

***Caring for Older Australians***

**Response to Productivity Commission Draft Report**

The Australian Institute for Primary Care & Ageing (AIPCA) welcomes the publication of the Productivity Commission's *Caring for Older Australians* Draft Report, and the opportunity to make further submissions to the Inquiry. In particular, we wish to express our support for:

- The adoption, as soon as possible, of electronic care plans that can be shared across the health system. Electronic care planning will improve communication and health outcomes, and reduce system gaps and adverse events.
- Moves toward consumer-directed care, and draw attention to the submission by Alzheimer's Australia on this point. All older people have a right to be involved in decisions related to their care; this is no less so for people living with dementia.
- Following from this point, we also support the submission on advanced care planning from Associate Professor Silvester and colleagues. We submit that the Commission should make clear recommendations that will assist older people, their families and involved staff to avoid prolonging life with unwarranted and undesirably intrusive treatments when the person wishes to receive the more appropriate palliative approach to care.

In this submission, AIPCA wishes to draw attention to the interface between the primary health care and aged care systems. The need to integrate health and aged care was recognised by the National Health and Hospitals Reform Commission (NHHRC),<sup>1</sup> and submissions to the Commission made by the Australian General Practice Network (AGPN; submission 295) and the Australian Medical Association (AMA; sub. 330) described many of the current practical problems with this interface. We wish to provide the Commission with further comment and analysis on two major interface issues discussed in the Draft Report:

- GP service provision in Residential Aged Care Facilities (RACFs)
- The proportion of the GP workforce actively involved in RACF care.

We also wish to make submissions on broader aged care workforce issues arising from the Draft Report.

We hope that this submission assists the Commission in the conduct of the Inquiry.

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<sup>1</sup> National Health and Hospitals Reform Commission (2009) *A Healthier Future for all Australians: Final Report*. Canberra: Australian Government.

### **RACF-primary health care interface**

- 1.1. The AGPN and AMA submissions described many obstacles to medical service provision in RACFs, with particular emphasis on the inherent financial disincentive to providing such services.<sup>2</sup> The AGPN characterised this disincentive in terms of the opportunity costs incurred by GPs providing medical services in RACFs, as compared with standard in-surgery consultations.<sup>3</sup> Both the AMA and AGPN argued that reform of the Medicare payment model for RACF services was necessary to alleviate the financial disincentive.
- 1.2. The AGPN submission made reference to a survey of RACFs conducted by Catholic Health Australia (CHA).<sup>4</sup> One of the survey's findings was that an increasing number of GPs stop providing care for their patients when they become residents of aged care facilities.<sup>5</sup> According to the survey, the medical care of residents in this situation was frequently taken up by GPs already providing services to other residents within that facility.
- 1.3. The generalisability of the CHA survey is somewhat limited, with respondents accounting for only 3.2% of all RACFs across Australia. However, the CHA findings are supported by an AMA survey of GPs. The AMA survey found that approximately one-quarter of GPs who reported increasing their RACF visits have done so because other GPs were reducing their visits.<sup>6</sup>
- 1.4. On the question of the adequacy of medical service provision in RACFs, the Commission's Draft Report largely focused on the Aged Care Access Initiative (ACAI).<sup>7</sup> The ACAI makes incentive payments to eligible GPs providing a certain number of RACF services during a financial year.<sup>8</sup> For 2010–11, the service thresholds and incentive payments are:
  - a. **Tier 1** – \$1,500 incentive payment for providing at least 60 eligible MBS services during 2010–11
  - b. **Tier 2** – \$3,500 incentive payment for providing at least 140 eligible MBS services during 2010–11.
- 1.5. Under the ACAI, GPs can receive up to a total of \$5,000 per financial year, with the incentive payments made in addition to normal consultation fees. Only those services claimed under

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<sup>2</sup> Australian Medical Association (2010) *AMA Submission to Productivity Commission Inquiry into Caring for Older Australians* (submission 330), p. 4.

<sup>3</sup> Australian General Practice Network (2010) *Australian General Practice Network Submission to the Productivity Commission Inquiry into Caring for Older Australians* (submission 295), p. 7.

