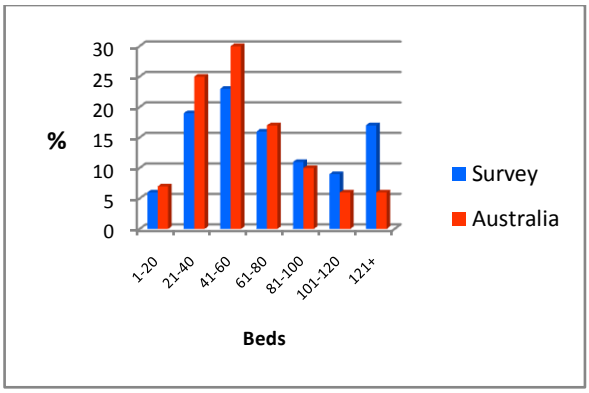
The web-based survey was sent to all aged care provider members of Catholic Health Australia and was conducted during January and February 2010.

Ninety responses were received, each representing a separate aged care home. This represents 3.2% of mainstream residential aged care services in Australia. The responses involved homes from 41 Approved Providers.

The survey respondents operate 6,364 beds, some 3.8% of aged care beds in Australia. Most respondents (81%) have both low and high care residents.

The geographic distribution [6] and size of respondents is as follows:





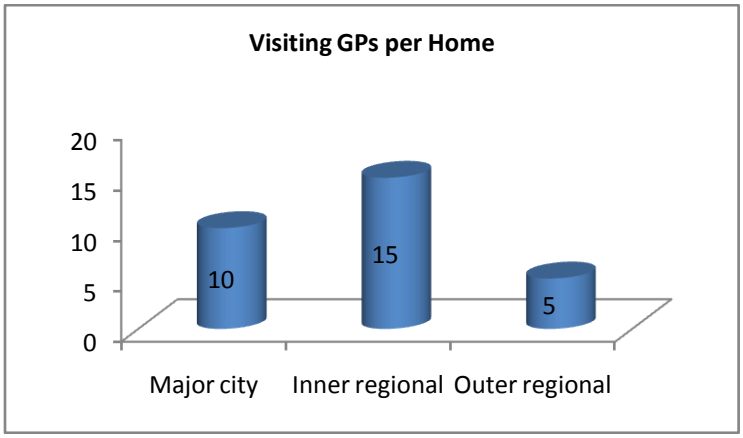
[6] Classified according to the *Australian Standard Geographical Classification(ASGC) Remoteness Areas* (Australian Bureau of Statistics)

2. Number of visiting GPs per aged care home

On average, there are 10 GPs visiting each home.

However the number of GPs attending homes can vary significantly. For example, in this survey, the number servicing a home varied from 3 servicing a 122 bed home to 13 GPs servicing a 30 bed home.

In geographic terms, this translates as follows:



From another perspective, it also translates to a ratio of one visiting GP for every 8 residents in major cities compared with one visiting GP for every 5 residents in inner regional areas and 11 residents in outer regional areas.

3. Residents entering in circumstances where their GP declines to continue service

In 43% of homes surveyed, it was reported that most residents (70% +) have entered aged care homes in circumstances where their GP has declined to continue to service them and alternative arrangements have had to be made. In 54% of homes, this was the case for more than half of the residents.

In 55% of homes surveyed, it was reported that most residents (70% +) had changed within a few months to a GP who has existing patients residing in the home.

This is a high figure given the choice principle embodied in Medicare. The result indicates that many older people who enter aged care homes experience a disruption in continuity of care at the same time as their dependence on primary care is peaking.

The risk of discontinuity of service is much greater, however, in the major cities. Only 17% of homes in major cities reported that most residents (70% +) continued to be services by their former GP, compared with 77% in inner and outer regional areas.

