

The Royal Australian College of General Practitioners

Submission to the Productivity Commission

Discussion Paper

Caring for Older Australians

17 March 2011



1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Productivity Commission for the opportunity to comment on its Draft Report *Caring for Older Australians*.

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting and maintaining the curriculum and standards for education, training, and quality clinical practice, and for supporting general practitioners in their pursuit of clinical excellence in community service delivery.

This submission has been made in response to the Australian Productivity Commission's Draft Report *Caring for Older Australians* issued by the Commission on 25 January 2011, which can be viewed at: www.pc.gov.au/data/assets/pdf_file/0011/104879/aged-care-draft.pdf

2. Overview

The RACGP welcomes the Productivity Commission's inquiry into aged care and supports:

- improving older Australians housing options and their means of paying for accommodation, every day living expenses and personal care
- giving older Australians and their carers easy access to aged care related information, nationally consistent needs assessment and care coordination, through a single aged care gateway
- investing in the aged care workforce, particularly as there are many disincentives currently preventing recruitment and retention in the aged care sector
- responding appropriately to patient diversity and special needs groups.

However, as people over the age of 65 experience 41.4% of the total burden of disease and injury in Australia,¹ it is equally important to look at healthcare as part of this inquiry into *Caring for Older Australians*. This is particularly the case given the inquiry identified that "current health services are not sufficiently responsive to aged care needs", and "limited integration of health and aged care services leads to inappropriate care and hospital admissions."

Hence, the scope of the inquiry should be broadened to look at older Australians health care needs, the adequacy of available health care services and how things could be improved.

Treating elderly patients is different to treating adults. General practitioners must differentiate between the effects of ageing and symptoms of disease, evaluate the implications of multiple pathological processes occurring simultaneously, manage the risk of poly-pharmacy and manage other complications arising from aged related mental and physical decline.

Essentially, better health service and funding models are required to support general practitioners. For services provided in community settings, Government needs to consider voluntary patient registration and a blended payment system that would include the current fee-for-service arrangements, plus:

- payment for each registered patient
- health care coordination payments
- block funding that can be used at the general practitioners discretion.

Funding should also be provided for practice nurse home visits, the engagement of informal carers and patient transport assistance.

In relation to patients living in residential aged care facilities (RACF) there are a number of obstacles that must be overcome before adequate in-reach services can be provided, including workforce issues, IT infrastructure, financial barriers and infrastructural disincentives.

The increasing role of general practitioners in the provision of palliative and end-of-life care also needs to be recognised and facilitated through the introduction of the appropriate MBS items, which should allow for engagement of a patient's family and/or informal carers in the process.

3. Response to discussion paper

While acknowledging the benefits of the proposed reforms in the report, the RACGP believes that achieving the inquiry's stated aim of "*promoting the wellness and independence of older Australians and their contribution to society*" is also highly dependent on healthcare.

Currently people aged 65 and over experience 41.4% of the total burden of disease and injury in Australia, despite making up only 13% of the total population.^{2 3} The leading causes of disease that are managed by health care professionals are cardiovascular disease (29%), cancer (25%), neurological disorders (17%), chronic respiratory failure (7%), diabetes (5%) musculoskeletal (5%), and genitourinary conditions (3%).^{4 5}

Over half (1.4 million people over 65) require assistance with the management of at least one form of disability lasting at least 6 months which restricts everyday activities, predominantly due to dementia (68%), Parkinson's disease (67%), arthritis (48%), leg/knee/foot injuries (46%), back problems (45%), and hearing disorders (43%).⁶

Health service planners need to understand what is involved in the provision of health care to older Australians, including:

