AMA

Putting health care back into aged care

CONTENTS

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GLOSSARY

Advance Care Directive (ACD)
A record that contains a person's needs, values and preferences for their future care and details of a substitute decision-maker, should one become necesary.

Aged Care Assessment Team (ACAT)
Aged Care Assessment Teams are run by state and territory health departments. They assess and help identify the care needs of frail, older people and their carers.

General Practitioner (GP)
A doctor based in the community who treats acute and chronic disease, referring more serious and/or complex cases to non-GP specialists. Often the first point of contact for someone who feels sick or has a health concern.

Home Care Package (HCP)
A Commonwealth government service that provides funding for care services for people with more complex care needs to receive help at home.

Medicare Benefits Schedule (MBS)
A list of the medical services for which the Australian Government will pay a Medicare rebate, to provide patients with financial assistance towards the costs of their medical services.

My Aged Care
A primarily web-based entry point to Australian Government–funded aged care services for the general public, managed by the Department of Health. Health professionals can refer patients to My Aged Care, or people can access it themselves online or by phone. Enquiries can trigger an assessment for eligibility which may then lead to the older person receiving government-funded aged care services.

My Health Record
A secure online summary of an individual's key health information. Healthcare providers involved in a person's care can access the record to find important health information such as allergies, medications, medical conditions, and test results. Individuals can decide what information is shared and not shared via the record.

Registered Nurse (RN)
A nurse who has completed their nursing degree qualification and is a licensed professional who provides care in different medical and community settings.

CONTEXT

The Royal Commission into Aged Care Quality and Safety (hereafter referred to as the Royal Commission) was launched on 8 October 2018. Commissioners were appointed to inquire into the quality of aged care services at present and how they can be improved in the future, with a particular focus on person-centred care — choice, control and independence for older Australians.

The Australian Medical Association (AMA) provided seven written submissions to the Royal Commission and appeared before it three times, highlighting the need to end the separation between the aged care and health care systems. This evidence articulated the need for General Practitioners (GPs) to be at the heart of health care for older people, providing crucial continuity of care and acting as an independent advocate for high quality, person-centred health care.

The final report of the Royal Commission was released on 1 March 2021. The AMA welcomes the diligent work of the Commissioners and their commitment to wide-ranging reform. The Government must now decide how to respond.

This report sets out the AMA's vision for putting health care back into aged care. While this vision aligns with the Royal Commission's ambition to achieve genuine person-centred care, it differs in some of the methods of how to get there.

The AMA looks forward to working with the Government further as it responds to the Royal Commission's recommendations.

EXECUTIVE SUMMARY

Older people have the same right to quality health care as any Australian. Sadly, this right is often not realised, as the Royal Commission has shown. High quality and coordinated health care is not the experience of many older people in the aged care system.

Meanwhile, health care for older people is getting more complex, not less. Increasing life expectancy and an ageing population means greater complexity of medical care in old age and increased demand for aged care and health care services now and in the future.

Reform is desperately needed because the scale of the problem is growing, but the system is already struggling. At the heart of the problem is the fact that aged care and health care operate as separate systems that enable very little or no continuity of care for older people. A detailed example of a patient journey is provided, which outlines the AMA's vision of what the patient journey should look like, juxtaposed with what currently happens.

This is all to the detriment of not only the health outcomes and quality of life of our older people, but also to public finances and the sustainability of our hospitals. The AMA estimates that if governments invested sufficiently in health and aged care, over four years (2021–22 to 2024–25), $21.2 billion could be saved in public and private health care from avoidable hospital admissions, presentations and stays from older people in the community or in nursing homes.

With the scale of the problem growing and the system already struggling, the Government should use the momentum from the Royal Commission to implement substantial and comprehensive reform of the aged care system.

What is missing from the current direction of reforms is a plan to ensure that the health care and aged care systems work together and complement each other in the future. The AMA provides this plan in the recommendations that follow, with detailed costings provided for select proposals.

Chief among these recommendations is the need to place the General Practitioner at the heart of health care in aged care. This is central to improving health outcomes and quality of life for older people and reducing avoidable hospitalisations. With the current setup of the aged care system, a GP's involvement in their patient's aged care journey is limited. The AMA calls for a number of changes going forward to incentivise, enable and resource GPs to drive proper person-centred care.

AMA members have been reporting for some time that there are insufficient nurses in nursing homes to support reliable and safe health care provision. The Royal Commission has now identified that only 15.4 per cent of nursing home residents are in homes with a staffing level of 'good' or higher. The AMA calls for minimum staff to resident ratios in aged care to be mandated by the Federal Government, with 24/7 access to an on site Registered Nurse.