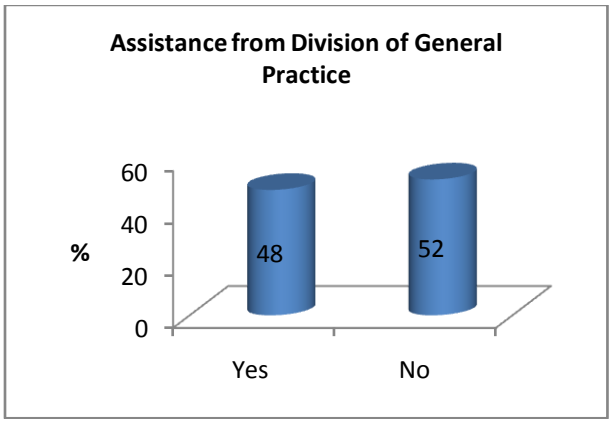
Some of the disruption is no doubt accounted for by people who move to an aged care home some distance from their former family home, notwithstanding the Commonwealth Government's regional

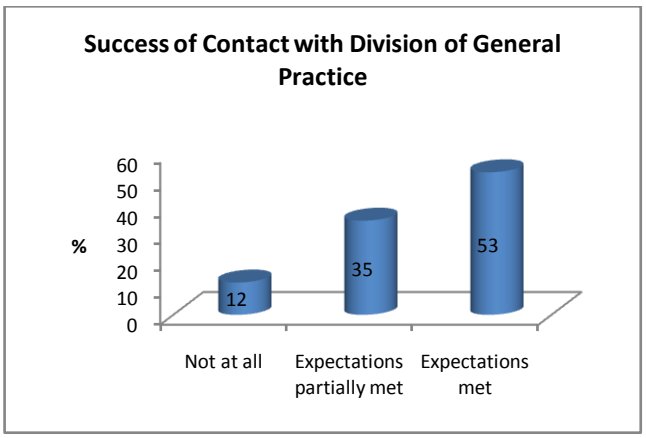
planning ratios. Some of the disruption may also reflect reluctance by some GPs to attend patients in aged care homes eg due to travel times involved in the major cities, practice disruption and remuneration levels. However the survey scope does not allow any firm conclusions to be drawn as to the primary reasons for such a significant disruption in continuity of care in major cities.

4. Relationships with Divisions of General Practice

Only 48% of respondents (43 homes) had sought or received assistance from their local Division of General Practice to improve GP services.

Of those, 88% had their expectations fully or partially met, with 53% fully met. Only 12% did not have their expectations met at all.





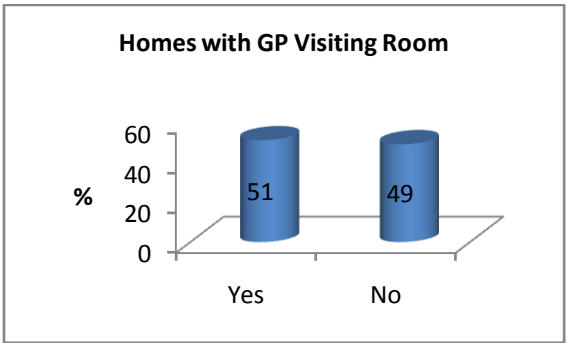
Homes in inner and outer regional areas are more likely to have sought or received assistance from their local Division of General Practice (57%), compared with 44% of homes in the major cities. The higher proportion of regional homes reporting ongoing difficulties with accessing GPs (see Section 7 below) may account for some of this difference.

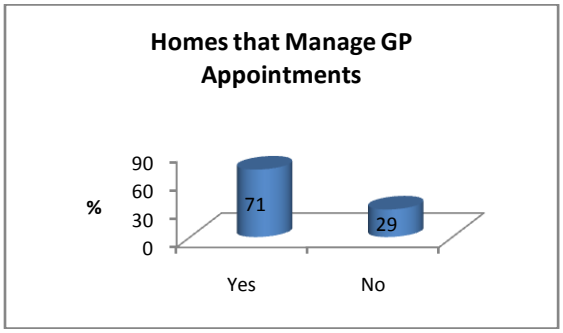
Homes in outer regional areas were marginally more likely to have been satisfied with the outcome of the association with their local Division.