- the differences between treating elderly patients and adults, as it is often difficult to differentiate between the effects of ageing and symptoms of disease which, where present, may be vague, non-specific, or have an altered clinical presentation
- the difficulties of evaluating the implications of multiple pathological processes occurring simultaneously and understanding how this affects the interpretation of test results, and metabolism of prescribed medications
- managing the increased risk of poly-pharmacy (the concurrent use of five or more medications that increases the risk of drug-drug interactions) and adverse drug events
- time efficiency, as many elderly patients talk, move, and absorb information slower than adult patients. Therefore, a health practitioner can address fewer elderly patients in a day than they would with the general population
- age related mental decline, which compromises their decision making capacity. This of course has implications for the protection of patient privacy, obtaining informed consent, involving carers (particularly those with enduring power of medical attorney), making use of advance care directives (where available), and the allocation of extra time to discuss and document decisions concerning palliative and end-of-life care.⁷

With the burden of disease and special healthcare needs of older Australians in mind, the RACGP provides input regarding:

1. the role of GPs in the community
2. the role of GPs in residential aged care facilities
3. palliative and end of life care
4. simplifying prescribing
5. telehealth consultations
6. information technology.

3.1 Role of general practitioners in the community

General practitioners treating patients living in the community contribute to the Discussion Paper's stated aim of "*promoting older Australians wellness, independence and their continuing contribution to society*" by monitoring their health status, reducing their risk of developing preventable diseases, treating acute health problems and managing chronic disease.

However, as acknowledged in the Discussion Paper, current services are not sufficiently responsive to aged care needs, and the limited integration of health and aged care services leads to inefficient care and hospital admissions.

To improve healthcare for older Australians within community settings, the College believes that the following initiatives should be introduced:

- chronic disease management model

- practice nurse home visits
- better support for family members and informal carers.

3.4.1 Chronic disease model

Continuity of care with a single general practitioner is associated with lower health costs, fewer presentations to emergency departments and higher patient satisfaction.^{8 9 10}

Therefore, to improve patients' wellbeing and reduce healthcare expenditure, it is vital that an effective chronic disease management model is developed that:

1. encourages patients to have a medical home
2. provides general practitioners with the necessary resources to effectively coordinate patient care
3. reduces red-tape in general practice and primary healthcare
4. reduces unnecessary restrictions regarding patient management
5. ensures that general practitioners can effectively manage the patient's care.

To achieve these desired outcomes, a chronic disease management model should include:

- voluntary registration, where patients voluntarily nominate a general practitioner and a general practice as their medical home
- a single coordination payment to the general practitioner for time spent coordinating the patient's care, which would include the MBS items 721, 723, and 732.
- continued fee for service payments to the general practitioner for specific episodes of care
- access to discretionary funding for other healthcare services, including additional physiotherapy, other allied health services, and transportation
- a fixed payment for every patient enrolled to the general practice for administration associated, including follow up and recall.

To ensure sustainability, ongoing funding and indexation for these capitation payments must be guaranteed, otherwise general practitioners will be left with rebates worth only a fraction of their original value in real terms.

Patients with limited mobility, who cannot claim travel expenses through the Department of Veterans Affairs, should have access to government subsidised transport schemes (e.g. Victorian Government's Multi Purpose Taxi Program and Queensland's Taxi Subsidy Scheme). However, due to the restrictive criteria of these schemes, often the patients who would benefit most are not eligible. In particular, the RACGP recommends that transport schemes allow general practitioners to nominate patients who would benefit from assisted transport due to short-term incapacity (e.g. a hip replacement).

Transport assistance should also be available for patients who have to travel over 100 kilometres (one way) to access the nearest medical and/or dental specialist.

3.4.2 Practice nurse home visits

New MBS items should be introduced for practice nurses to provide home-visits for and on behalf of general practitioners via a generic nurse item number.

Providing funding for practice nurse home visits to older Australians will improve the efficiency and effectiveness of home care for older Australians, enabling them to live independently longer.

3.4.3 Better support for family members and informal carers

As the Commission rightly identifies, family members and informal carers play a large part in the provision of both personal and health care for older Australians.

Therefore MBS items for general practitioners to consult with family members and/or informal carers, regarding the care of older patients, should be introduced. This would enable general

practitioners and informal carers to share information, lifestyle advice and agree on care plans.

