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AMA

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The Secretary
Senate Community Affairs References Committee
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Inquiry into Aged Care

Introduction

The Australian Medical Association (AMA) welcomes the opportunity to make a submission to the Senate Community Affairs References Committee's Inquiry into Aged Care. We have also noted the submission to be made by the Australian Society for Geriatric Medicine.

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 AMA has an important advocacy role regarding the care of older Australians.

The AMA submission addresses each term of reference:

- (a) the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training;
- (b) the performance and effectiveness of the Aged Care Standards and Accreditation Agency in:
 - (i) assessing and monitoring care, health and safety,
 - (ii) identifying best practice and providing information, education and training to aged care facilities, and
 - (iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff;
- (c) the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements;
- (d) the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly; and
- (e) the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

Term of reference (a): access and workforce issues

Older Australians must have access to quality aged care services wherever they live: in residential aged care homes, or in the community. This access is currently being increasingly restricted by shortages of qualified health and aged care professionals.

Shortages of adequately skilled staff and disincentives for GPs to visit residential aged care facilities impact on the quality of care provided to residents.

In the AMA's view, this is partly a resource problem, partly a training problem, and partly an environmental or culture problem.

These problems reflect the perceived lack of value of aged care residents, older Australians, and their carers.

This must be addressed if our older citizens are to receive the care services they need, are entitled to, and deserve.

One of the major issues confronting aged care is workforce. However, there are substantial disincentives and barriers that currently make it difficult for GPs, geriatricians, nurses, other health professionals, and carers to operate in the aged care sector.

These disincentives include an inequitable fee structure for doctors and inequitable wages for nurses and other care staff. For instance, it is a matter of great concern that aged care nurses are paid up to 25 per cent less than acute care nurses in hospitals.

GP participation in Residential Aged Care facilities has declined. Only 16% of GPs visit nursing homes on more than 50 occasions per year (i.e. less than 1 per week).

We are not just talking about money. There are other, environmental, factors which make it difficult for health professionals to participate effectively in the care of older Australians. These disincentives and barriers that currently make it difficult for GPs, geriatricians, nurses, other health professionals, and carers to operate in the aged care sector include:

1. an inequitable fee structure for doctors
2. the absence of appropriate Medicare Benefits Schedule items for consultations by geriatricians
3. the large number of non-face-to-face administrative tasks and red tape expected of GPs
4. the lack of integration of medical services in the aged care system; and
5. the absence in many residential facilities of consultation rooms with adequate treatment facilities and plug-in computer facilities that would facilitate access to patient records for all visiting health professionals, and would save duplication of records.

All aged care workers must be better paid for the work they do. The remuneration, working conditions and facilities for all aged care workers – doctors, nurses, other health professionals, and carers – must be commensurate with the high quality care and comfort and companionship they provide.

Federal/State cost-shifting/blame-shifting between the State controlled (but partially Federally funded) public hospital sector and the Commonwealth funded aged care sector must be overcome.

The Medicare Benefits Schedule needs to provide more realistic rebates which will cover the costs of providing appropriate medical care within the residential aged care environment.

The AMA was disappointed that neither the Government's recent National Aged Care Workforce Strategy nor National Aged Care Workforce Census considered medical practitioners to be part of the aged care workforce.

The demographic challenge

Demand for aged care services is rapidly growing as the population ages. In 1998, the number of Australians aged over 65 years was 2.3 million. This figure is projected to increase to 4 million in 2021 and to 5.7 million in 2041. Those people aged eighty-five and over are projected to rise from about 1.3 per cent of the population to 2.1 per cent of the population by 2021.

The Government's *Intergenerational Report* tabled with the 2002 Budget starts with the questionable assumptions that retirement age will continue to drop, that older people will make reducing contributions to the revenue base, that the tax base would erode, and that society would not adapt to changing socio-demographic circumstances.

The challenge for government is to adopt public policies which will enable society to adapt to changing socio-demographic circumstances.

Governments must look beyond the next election and commit adequate funding and deliver responsible progressive health policies to ensure access and affordability to high quality health and aged care services for all Australians, no matter where they live and no matter their socio-economic background.

The greatest challenge now facing the Australian health system is to ensure there are enough doctors and other health professionals with the necessary skills to serve the growing and ageing Australian population.

A combination of poor medical workforce policy from successive federal governments, the medical indemnity crisis, and high practice costs is forcing more doctors out of medical practice in towns and suburbs all over Australia.