<sup>4</sup> Catholic Health Australia (2010) *Survey of Access to General Practice Services in Residential Aged Care* Canberra: Catholic Health Australia. Available at: [www.cha.org.au/site.php?id=913](http://www.cha.org.au/site.php?id=913)

<sup>5</sup> Ibid, p. 4.

<sup>6</sup> Australian Medical Association (2008) *AMA Survey of GP Services to Residential Aged Care Facilities: Summary of Results*. Canberra: Australian Medical Association. Available at: <http://ama.com.au/node/4213>

<sup>7</sup> Productivity Commission (2010) *Caring for Older Australians: Draft Report*. Canberra: Productivity Commission, p. 373.

<sup>8</sup> Medicare Australia (2010) *Practice Incentives Program: General Practitioner Aged Care Access Incentive Guidelines – September 2010*. Canberra: Australian Government. Available at: <http://www.medicareaustralia.gov.au/provider/incentives/pip/files/gp-aged-care-access-incentive-guidelines.pdf>

Medicare provider numbers linked to PIP practices are eligible for inclusion towards an individual GP's total.

- 1.6. The Commission's Draft Report appears to endorse the ACAI, noting the view of the Australian National Audit Office (ANAO) that eligible services have "increased at a faster rate than comparable services".<sup>9</sup> Further, the Commission restated DoHA's view of the ACAI as being:

[...] effective in increasing GP service delivery to residents of RACFs, noting that this is an assessment relatively soon after payment implementation.<sup>10</sup>

- 1.7. Other views of the ACAI are far less positive. The AGPN's submission to the Inquiry has already highlighted two critical issues with the ACAI:<sup>11</sup>
- a. That the Tier 1 threshold of 60 services per year can be achieved by a GP providing just one service per month to five residents. This was described by AGPN as "a very small patient load."
  - b. For those GPs providing very high levels of RACF services, the ACAI incentive payments are quite low on a per-service basis.
- 1.8. Further to these issues raised by AGPN, we submit that the Commission should examine the operation of the ACAI in more detail, particularly in terms of:
- a. the heterogeneity of RACF services being provided; and
  - b. the ongoing depletion of "RACF-active" GP workforce, as suggested by the AMA and CHA surveys.

### **Service heterogeneity**

- 2.1. We submit that the Productivity Commission should critically assess what is meant by "service delivery to residents". While all eligible services count equally towards the ACAI payment thresholds, it cannot be said that all ACAI-eligible services are equal.
- 2.2. To illustrate the differences in clinical complexity, administrative requirements and GP time involved with the different ACAI-eligible Medicare services, we offer the two most contrasting examples: in-facility Level A consultations (MBS item 20) and Residential Medication Management Reviews (RMMR; MBS item 903).
- 2.3. In summary, the requirements for these RACF services are:
- a. **Level A:** an in-facility professional attendance "for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management."<sup>12</sup>

<sup>9</sup> Productivity Commission, above n. 7, p. 373.

<sup>10</sup> Ibid.

<sup>11</sup> AGPN, above n. 3, p. 6.

- b. **RMMR:** a collaborative review of a resident's medication regimen with a pharmacist, involving a review/discussion of the pharmacist's assessment, development/revision of a resident medication plan, and consultation with the resident to discuss the medication plan and its implementation.<sup>13</sup> Additional regulatory requirements apply to the clinical need for an RMMR, the frequency of review, the clinical justifications for more frequent reviews, the extent of clinical activity included in the RMMR payment, GP eligibility to conduct the review, communication between the GP and the pharmacist and the timeframe for the completion of the review.<sup>14</sup>
- 2.4. While the MBS consultation fees payable for these services reflect the difference between the two, both services count equally towards the ACAI threshold.
- 2.5. The AGPN has already highlighted the relatively low patient load necessary to reach the first ACAI threshold. The lack of service weighting within the ACAI heightens this concern: not only is the threshold readily achievable with a small patient load, the threshold may also be reached by providing "easy", rather than "hard", services.
- 2.6. To further inform the Commission on this issue, AIPCA has analysed Medicare data on GP service provision in RACFs over the last decade. A similar analysis performed by AIPCA on GP consultations generally was published in the *Medical Journal of Australia* in 2010.<sup>15</sup>
- 2.7. Our *MJA* study demonstrated that in recent years there has been a trend away from longer, more complex GP services, and a considerable increase in Level A consultations. We note that any similar trend in the RACF consultation pattern would not be apparent to the Commission in the information provided to the Commission by ANAO/DoHA, which only describes *total* service volume.
- 2.8. Our *MJA* study examined in-surgery GP consultation services only; consultation services provided in RACFs were not included. Our analysis for the Commission focuses on RACF-based GP consultations (standard and after hours). The analysis differentiated the RACF services types by three levels of complexity: Level A consultations, Level B consultations and Level C/D consultations. Rates for the more complex Level C/D consultations were also supplemented by the "special items", namely the RMMR, the (now defunct) Comprehensive Medical Assessment (CMA, MBS item 712) and multi-disciplinary care plans (MDCP, item 731), as per our established methodology.<sup>16</sup>