3.2 Role of general practitioners in residential aged care settings

Primary medical care in Residential Aged Care Facilities (RACF) includes disease prevention, management of chronic illnesses, rehabilitation, palliative care and end of life care.

Primary medical care is largely provided by general practitioners, locum GPs working closely with RACF staff, the resident, their families, informal carers, nurses and pharmacists - with additional input as required from allied health professionals and other medical specialists.

While the RACGP supports Recommendation 8.5 (which states that *Australian, state and territory governments should, subject to further evaluation, promote the expanded use of in-reach services to RACF and the development of regionally or locally based visiting multi-disciplinary health care teams*), realistically this can only be achieved by addressing the long standing barriers to the provision of in-reach services to RACF.

Therefore, the RACGP provides input regarding:

1. difficulties in delivering in-reach services
2. financial disincentives
3. funding solutions for in-reach services.

3.2.1 Difficulties in delivering in-reach services

Due to a range of clinical, workforce, funding and infrastructural constraints, older Australians living in RACF (who are among the sickest and frailest Australians) often do not receive sufficient and timely medical care.

That is, when compared with patients of the same age and sex living in the community, patients in RACF need more:

- time for face-to-face consultations and discussion with informal carers and RACF staff
- time with other medical specialists and allied health professionals providing in-reach services
- follow-up phone calls during normal business hours, and
- out-of-hours visits.

Currently, general practitioners while in private practice provide a significant amount of advice to nursing staff, where important clinical decisions are made about the care of patients. The process is time consuming and without remuneration.

RACF staffing is another key determinant of efficient and effective service delivery. RACF have a tendency to employ a large number of casual or agency staff who have little time or reason to establish cooperative long-term relationships with general practitioners providing in-reach services. This negatively impacts quality and continuity of care. High staff turnover also means that general practitioners work with inexperienced staff who are often under-skilled and unfamiliar with their patients.

Combined, these factors can result in unnecessary 'panic calls' to local general practices, unnecessary call-outs, unnecessary hospital admissions, poorer standards of patient care and a lack of continuity of care. Such issues need to be addressed if in-reach services are to succeed.

3.2.2 Financial disincentives

The funding model for the provision of general practitioner in-reach services needs to be urgently reviewed, as it does not recognise the added time involved and the complexity of the care provided, that is:

- Medicare only funds about 50% of the time general practitioners spend on aged care in RACF, because the Medicare rebate is based on the face-to-face consultations between the patient and the doctor, and does not recognise all the non-face-to-face time involved in their care
- Medicare does not fund the time spent writing up prescriptions for patients, or talking with other medical specialists as needed, unless the general practitioner stays with the patient while performing these activities
- General practitioners receive increasingly lower fees based on the number of patients they see in the RACF. Whilst arguments can be made for “economies of scale” based on the number of patients seen, the current fee structure is not consistent with other general practice services, which do not reduce in value as more patients are seen.
- For most general practitioners, it is impractical to bill privately to aged care residents (due to their limited financial means, logistics, dementia etc.), so residents are usually bulk billed. Without appropriate indexation, the rebate continues to fall over time and is both a disincentive and a barrier.

In summary, Medicare does not properly support general practitioners wanting to provide in-reach services to patients in RACF.

3.4.4 Funding solutions for in-reach services

The existing Medicare rebates for patients in RACFs must be replaced with rebates that:

- remove the requirement for “face to face” time from MBS descriptors for aged care facilities. Essentially, the only requirements should be that the patient is onsite, as much of the work undertaken by general practitioners (phone calls and discussion) do not require the patient in the room
- do not reduce in value as more patients are seen
- include longitudinal fee-for-service payments for general practitioners based on the number of patients in aged care facilities, not based on visits to aged care facilities (i.e. provide incentives for effective management of patients, not for the provision of episodic care)
- are fixed as a percentage of the equivalent attendance item number in the surgery, for example 150% to 200% of equivalent surgery item number
- include non-clinical time that general practitioners spend between episodic visits (e.g. changing prescriptions to address changes in the patient’s needs, or having discussions about the care of the patient with RACF staff, relatives or hospital staff)
- permit the delegation of tasks to general practice nurses, and on occasion, other staff with clinical training.