This result suggests that there may be some scope for more homes to approach their local Division of General Practice for help in accessing GP services. The survey provides no information as to whether local circumstances concerning some Divisions may account for the large number of homes who have not received assistance, or whether it reflects a lack of initiative on the part of some providers.

5. GP visiting rooms and management of appointments

Half of the homes responding to the survey (51%) reported that they had a visiting room for GPs and 71% reported that they managed appointments for GPs. The survey did not provide any information as to the fitness for purpose of the room eg whether it was a dedicated and equipped room or a multipurpose room.

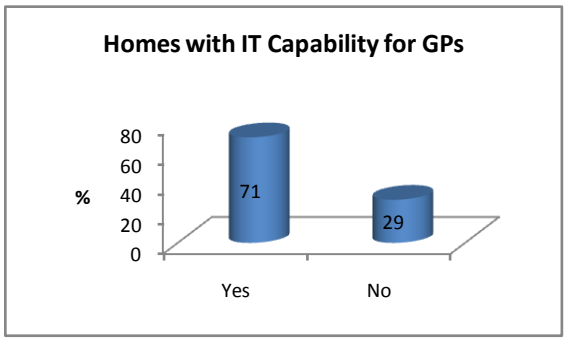




Homes in the major cities are more likely to have a GP visiting room (54%), compared with the homes in regional areas (40%).

6. IT capability for visiting GPs

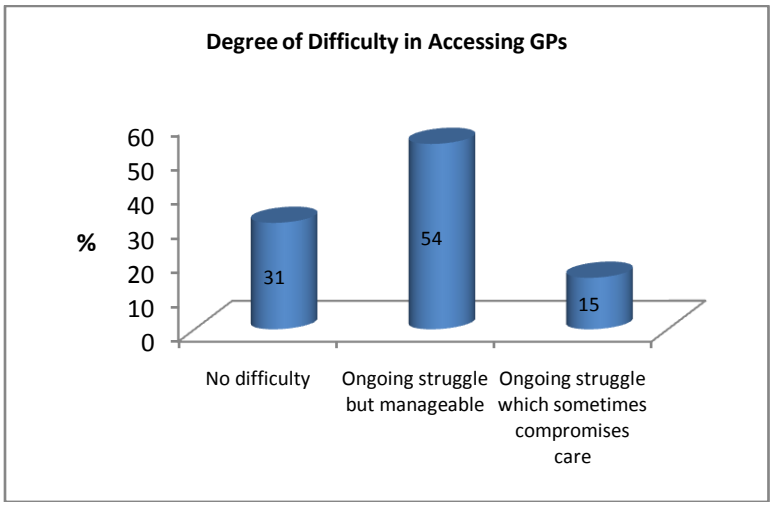
Most of the homes (71%) reported that they had IT capability for visiting GPs. However, 40% of homes with IT capability reported that very few of their visiting GPs used the IT capability. Again, the survey did not provide any information as to the suitability of the IT capability.



In contrast to the situation with GP visiting rooms, homes in regional areas are more likely to have IT capability (80%), compared with homes in the major cities (67%).

7. Degree of difficulty in accessing GPs

A third of respondents (32%) reported that they have no difficulty in accessing GPs to attend their residents, and a further 54% reported that they were managing even though it was an ongoing struggle. Disturbingly, 15% of respondents reported that the difficulty they experienced in accessing GPs sometimes compromised patient care.



More aged care homes in regional areas reported that accessing GPs was an ongoing struggle (80%), compared with homes in major cities (63%).

8. GP access and availability of support services for visiting GPs

Visiting room

Homes which have a visiting room reported marginally less difficulty in accessing GP services. Some 64% of homes with a visiting room had ongoing difficulty accessing GPs, whereas this increased to 77% for homes that did not have a visiting room.