The problem is far worse in regional and outer-suburban areas. The workforce shortage is a direct consequence of restricting the number of medical students and medical provider numbers – together with the underfunding of Medicare – especially since the mid-1990s.

Budget

Aged care was a key focus of the 2004 federal Budget. The AMA described the Government's 2004 Budget initiatives in aged care as a welcome recognition of the care needs of older Australians. In particular, we welcome the increase in community care and transition care places, but regret that these are at the expense of residential aged care places.

While the focus of the 2004 Budget was on residential and community care places – and not medical services – any move to improve access and quality in the aged care sector is overdue and welcome.

Reducing bureaucracy is commendable if it can be achieved. The streamlining of the aged care assessment and classification administration is a welcome reform that should reduce the stresses that currently act as a real disincentive for doctors, nurses, and allied health professionals to work in the aged care sector.

The AMA welcomes the short term measures to help ease the capital funding crisis in aged care,

but much more needs to be done.

It is disappointing that the bigger picture for the long term has been neglected. For example, there is nothing about making dementia a National Health Priority, or allocating additional research money to addressing the dementia epidemic.

Overall, in the budgetary surplus situation, the aged care package could have done so much more to address the bigger picture of the future needs surrounding ageing in our society.

MedicarePlus aged care initiatives

MedicarePlus will provide \$47 million over three years toward improving the provision of medical services to patients in aged care facilities. This is not nearly enough.

The AMA is concerned that the implementation of the MedicarePlus Aged Care Initiatives measures to enhance medical participation in residential aged care through the “Panels of GPs” to be run through Divisions of General Practice could fail because:

- the funds available are so small as to constitute a pilot, while the implementation is to be comprehensive and national, with all local divisions, and every aged care home, being encouraged to participate;
- the legal advice to the Department of Health and Ageing about professional indemnity risk raises real questions about the viability of the “Panels of GPs” project and the potential exposure of doctors in this work;
- the administrative and funding models to be used will not create a climate which is likely to attract substantial numbers of new doctors into providing services in residential aged care;
- the administrative and funding models to be used make it difficult if not impossible for geriatricians, other medical specialists, and other health professionals, to participate;
- this will not support better integration of services.

The AMA believes that consideration should be given to alternative funding models which would enable the introduction of the GP Facility Adviser model as advocated by the AMA, and for geriatricians, other medical specialists, and other health professionals to participate in initiatives to enhance integrated medical care in the residential aged care environment.

The AMA welcomes the new Comprehensive Medical Assessment for people in residential aged care.

Environmental factors

Purpose-built consulting rooms within aged care homes, with adequate examination facilities, modern clinical equipment, and access to electronic prescribing, records and billing services, and a new Medicare attendance item for comprehensive on-site aged care consultations are needed if aged care residents are to get the health care they deserve.

Information technology has become an important aid in medical practice. Access to IT within an aged care facility would improve the manner in which medical services can be delivered. It would also help to overcome the problem that information needs to be replicated, sometimes 4 times. This is a major disincentive to work in the aged care environment.

Education and training

There is a need to foster and enhance education and training for all in the aged care workforce in residential aged care facilities, including the fostering of undergraduate and postgraduate education in geriatric health.

This would ideally involve better integration of training and education between educational institutions such as universities, and aged care facilities, and give us the opportunity to develop the exciting concept known as ***teaching nursing homes***, providing education and development opportunities for doctors as well as nurses and other aged care staff.

We are pleased that there are now some initiatives under way which may help address this situation.

The biggest concern we have is the total lack of a strategy to address the medical workforce shortages. Many doctors are retiring early or working part-time and there are insufficient doctors to take their place. Doctor shortages cannot be reversed overnight.

While the AMA sees a need for more medical places and medical schools, we would rather see them established in rural and regional areas. The UWS School may duplicate existing services and drain already stretched teaching resources.

Undermining the teaching initiatives is the Government's ill-advised policy of unfunded bonded medical places. In the AMA's view, these bonds will not solve the workforce problems across the health and aged care sectors, they will make them worse.

Term of reference (b): Aged Care Standards and Accreditation Agency

The well-developed health service and residential aged care systems in Australia can be characterised as funding and bureaucratic "silos".

The Commonwealth sets the regulatory environment for residential aged care facilities, regulating standards of service provision and all income streams/funding.

The current Australian aged care subsidy and accreditation systems purport to fund and assure a quality multi-disciplinary care service but result in a "pseudo-stand-alone" system.

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.
- 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.

Much of the red tape for these two inspectorial regimes are duplicated across the two

requirements.