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<sup>12</sup> Medicare Benefits Schedule Online: MBS item 20  
(<http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=20>).

<sup>13</sup> Medicare Benefits Schedule Online: MBS item 903  
(<http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=903>).

<sup>14</sup> Medicare Benefits Schedule Online: Explanatory Note A41  
(<http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A41&qt=NoteID>).

<sup>15</sup> Taylor MJ, Horey D, Livingstone C & Swerissen H (2010) "Decline with a Capital D: Long-term Changes in GP Consultation Patterns across Australia." *Medical Journal of Australia* 193: 80–83.

<sup>16</sup> Taylor et al., above n. 15. For this analysis, the methodology was modified to consider the RACF permanent resident population, rather than the Australian estimated resident population, for each financial year. The

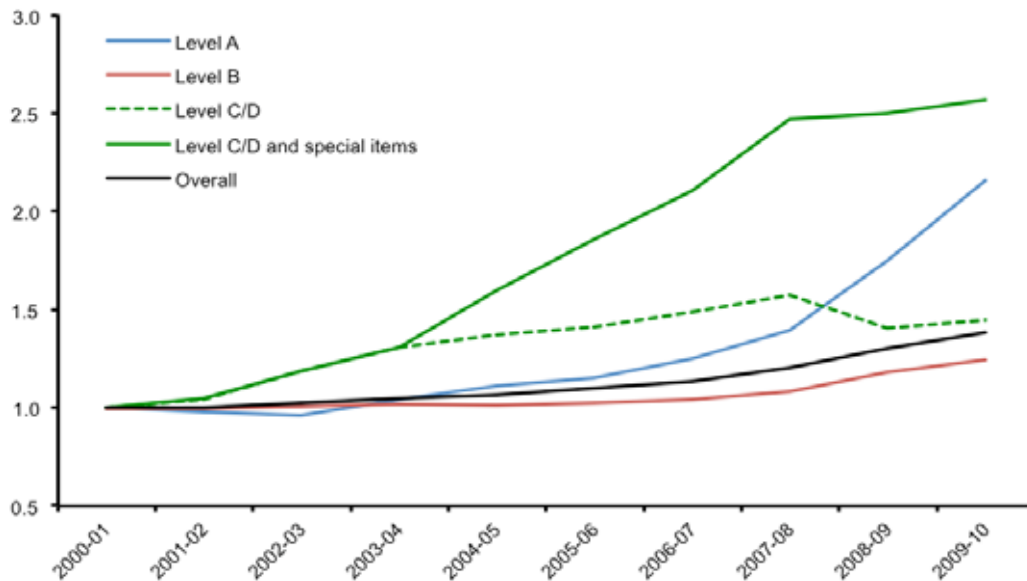
- 2.9. Figure 1 shows the results of our analysis, with service provision rates per 1,000 residents expressed relative to the base year (2000–01). The notable findings are:
- a. For RACF services overall,<sup>17</sup> there was relatively little change in the rate of service provision over the past 10 years. The average annual percentage change in the service delivery rate was +3.72%; from approximately 11.9 services per resident in 2000–01 to 15.5 services per resident in 2009–10.
  - b. The overall service delivery rate mirrors the Level B service delivery rate, given that Level B consultations are the most common form of service. Since 2000–01, the average annual change in the Level B service delivery rate was +2.56%; however, in the year immediately following ACAI implementation (2008–09), an 8.97% increase was observed on the previous year.
  - c. Level C/D consultations in RACFs experienced only moderate growth over time (+4.38% average annual change). When combined with delivery rates for the special items, substantial growth was observed relative to the 2000–01 base year due to the fact that the special items were progressively introduced from 2003–04 onwards. Unlike the general trend across Medicare, no appreciable decline in the delivery rates of Level C/D and special items was observed in recent years.
  - d. Level A consultation delivery rates in RACFs increased substantially, commensurate with the trend towards increased Level A consultations throughout Medicare. The average annual change in Level A delivery rates was +9.32%; in the year following ACAI implementation, an annual increase of +25.16% was observed.

