

Productivity Commission Inquiry

Caring for Older Australians

Background

Public inquiries give the opportunity for all points of view to be heard and considered. Participating in an inquiry means taking an active role in Australia's public policy formation. The success of each inquiry depends largely on the participation of community members and organisations.

Inquiry outline

The Productivity Commission has invited interested parties to contribute to an inquiry into Australia's current aged care arrangements. In undertaking the inquiry, the Commission will develop options for further structural reform of the aged care system so it can meet the challenges facing it in coming decades. In particular, the Commission will:

- examine the social, clinical and institutional aspects of aged care in Australia, building on the substantial base of existing reviews into this sector
- address the interests of special needs groups
- develop regulatory and funding options for residential and community aged care (including the Home and Community Care program)
- examine the future workforce requirements of the aged care sector
- recommend a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust
- examine whether the regulation of retirement specific living options should be aligned more closely with the rest of the aged care sector
- assess the fiscal implications of any change in aged care roles and responsibilities.

In the course of the inquiry, the Commission will consult widely with older Australians, their carers, aged care providers, government agencies and other interested parties.

Introduction

There are significant challenges facing general practice that negatively impact on its capacity to provide services to a large number of elderly Australians and several of these issues will not be easily or quickly remedied.

Major obstacles faced by general practice to caring for older Australians

Demand pressures

The increasing age of the population and related increases in chronic illness and multimorbidity, more complicated medical treatments being provided on an outpatient basis and shortened hospital stays mean general practice care is in high demand and is becoming

more complex. In 2008/09, people aged over 45 years made up more than 60% of those who saw their General Practitioner (GP), up from 27% in 1999/2000 [1]. There were around 25 million more problems managed at GP visits in 2008/09 than in 1999/2000. Health care support to older Australians in the community including home visits to elderly patients who are too frail to attend in person is essential to prevent movements into institutionalised care. A 2008 investigation found there has been a marked decline in the rate of home visits by Australian GPs over the past decade [2]. Demand pressures from the ever increasing number and complexity of regular practice consultations reduce the capacity of general practice to provide services outside the practice. GPs providing at least one home visit a year in 2006-08 was 22% compared with 41% in 1998/2000 [1]. This decline is particularly significant for patients in older age groups (65+ years) [1]. As a result many frail elderly patients who need medical care are faced with little choice other than to call an ambulance. A number of factors have been blamed for the fall off in home and nursing home visits including the continued expansion of corporate general practice which usually doesn't include home visits in its service provision program because of reduced profitability; reduced incentive overall due to relatively poor remuneration for travel time and visits compared with staying in the practice, and not wanting to turn away around four (and often more) on-site practice patients to attend one home visit, especially where a practice is struggling to meet the magnitude and needs of on-site patients [3].

There are no resident general practitioners in residential aged facilities (RACFs) in Australia [4]. GPs providing at least one nursing home visit a year fell from 22% in 1998/2000 to 17% in 2006/08 [1]. Medicare figures from 2006/07 indicate that almost 60% of GPs provided no MBS services to residential aged care patients and that only 12% provided more than 100 services [5]. A recent study demonstrated that problems managed by GPs in nursing homes differ considerably from those managed in practice encounters. Dementia (especially Alzheimer's disease) is the problem most frequently managed in nursing homes at a rate 33 times higher than in everyday general practice [6]. It is estimated that up to half of the residents in RACFs have dementia with the majority of these requiring high-level care [7]. This has an enormous impact on the workload and time pressures of GPs working in this setting. Overall GPs perceive work in aged care facilities as poorly paid and time-consuming. They also report the average time away from their practice while visiting an RACF is almost 2 hours [3]. The number of people in residential aged care continues to rise in Australia.

Workforce

The General Practice Activity in Australia 2008/09 report [1] indicates that General Practitioners (GPs) aged over 55 make up 46% of the current GP workforce, up from 27% in 1999/2000 [1]. The recent increase in university places for medical students may not result in large increases in GP numbers as many will be offset by the numbers of ageing GPs reducing work hours and retiring. The AIHW report a significant increase in the proportion of GPs working 10 clinical sessions per week or less, from 66% in 1999/2000 to 78% in 2008/09 [1]. The proportion of GPs working 11 or more sessions per week almost halved, from 18% to 10% over the same period [1]. The concurrent need for more and replacement medical specialists across a number of chronic disease areas (due to increasing patient numbers and retirement) means that medical graduates more attracted to these speciality areas may discount a career in primary care. Those medical graduates that opt for a general

practice career will need training supervisors which are not currently available in the numbers that are predicted will be needed.