IT capability

Similarly, 61% of homes with IT capability for GPs had difficulty accessing GP services, whereas the figure increased to 88% of homes without IT facilities.

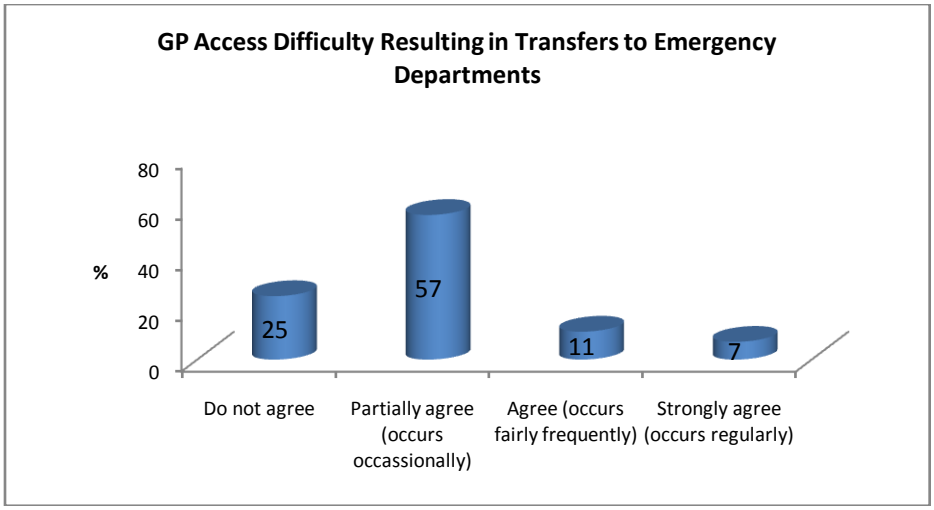
Management of appointments

Homes that manage appointments do not seem to have less difficulty in accessing GPs. Some 71% of homes that provide this service reported that they still have difficulty accessing GPs, not significantly more than the percentage of homes that do not manage appointments (64%).

9. Transfers to hospital emergency departments

Survey respondents were asked to what extent they agreed that difficulty in accessing GP services, including locum services, was resulting in transfers to hospital emergency departments.

A quarter of respondents (25%) did not agree that access to GPs was resulting in transfers to emergency departments. A further 57% reported that GP access problems occasionally resulted in such transfers, whereas 18% reported that transfers occurred fairly frequently or regularly.

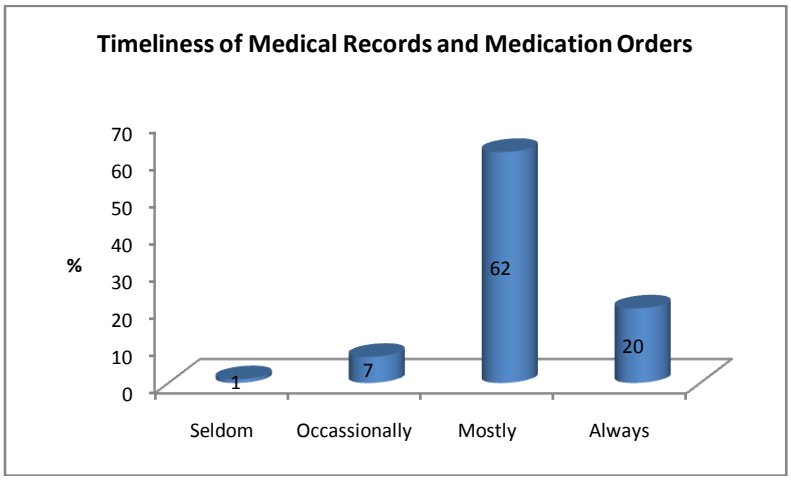


More homes in the major cities (23%) agreed that difficulties in accessing GPs was resulting in fairly frequent or regular referrals to emergency departments, compared with 10% of homes in regional areas. Yet, as we saw earlier, more homes in regional areas reported difficulties in accessing GPs. This suggests that homes in the major cities may be more likely to transfer residents to emergency departments because they are more easily accessed.