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RACF permanent resident population as at 30 June 2009 was used as the reference population for the age–sex standardisation processes.

<sup>17</sup> This combined service rate is broadly similar to the information already provided to the Commission by DoHA/ANAO.

**Figure 1: Relative rate of in-facility GP service provision to residents, FY2000–01 to FY2009–10**



- 2.10. There is a Medicare-wide trend towards higher rates of Level A consultations, but they still constitute a relatively small area of activity.<sup>18</sup> The increased rate of Level A consultation service delivery in RACFs should not be ignored. Even if this recent increase simply mirrors the system-wide trend and is in no way driven by the ACAI, it must be borne in mind that the ACAI will still reward this changed service delivery.
- 2.11. The major question arising from these findings is that of appropriateness: does the altered consultation pattern meet the medical needs of residents? Using only the MBS descriptor to explain the purpose of these consultations, it would appear that in recent years there has been an increase in the “obvious” problems in RACFs requiring “straightforward” care by GPs. Given the increasing complexity of care required by residents, this seems counter-intuitive.
- 2.12. We submit that several factors may be influencing the increased delivery of Level A consultations, and the Commission should take note of these factors as illustrations of the difficulties with the RACF–primary health care interface. In summary, the Commission should consider:
- a. *GP workforce* – as discussed in the next section, there is a continuing decline in the number of GPs providing services in RACFs. This may increase the pressures on those GPs who remain in RACF practice, as illustrated by the AMA and CHA surveys. Such pressure may manifest as increased provision of Level A consultations. As per the AGPN submission,<sup>19</sup> there is already anecdotal evidence of sub-optimal care, and increased Level A consultation provision may be a symptom of this if these consultations are not commensurate with resident need.

<sup>18</sup> Taylor, above n. 15.

<sup>19</sup> AGPN, above n. 3, p. 5.

- b. *Changes in organisation of RACF practice* – an alternative view of the increased rate of Level A consultations is that they are appropriate to resident needs of a minor nature. The increase would then represent a boost in service provision from GPs (ACAI eligible or otherwise) being “in the corridor” and providing services that might otherwise have been delayed (e.g. medication adjustments, minor resident care issues).
- c. *Aged care workforce* – the changes in the aged care workforce and the reduced numbers of registered nurses working within aged care may also contribute to the increased rate of Level A consultations. As above, Level A consultations represent GP intervention into “obvious” problems requiring “straightforward” management. The increased rate observed here may reflect increasing need for GPs to intervene in aspects of resident care previously managed by nursing staff. If so, this represents a significant interface problem, and a poor use of precious GP resources.

### **GP workforce**

- 3.1. The CHA and AMA surveys demonstrate that within the medical workforce, there has been a shift away from practising in RACFs.<sup>20</sup> This is likely to increase; the AMA data indicated that approximately 16% of GPs currently visiting RACFs did not intend to visit any new residents in the future.<sup>21</sup>
- 3.2. We submit to the Productivity Commission that the proportion of the general practice workforce that is “RACF-active”, and the extent to which they are active, must be taken into account when considering the RACF–primary health care interface, and particularly the ACAI.
- 3.3. The ACAI information provided by DoHA indicates that:
  - a. there was a 5% increase in the number of residents seen by GPs eligible for the Tier 1 ACAI incentive, as compared to the previous year; and
  - b. there was an increase in service provision by GPs receiving ACAI incentive payments, compared to those who are not.
- 3.4. In relation to the first point, it is not clear from all the available information what is driving this increase in resident load. On the one hand, it may be the result of “resident-seeking” by GPs encouraged by the ACAI. Alternatively, it may be that the increase in patient load is the result of “GP-seeking” by residents whose previous GP has discontinued caring for them, as per the CHA survey findings.
- 3.5. DoHA’s second point is hardly surprising. Given that ACAI-eligible GPs have an increased patient load, it obviously follows that they would also be providing more services. The DoHA analysis of this increase in service provision must be adjusted for patient load in order to