In spite of these significant barriers, there are other seemingly straightforward obstacles to the provision of general practices services to older Australians that could and should be remedied now to ensure that the greatest number and quality of health care services are provided to this vulnerable group.

Practical obstacles faced by general practice to caring for older Australians

Residential Aged Care

Environment

Historically, Australian GPs have played a prominent role in the care of RACF residents. It is widely reported that RACFs are, in general, highly challenging work environments for GPs with limited and often outdated treatment facilities and medical equipment [8] [9] [10]. Significant levels of responsibility are usually placed on GPs in these settings with little support available from on-site ancillary and nursing staff. A 2008 Australian Medical Association (AMA) survey of GPs [3] found among the major factors behind decisions not to conduct aged care visits were a lack of required resources and adequately trained nursing staff to implement planned care.

Inadequate or no car parking and poor or no access to facilities after hours add important weight to decisions not to service RACFs. Agreed protocols for supporting general practice staff when they are on-site and a simple map of the residents' rooms with names that allow general practice staff to easily and quickly find patients are further simple actions that will aid the general practice-aged care partnership.

Many of those GPs that do have patients in RACFs report having more than a few nursing home patients is very difficult due to the time-consuming paperwork that is required both on and off site. Many of the forms and other documents that GPs are required to complete are often unique to the facility and additional to their own patient records. Most RACFs do not accept medication charts that GPs print from their clinical software adding to existing GP time pressures and duplicate records. Clinical software available in the large majority of RACFs does not match or communicate with common medical software used in general practices, nor does it match systems used in other RACFs which means that general practice staff must often learn a range of different clinical management systems.

Quality of care

GPs report that the care plans they develop for RACF residents are not always consistent with actual care provided in the facility and they largely blame inadequate nurse numbers and inferior nursing care skills for the delivery of deficient care. They also report that many RACFs rely too heavily on agency nurses that are unfamiliar with the residents or themselves, and lack the necessary skills or commitment to provide adequate levels of quality care.

In Australia, up to 40% of people aged over 65 years in residential aged care are prescribed an average of 10 medications [11]. In many cases, there is no evidence of benefit for

polypharmacy but there is often clear evidence of harm [12]. Research suggests medications can be safely withdrawn in elderly people even those known to be addictive [12], however when GPs visit RACFs they are often overburdened and time-pressed with no opportunity to support medication withdrawal. Adding to this is the absence of adequate evidence for many treatments in the elderly, leading to insufficient information to support medication benefit versus harm decisions where clinical trials generally exclude the very elderly for fear of increased risk of adverse events and the potential confounding caused by multiple comorbidities [12].

Clinical trials that have recruited RACF residents that are very frail are virtually non-existent. When older people are included in studies they tend to be the fit elderly, who are not necessarily representative of the population most likely to be treated with the drug being trialled. Moreover most clinical management guidelines, if they were able to be extrapolated to an elderly frail cohort, are generally developed to support best practice care for single diseases only, yet elderly people almost always have co-existing chronic and acute physical and mental health problems [13]. Among the most difficult problems for GPs is the appropriate treatment of elderly dementia patients with marked behavioural disturbance, particularly when agitated RACF workers apply pressure on the GP for a quick solution.

Home/Community Care

Environment

General practice has long identified considerable complexity in assessment and community health and social care options for elderly people including multiple state and federal level funding programs, lack of coherent and transparent assessment processes across programs, multiple assessment tools, multiple data collection tools and requirements, lack of interoperability between the different information communication and management systems, poor commitment to consistent policies and protocols across services, and poor discharge and transition planning between the acute and community care sectors. These problems lead to confusion and an absence of up-to-date information about which programs GPs should refer patients to, how to refer, average wait times and patient costs of each of the available programs.