While clinical issues are fundamental underpinnings to many of the Aged Care Standards and Accreditation Agency's standards, the Agency has no way of adequately taking into account medical issues in either the development or operation or review of these standards.

The AMA has been unsuccessful to date in its offer to provide this insight through membership of the Agency's consultative group, the National Agency Liaison Group (NALG). We believe that as the role of medical practitioners in providing quality health care to older Australians is central to their well-being, this step would help ensure that a continuum of care is available to older Australians who live in aged care homes.

Such involvement would strengthen the credibility of the Aged Care Standards and Accreditation Agency, in recognising the key role of quality clinical care in achieving a balanced practical approach to overall quality of care.

Term of reference (b): young people with disabilities

Residential aged care homes are designed for people over 65 years of age, many but not all of whom are facing issues related to the end of their life.

According to the advocacy organisation Young People in Nursing Homes, people under 65 comprise around 4.5% of nursing home residents. When young people are admitted to an aged care home, they can lose access to many of the community services available to other people with a disability. This is a tragic situation for the individuals and their families. The AMA believes that alternative options must be developed as a matter of urgency.

The AMA is sympathetic to the advocacy by Young People in Nursing Homes that it is inappropriate for young people to be accommodated in aged care homes, as invariably the issues faced by these young people and their families, and their lifestyle wishes, will be different. While the level of care required by residents - young and old - may be comparable, there are significant social and cultural differences that need to be recognised and addressed.

There are a variety of diseases and disorders that particularly affect young people to the extent that they require residential care. These include:

- people with Multiple Sclerosis and other neurological conditions;
- people with acquired brain injury;
- people with physical and / or sensory disability.

Allocation of resources to manage such conditions must consider the distinctiveness of the disease and of the social and cultural environment and the particular needs of young people.

In July 2001 the Australian Medical Association convened a summit *Adolescence: An Opportunity for Health* that developed *National Youth Health Priorities 2001*. This document outlines the AMA's position that there should be appropriate long-term residential care for young people who require it as a result of accident, illness, or disability. These priorities were endorsed by key stakeholders.

In cities with sufficient numbers of young people with disabilities needing and wishing residential care, residential care facilities dedicated to their needs should be developed.

However, it must be recognised that one need which would undoubtedly be felt by young people

with disabilities is to be able to live close to their families and friends.

In many regional and rural areas, this would not be possible because there would simply not be enough young people with disabilities to justify a stand alone facility in each town.

In regional and rural areas, therefore, it may be necessary to redefine the roles of some residential facilities, to enable them to improve the scope of the services they provide to better meet the needs of all residents.

In this way, a new type of residential home would emerge in regional and rural areas, providing services for people of all ages with complex, chronic conditions and disabilities, with staff trained in and sensitive to the needs of younger people with disabilities.

One obvious impediment to this apparently obvious development is the current funding model, under which the Federal Government has responsibility for residential aged care facilities, while the State and Territory Governments have responsibility for accommodation and ongoing management of young people with disabilities.

Senate committees in recent years have often played a very constructive role in developing bipartisan solutions to difficult social issues. It would be very useful if this committee inquiry could move towards an acceptable outcome to this tragic situation.

Term of reference (d): community care

Most older people do not need, and never receive residential aged care services. People would generally prefer to remain in their own homes, supported as necessary by community care services. While Government has expressed support for this option for some 20 years, funding levels remain inadequate.

There is increasing recognition that community care programs can no longer be considered in isolation from other service sectors, including residential aged care, disability services and primary and acute health services.

The AMA welcomes the increase in community care places announced in the 2004 federal Budget. However, we regret that it is at the expense of residential aged care places.

Term of reference (e): continuity of care and transition issues

Access to health care is particularly important for older people, who are more likely than younger people to suffer from compound conditions requiring on-going care and monitoring, though not acute care except for short periods.

The February 2004 National Aged Care Summit hosted by the AMA in partnership with our fellow members of the National Aged Care Alliance agreed that aged care is fundamentally a health care issue.

All political parties need to acknowledge that there are serious barriers to the delivery of appropriate care for the aged, due to inflexibility in health funding programs, a separation of responsibilities, the lack of transition care and other options, inadequate integration of services, and the shortage of both nursing home beds and community care.

The well-developed health service and residential aged care systems in this country, with their funding and bureaucratic “silos”, tend to cause a limiting mind set in approaching the issue of service provision for older people who have ongoing disability and complex health service needs.