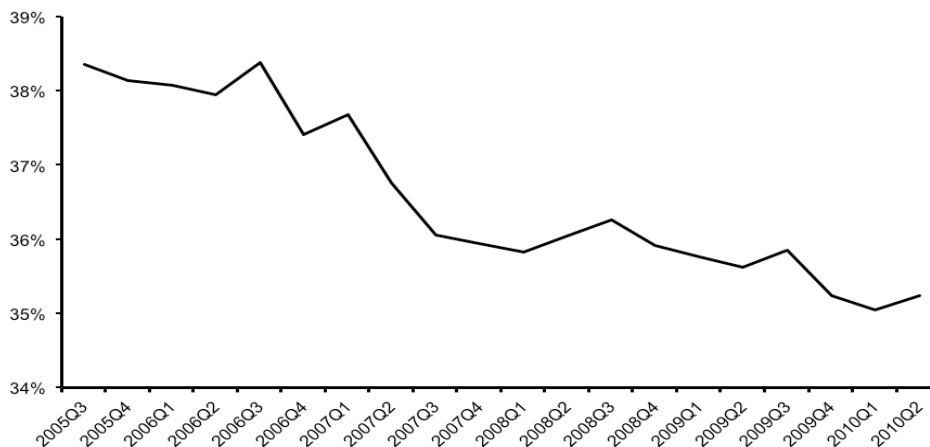
<sup>20</sup> CHA, above n. 4; AMA, above n. 6.

<sup>21</sup> AMA, above n. 6, p. 2.

determine the effect the ACAI is actually having, particularly in light of the changes in service types described in this submission.

- 3.6. We submit that the AMA and CHA surveys are supported by system-wide workforce data. From our analysis of Medicare billing data, it is clear that there was a slight decrease in the proportion of the GP workforce considered “RACF-active” (Figure 2).<sup>22</sup>
- 3.7. For 2005–06, the earliest period for which this data is available, the proportion of the GP workforce providing Level B consultations in RACFs was approximately 38%. Since then, this proportion has decreased steadily to approximately 35% of the GP workforce in 2009–10. While only a slight decrease in percentage terms, the Commission should consider that if the 2005–06 RACF-active proportion were maintained, there would have been approximately 700 more GPs providing Level B consultations in RACFs in 2009–10.

**Figure 2: Proportion of GP workforce providing RACF consultations, FY2005–06 to FY2009–10**



- 3.8. As per the AMA submission, this attrition may represent the retirement of the “dedicated doctors” working in RACFs.<sup>23</sup> Equally, this may also represent the effect of the strong financial disincentives inherent in RACF practice. Whatever the cause(s), it is clear that the ACAI does not encourage GPs *into* RACF practice, and may serve only to maintain those GPs already engaged in RACF practice.

**Aged care workforce issues**

- 4.1. We were surprised to see workforce issues not highlighted in the Draft Report’s “Key Points”, and assume this oversight will be rectified in the Commission’s Final Report. Integral to any

<sup>22</sup> Due to data limitations, it is necessary to define an “RACF-active” GP as any practitioner who bills Medicare for a Level B RACF consultation. This service is used as the base activity for calculating the RACF-active proportion of the workforce as it is the most frequently provided service within RACFs by volume. The total GP workforce is defined as the number of practitioners billing any type of GP attendance (RACF or otherwise).

<sup>23</sup> AMA, above n. 2, p 4.



improvements in aged care is a sustainable, appropriate workforce. Furthermore, the expected reduction in informal carer support has been well-described elsewhere and does not require further elaboration here.