Recommendations

General Practice

Health care for older Australians should be needs based and supported by an absence of financial barriers to the provision of necessary care. To attract many new and retain existing GP services in RACFs and home based care there is an urgent need to develop a general practice aged care funding model that properly compensates the sector by taking into account:

- The level and extent of care complexity required by older home based and RACF residents, including physical and mental multimorbidity, and polypharmacy management and withdrawal
- The opportunity costs of each RACF or home visit in terms of the remuneration that would have been available to the practice had the RACF visit not taken place, including travel time and work not involving face-to-face patient care such as repeat

scripts, on and off-site documentation, family conferences, pathology/radiology follow-up etc

To maximise the positive potential of the funding model it should include:

- The unrestricted use of general practice nurses and allied health professionals to assist in the delivery of care in RACFs/homes.
- The unrestricted ability of RACFs to develop service agreements with general practices to ensure guaranteed resident access to care.
- Phone consultations with RACF nursing staff and home based patients.
- Funding for RACF and home based patient transport to and from the general practice where appropriate.
- A commitment that the value of payments under a new general practice aged care funding model will be properly indexed to keep up with the costs of providing aged care and that remuneration 'form filling' requirements are within acceptable limits.
- Funding for Divisions of General Practice to promote the new funding model to RACFs, consumers and general practices, and educate practice staff and GPs on its conditions and administrative requirements.
- Dedicated recurrent funding for successful programs such as the *Aged Care Access Initiative* which has allowed Divisions of General Practice and RACFs to work in partnership to broker access to and deliver essential Allied Health Services in RACFs including preventative health measures such falls prevention, dental services and exercise programs.

Residential Aged Care

Funding

To ensure adequate recurrent funding is available to RACFs a funding model should be developed that provides for population predictions of health problems based on calculated age distributions and current knowledge of the major problems impacting the health of residents.

Skill

It should not be left to chance that well-intentioned but underpaid, undertrained workers will manage to care for patients who arrive and live on, in far sicker states, than RACF residents did previously. Consistent agreed minimum competencies and processes of ongoing assessment, training, support and supervision are needed for nursing staff in RACFs. For general practice to better service RACFs it needs to have confidence that it will be fully and appropriately supported by well trained staff and that there will be a sufficient number of registered nurses to assess and appropriately care for residents and liaise with general practice staff.

Environment

There are several important general practice requirements that need to be addressed if it is to gain the confidence that it can operate effectively in RACFs, including:

- Access to adequately equipped clinical treatment areas that offer patient privacy.
- Building conditions that meet minimum health and safety standards.

- Improved information technology that ensures each patient has only 'one health record' with the capacity to connect systems between the RACF and practice.
- Computer generated medication charts with current photographs of each resident.

Home/Community Care

Government programs

Improvement in coordination between all levels of government involved in the delivery of services to older people is needed to reduce service and program duplication, and widespread confusion among the elderly and general practice.

Research

Improvements in the level of research funding available to better inform the health care and wellbeing of older Australians is urgently needed. As is the establishment of a collaborative inter-professional process for the development of integrated clinical management guidelines to support the best practice care of older Australians with multiple physical and mental morbidities.

GP NSW would be happy to advise the inquiry in person should this be required.

GP NSW contacts

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References

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About the NSW Divisions of General Practice Network

General Practice NSW Ltd (GP NSW) is the state based support and education organisation for 33 Divisions of General Practice in NSW. The Divisions of General Practice Program is part of the Australian Governments General Practice Strategy. GP NSW is an active organisational member on a wide range of state level health advisory, research and program specific groups, and regularly informs high level policy on General Practice and broader primary health care issues.

The NSW Divisions of General Practice Network works to enhance communication and integration between GPs and the wider health system, and improve the health of the community by supporting General Practice collaboration with other health professionals in the delivery of quality health care. The Divisions Program has been successful in contributing to General Practice participation in health planning and policy development, identifying and targeting population health priorities at a local level, improving the coordination of health services in the community and improving the quality of general practice.

The operational and general practice professional support capacity of the NSW Divisions of General Practice Network is significantly contributing to:

- The coordination and delivery of effective multidisciplinary community care through a case management and coordination model, with flexible, effective health care delivery
- An integrated health system in which community-based health services including GPs, aged care, allied health providers and medical specialists are supported by communication systems (e-health)
- Models of care that focus on patient needs rather than reactive to demands on the system or purely profit driven.
- Increased numbers of people with chronic disease enrolled in self management courses/groups
- Community assessment and management of targeted population groups discharged from public hospitals that are designed to meet each patients assessed clinical and ongoing support needs

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