The different government agencies responsible for ‘their’ silo of health care, whether it be, for example, acute health care, non-acute or sub-acute medical care, residential aged care, community-based care, or the Pharmaceutical Benefits Scheme, are too-often concerned only with ‘their’ bottom line, and not with how ‘their’ program impacts with the ‘other’ silos in influencing overall health outcomes for all Australians.

Australia needs to break down the silos on several levels, including political, professional, and institutional. Together 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.

Transition

Thousands of Australians are trapped in the wrong environment for the type of care they need. There are many people in hospital who no longer need acute care, but are unable to care for themselves at home and cannot access appropriate residential or community care. Similarly, there are people in nursing homes who should be in hospital, and people in the community who ought to be in either hospital to treat particular conditions, or in aged care homes.

A key issue is that people have access to:

- a clear and accurate diagnosis;
- a clear definition of their impairment;
- an opportunity to minimise their disability through appropriate care arrangements.

This requires an appropriately funded sub-acute service. Specialist sub-acute services cannot be delivered in an aged care home environment.

There needs to be a new national model for funding of Commonwealth and State programs for improved coordination of hospital, residential aged care facilities and community-based services.

The AMA urges governments to cooperate on:

- improving the interface between hospitals and primary and aged care services;
- taking steps to improve the ongoing provision of care for older Australians between aged care, health care and rehabilitative care.

The AMA urges the Commonwealth, State and Territory Governments to commence research into the causes and contributing factors towards public hospital access block and emergency department overcrowding.

Additional beds in aged care homes, more community care places, and more transitional care must be provided if ageing Australians are to receive adequate and appropriate care.

The new stream of transition care of up to 2,000 places to be created to help older people moving to aged care after a hospital stay is a good initiative. However, these places should not be taken from existing residential places.

The implementation of the transition care measures needs to recognise that the rehabilitation and care needs of people moving out of acute care are likely to be greater than normally provided in a nursing home setting - and provide for those sub-acute needs with the necessary clinical care.

It is a matter of concern to doctors that this seemed to be the only form of assistance in this year’s federal Budget to ease the pressure on our public hospitals. There is nothing else in the Budget to

enhance continuity of care between hospitals, aged care homes, and the community.

Better continuity of care must be achieved by conscious policies and strategies aimed at enhancing integration and communication.

Dementia

Dementia is becoming one of Australia's greatest public health challenges.

The Alzheimer's Australia 2003 paper *The Dementia Epidemic* projected that well over half a millions Australians will have dementia by mid-century, 2.3 % of the population. This compares to the 2002 figures of 162,000 Australians, or 0.8% of the population, with diagnosed dementia. This paper - supported by lead academics in epidemiology and dementia care - called for dementia to be a national health priority area.

There is no current national strategy for early identification of dementia - important not only for treatment, but for counselling and support. Early identification helps people with dementia who are aware of subtle cognitive changes by reducing their anxiety and stress. It also gives them a clear opportunity for control over key decisions prior to the onset of more significant cognitive decline. In the late stages of disease there is emerging evidence that both non-pharmacological and pharmacological strategies can improve the management of the behavioural and psychological symptoms of dementia. A number of specific environmental strategies have also been demonstrated to have benefit.

In addition to the current symptomatic treatments (the acetyl cholinesterase inhibitors), a number of disease modifying agents are now completing phase two/three clinical studies and could be predicted to be "market ready" in the next four to five years.

The AMA was successful in obtaining some easing of the PBS prescribing restrictions on cholinesterase inhibitors, and is engaged in ongoing consultation with PBAC chair Professor Lloyd Sansom on these issues.

The epidemic of dementia is now clearly burdening many of our older people, and the aged care and health services that must deal with it. It needs urgent attention. Good dementia care requires the integration of primary health care, community care and hospital care and to achieve this a national perspective is required.

In order for our society to come to grips with this epidemic, the AMA supports calls for dementia to be identified as a National Health Priority, and to have substantial funds for both research and treatment devoted to dementia.

Outside Government jurisdictions there is wide support for dementia to be a national health priority area. Key stakeholder groups such as Alzheimer's Australia, Carers Australia, the Mental Health Council, the Australian Society of Geriatric Medicine, the Australasian Faculty of Old Age, and the National Aged Care Alliance, as well as the AMA have all supported dementia becoming a national health priority area.

The care of people with dementia should be part of the expected skills set in all aged care facilities and services. Challenging behaviour as a result of dementia, psychiatric illness, developmental disability, or other causes such as head injury, require specialised staff and facilities to complement geriatric services.

Conclusion: Challenges for the future

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

Yours sincerely

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