- 4.2. We submit that the Commission should consider the dynamics of the nursing workforce in more detail, particularly its ageing nature. Between 1997 and 2008, the nursing workforce “aged” considerably, with the proportion of nurses aged 50 years or over increasing from 18.9% to 34.4%.<sup>24</sup>
- 4.3. We submit that the combination of an ageing workforce, health professional shortages, decreasing numbers of professionals choosing to work in aged care and the continuing growth in demand make this an area to which the Commission must give its full attention.
- 4.4. Every report on the aged care workforce since 1999 has made recommendations on how to address these issues. While government and industry have adopted some of these recommendations, the need to change education preparation has been largely ignored. We submit that the Australian Health Practitioner Regulation Agency and National Taskforce on Workforce should be required to address these issues.
- 4.5. Issues around health professional education in the “clinical years” should be considered by the Commission. Despite the enormous change in health care requirements and the demands related to ageing and chronic care, most clinical preparation still concentrates on teaching hospitals. The fact that most patients of teaching hospitals are older people also appears to be ignored. We commend the work undertaken in Victoria on improving care of older people; however, this alone is insufficient. We submit that the organisation of care and the professional boundaries remain inappropriate in the current, and for future, contexts.
- 4.6. A major realignment of education, skills mix and scope of practice is required to avoid adverse events, the neglect of older people and the critical shortages of health professionals prepared for and to work with older people. It is probable that most people will be using the health system for several decades to manage chronic conditions and acute-on-chronic conditions. The current employment divisions between primary care, community, hospital, rehabilitation, RACF and palliation serve only to undermine the health system’s approach to our future requirements.
- 4.7. We submit that such divisions are also evident in the Commission’s approach. In particular, the Draft Report (Figure 3, p. xxix) gives a very strange misrepresentation of care and support. Under “Specialised Care”, it appears that health and nursing are separate from dementia, continence, palliation and rehabilitation. In reality, health and nursing involve all these areas (and more). The figure may be attempting to illustrate that needs may range from simple assistance through to complex care requiring specialist intervention, but this is not clear. In addition, the term “challenging behaviour” has long been considered inappropriate; “need-driven behaviour” is more accurate.

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<sup>24</sup> Australian Institute for Health and Welfare (2010). *Nursing and Midwifery Labour Force 2008*. Canberra: AIHW. Available at: <http://www.aihw.gov.au/publication-detail/?id=6442468396>

- 4.8. While many may not agree, we submit that the Commission should consider that the traditional “RN role” as we understand it may become less central. A more appropriate mix may well be specialists, allied health practitioners, pharmacists, GPs, nurse practitioners, ENs and health assistants (i.e. PCAs who can safely support nurses and allied health professionals). With fewer GPs and RNs, it is essential that the skills of these professionals be targeted to where they are most needed and used efficiently and effectively across the system. Research has already demonstrated the benefits that emerge from the deployment of nurse practitioners and medication-endorsed ENs. Barriers to geriatric specialists working in RACFs need to be removed and referrals streamlined. Furthermore, we suggest that continuing calls for “more”—be it university places, nurses/doctors and beds—are ill-informed and self-serving. A response is required that is driven by health client needs, and not health provider/professional bias.
- 4.9. Rurality adds a particular dimension to concerns about future aged care provision, and this applies to both the formal workforce and the informal workforce. Rural areas are rapidly growing older as a result of two trends: young people moving away for education and employment (leaving older people behind); and older people moving to rural areas for retirement as “sea changers” or “tree changers”. Rurality thus poses particular challenges to the future of aged care in Australia, particularly in view of the description of ageing in rural areas as being “vulnerable people, vulnerable places”.
- 4.10. Issues associated with the formal workforce are particularly acute in rural areas, where there are special issues associated with recruitment, retention, skills mix, training and education of appropriate staff. Some regions and some areas of care struggle with accessing an appropriately skilled workforce. Local pressures have also resulted in good examples of local innovation, which are important to understand in order to apply such approaches elsewhere. These include practices such as “grow-your-own staff”, providing education and training locally and using local providers (e.g. La Trobe University) to design appropriate courses to up-skill staff. Local university involvement should be rethought, with particular attention directed to training staff (e.g. nurses and allied health practitioners) to practise in rural and remote areas. This would also include broadening attempts to attract health services staff to working in aged care.
- 4.11. Retention of the aged care workforce in rural areas requires particular strategies. As above, it is well known that the current workforce is ageing, and this concern becomes acute as the generation of “baby boomer” health professionals reach retirement age and create a shortfall in the health workforce. Current workforce strategies tend to aim for the recruitment of younger/overseas-trained health professionals to rural areas; few strategies focus on retaining older health professionals. There is an urgent need to develop solutions to retain older health professionals; research and consultation with the existing workforce is needed to address this.
- 4.12. Recent work using National Institute of Labour Studies (NILS) data suggests that retention and turnover among nurses (and PCAs) is not uniform across the aged care industry.<sup>25</sup>