10. Timeliness of medical records and medication orders

The respondents were asked whether visiting GPs update the resident medical records and sign medication orders in a timely manner.

Almost all respondents (94%) responded that GPs were mostly or always signing medical records in a timely manner. However, timeliness was a problem for 6% of the respondents.



11. Participation in care plans, medication reviews and health assessments

Respondents were asked what percentage of the visiting GPs participated in care plan reviews, medication reviews and comprehensive health assessments.

Only 21% of homes reported that most of the GPs servicing their homes participated in care plan reviews, with a further 19% reporting that about half of their GPs participated in care plan reviews.

Participation in medication reviews and comprehensive health assessments was significantly higher, with 78% and 61% of homes respectively reporting participation.

12. Issues of concern regarding GP interactions with homes and residents

Respondents were asked to list their three main issues concerning the way GPs interact with their home and their residents. Six respondents did not answer this question and of those who did, a number listed fewer than three issues.

Of the 84 respondents who answered the question, 10 (12%) indicated that they had no issues of concern regarding their interaction with their GPs. They indicated that the relationship was working well.
The most frequently raised issues by the other 74 respondents are listed below:

Issue	Frequency
Home visits difficult to organize/ timeliness of visits/ reluctance to take on new or difficult residents/GPs need to be chased up/ screening by GP receptionists	38
Poor or inadequate documentation (including for ACFI purposes) / poor communications and information sharing	36
Inadequate after hours and emergency access, including locums not reviewing residents adequately	22
Rushed consultations / not enough time allowed	19
GPs do not visit at convenient times for residents and staff / visiting times unpredictable	16
Inadequate involvement of and consultation with RNs, carers and family / unavailability to participate in family reviews	11
Inadequate knowledge of and attention to end of life and palliative care	6

Other issues mentioned include difficulties involving pharmacies and prescriptions, lack of a dedicated and equipped GP visiting room, IT not used by GPs, shortage of bulk billing GPs and a lack of mental health knowledge.

Some of the more commonly raised issues could be addressed by better processes and coordination, but many also suggest that a causal factor is the under supply of GPs or GP unwillingness to engage fully in residential aged care. Even the latter could be explained in many cases as being due to the pressures on GPs given the overall shortage.

The characteristics of the homes that reported no issues of concern regarding their interaction with GPs are worth noting. While acknowledging the small number of homes involved (10), these homes were:

- more likely to be located in a major city (90% compared with 65% for the survey)
- more likely to have a GP visiting room (90% compared with 51% for the survey)

- somewhat more likely to have IT capability for the GP (90% compared with 71% for the survey) though, consistent with the overall survey, only half of the GPs used the IT capability
- marginally more likely to manage appointments (80% compared with 71% for the survey)
- no more likely to have sought or received assistance from the local Division of general Practice (50% compared with 48% for the survey)
- more likely to have visiting GPs who participate in care plan reviews (50% compared with 21%), medication reviews (90% compared with 78%) and comprehensive health care assessments (100% compared with 61%)
- were being serviced by fewer GPs (5 GPs per home compared with 10 GPs for the survey average) and had higher doctor /patient ratios (1:11 compared with the survey average of 1:7)

The above suggests that the homes with the best interactions with GPs are city- based (where the ratio of GPs per head of population is higher than other areas), have visiting rooms and manage appointments, and have a core group of GPs servicing a significant number of residents each to whom new residents are prepared to transfer, and have a high rate of participation in patient reviews. The presence of IT capability or contact with or assistance from a Division of General Practice does not appear to have been a distinguishing characteristic for this city-based group of homes.

The survey generally points to an overall shortage of GPs being responsible for access difficulties, including to the extent that many GPs are not fully engaging in the care of aged care residents. This situation raises the question as to whether some of the pressure could be taken off GPs through greater use of nurse practitioners dedicated to residential aged care.

Catholic Health Australia

April 2010