The RACGP has been seeking such change for years, and if general practitioners increase in-reach services to RACFs, it will lead to better disease prevention and management. Therefore, there would be fewer hospital admissions, and ultimately savings in public monies.

3.3 Palliative and end-of-life-care

Palliative care requires a multidisciplinary approach, with general practitioners playing a central and increasing role.

When providing palliative care, general practitioners:

- attend to the physical and psychosocial aspects of a patient’s care, including their cultural sensitivities
- attend to ethical issues
- provide carer support
- organise multi-disciplinary service coordination.

Ideally general practitioners should have an MBS item number to discuss end of life care decisions with a patient’s family member or carer. This could be used in both the residential and the community healthcare sectors. Case conferencing item numbers used in residential

care facilities cannot always be easily used in the community, because of the requirement to have two other providers present. Therefore, a new MBS item is required.

3.4 Simplifying prescribing

A general practitioner should only have to prescribe a medication once. At present, a general practitioner writes a script, then duplicates this on a medication chart, and is sometimes requested to provide yet another medication list to pharmacies.

The obvious change is to allow pharmacies to prescribe directly from facility medication charts and to allow ongoing dispensing from those charts without renewed prescription for an adequate length of time (e.g. 12 months).

3.5 Telehealth consultations

There are a range of benefits that could be actualised from the use of synchronous and asynchronous telehealth consultations for older patients living in the community and residential aged care facilities, particularly for those who have limited mobility.

Telehealth technologies can be used to monitor wellbeing indicators (such as blood pressure and glucose levels) and obtain other health-related information, including:

- monitoring of patients' health status and any changes to it
- identifying any ongoing trends
- prioritising patient care
- detecting patients who are at risk of developing sudden critical conditions that can be treated in advance to prevent hospital admissions.

To support such clinical activities, the Government should consider extending use of MBS items for telehealth consultations between general practitioners and nurses in aged care facilities.

3.6 Information technology

The penetration of information technology (IT) into Australia's RACFs is very low, despite the recognition that significant service improvements could be gained through its use and linkage to both general practices and pharmacies through a central web-based portal.

The General Practice Information Management and Technology Strategic Framework, which was operationalised through the General Practice Computing Group (GPCG), greatly enhanced availability of IT in general practices. A similar approach is needed to improve in-reach services for patients in RACFs.

The Australian Government should provide technology and training needed to:

- enable RACF staff to seek on-line advice from a patient's general practitioner for minor changes to medication and/or treatment options, thus avoiding time delays caused by the general practitioners having to visit patients in care facilities for this purpose
- enable electronic authorisation and issuing of scripts by general practitioners directly to pharmacies, increasing the speed of pharmaceuticals delivery to care facilities
- enable visiting general practitioners to access and maintain full electronic records on patients
- enable care facility staff to access and share relevant information on residents for the purposes of monitoring care
- reduce admissions and re-admissions to hospital due to therapeutic misadventure caused by duplication of medications, or missing notes on changes to medication management
- facilitate claims, billing and payment.

4. Concluding comments

The RACGP welcomes the Productivity Commission's inquiry into aged care and supports improvement of older Australians accommodation options, the affordability of their daily living expenses and personal care.

However, the College is keen to see equal attention paid to health care arrangements for older Australians as their level of independence and their ability to contribute to society is also highly dependent on their health status.

As acknowledged in the report, "current health services are not sufficiently responsive to aged care needs" and "limited integration of health and aged care services leads to inappropriate care and hospital admissions." Hence the Commission should expand the scope of its enquiry to look at how the current situation can be improved.

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