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<sup>25</sup> Howe AL, King D, Ellis J, Wells Y, Wei Z, & Teshuva K (2010) “Stabilising the aged care workforce: An analysis of worker retention and intention.” *Australian Health Review* (submitted).

Rurality is a factor, as is whether the focus is residential care or community care, and worker attributes. Overall, intention to remain is higher in rural than metropolitan areas, but this possibly due to the lack of options for changing employment. Intention to remain is also higher in community rather than residential care, for permanent rather than casual employees, and where employees perceive that their skills are valued and used within the workplace.

- 4.13. Informal support is also critical to the future of aged care, and it cannot be assumed that volunteers and carers will be available to provide the level of informal support required in ageing rural communities. Burnout of volunteers is a significant concern in rural areas where there are high levels of bonding social capital and local social support, and the volunteer pool is declining.
- 4.14. We submit that the Commission needs to be aware that, in the contemporary context, volunteers need to be supported and managed, and that organisations require resources to do this adequately. Yet volunteers operate in many crucial aspects of aged care, and make a significant difference to the quality of life of many older people. Their contribution requires further acknowledgement and support.
- 4.15. Similarly, carers are an especially valuable resource in rural communities. As a result of local population ageing, the number of older carers residing in rural areas is increasing. However, rural older carers are at risk of social isolation due to decreased social networks associated with ageing and caring responsibilities, and geographical isolation associated with rurality. Given that social isolation can impact upon psychological wellbeing and caregiving competency, strategies that can offer increased social participation and social support for this group need to be identified.

### **Summary**

- 5.1. We submit that the information provided to the Commission regarding the ACAI was not sufficiently detailed, and that further analysis is required. As per the AGPN submission, there is a point beyond which the ACAI's incentive is diluted.<sup>26</sup> Given the apparent increase in resident load per ACAI GP observed by DoHA, and the declining workforce involved in RACF care, this point may be reached very soon.
- 5.2. It is clear that a number of different factors may be responsible for the changes observed here for service provision and workforce. The relative extent to which these factors contribute must be ascertained in order to properly inform future reform approaches.
- 5.3. We submit that the Productivity Commission should consider alternative models for improving the RACF–primary health care interface, beyond that of the ACAI and its simple volume-based approach. Any incentive system based solely on quantity, with no regard to quality, is sub-optimal to say the least. A system designed to encourage more comprehensive care of residents, and which removes the financial disincentives of the current system, would be more appropriate.

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<sup>26</sup> AGPN, above n. 3.

- 5.4. AIPCA is currently conducting detailed research on the dynamics of GP service provision in RACFs. Our preliminary findings show that “sessionality”—the number of services provided in a single GP visit—may be an important factor in providing more comprehensive care. A redesigned incentive system may use this as the quantity target, with additional weighting towards the provision of enhanced primary health care services (e.g. RMMRs) to encourage quality.
- 5.5. Workforce issues, particularly in rural areas, require greater consideration by the Commission. Research, such as that conducted at the John Richards Initiative in rural Victoria, is urgently needed to address issues associated with the delivery of health and aged care services in rural Australia, where the challenges are quite distinct from those in urban areas.
- 5.6. We submit that a “more of the same” approach will not address these issues, and there must be major realignment of education and delivery systems in line with the health care needs they are expected to address.

We hope that this submission provides the Productivity Commission with a more detailed picture of the RACF–primary health care interface, and of the broader issues confronting the aged care workforce.

Yours sincerely

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