Person-centred care will always be hampered as long as IT systems do not permit the sharing of key health information between the health professionals involved in a patient's care. GPs, nurses and other medical practitioners, must be able to communicate and record details of medications and important health events. As a first step towards improving the situation, the AMA calls for greater clinical and aged care systems interoperability, including between My Aged Care and My Health Record.

Finally, older people are waiting far too long to receive Home Care Packages so that they can live well and live independently at home for as long as possible. There simply isn't enough funding allocated. The AMA calls for increased funding so that Home Care Packages are available to all those who need them, at the level of their need and a maximum of three months following their needs assessment.

While implementing these reforms will create savings in costly hospital transfers and unnecessarily long hospital stays, ultimately it will likely be a net cost to provide proper health care in an aged care setting. Despite that, the Government should invest in this care as a matter of principle to uphold basic human rights, and not with the expectation of breaking even. Governments will have to give thought to how this necessary care will be funded, whether it be a tax, an increase to the Medicare levy, or some other mechanism. While recognising that most recipients of aged care services will have made substantial financial contributions over many years as taxpayers, given the scale of investment needed, people who are able to make financial contributions should be asked to do so, with a safety net put in place for those who are not.

Aged care and health care must complement each other and work together for the benefit of older people and the wider community. Now is the time to design and implement adequate health and aged care policies to meet the current and future demand and needs of our older people.

Summary of recommendations

1. Increase Medicare rebates for nursing home attendances by GPs by 50 per cent to compensate for the additional time and complexity involved in comparison to a GP consultation in their own rooms.

   Detailed costing provided.

2. Introduce MBS telehealth items for phone calls between the GP, nursing home staff and relatives.
3. Introduce a Medical Access Aged Care Quality Standard for nursing homes.
4. Introduce Care Finders who work closely with GPs to coordinate both health and aged care services.
5. Introduce hospital aged care outreach teams in all local health networks, in coordination with a patient's usual GP.
6. Ensure that Aged Care Assessment remains with State health services which involve medical specialists, coordinating and collecting information from the older person's usual GP.
7. Mandate minimum staff-to-resident ratios in nursing homes.
8. Mandate 24/7 on site Registered Nurse availability in nursing homes, and according to the level of residents' needs.
9. Mandate a minimum qualification for personal care attendants that includes basic health care, and continuous training of the aged care workforce with specific funding attached for training.
10. Ensure interoperability between GP clinical and aged care software systems, including My Aged Care and My Health Record.
11. Ensure that Home Care Packages are available to all those who need them, at the level of their need and a maximum of three months following the assessment.

    Detailed costing provided.

PROBLEM

Quality and continuity of care

At the point in an older person's life when they most need coordinated health care to manage complex medical needs, coordination and continuity often falls apart.

Older people have the same right to quality health care as any Australian.

Care for older people in the appropriate environment is a basic human right. Older people should have the same choice of medical care as the rest of the population, including the choice of medical practitioner. The AMA believes that this right should be fiercely guarded. Health care decisions should not be made by aged care administrators any more than by private health insurers; only independent doctors can act honestly and freely in their patients' best interest.

But these rights are often not realised, and the challenge is only growing.

Unfortunately, high quality and coordinated health care is not the experience of many older people, as the Royal Commission has shown. The Royal Commission Interim Report stated that in aged care, there is "inadequate access to, and integration with, the broader health care system, impacting on the health outcomes of older people"[2]. And the Royal Commission Final Report stated:

> People living in residential aged care have unequal or insufficient access to health services to meet their high health care needs. This is particularly concerning given that people living in residential care often experience high rates of complex health conditions. The health and aged care systems are not meeting the expectation that they will provide appropriate health care for older people.[3]

Meanwhile, health care for older people is getting more complex, not less. At a population level, Australians have one of the highest life expectancies in the world, at 82.8 years. For Aboriginal and Torres Strait Islander peoples this is notably lower, at 71.6 for males and 75.6 for females, compared to 80.2 and 83.4 for non-Indigenous Australians, respectively. Life expectancy is increasing, and the gap between Indigenous and non-Indigenous Australians is narrowing.[4]

The gradual improvements in life expectancy are largely due to the high quality of life experienced by most Australians as well as the highly functioning Australian health care system. But this results in more years of life lived with chronic disease and often greater complexity of medical care in old age (i.e. the management of co-morbidities and polypharmacy).[5]

Further to this, the population is ageing. By 2057, it is projected that 22 per cent of Australians (8.8 million people) will be over 65, compared to 15 per cent (3.8 million) in 2017[6]. As a result, there will be an increased demand for aged care and health care services in the future.

Appropriately-funded reform is desperately needed now because the scale of the problem is growing, but the system is already struggling. At the point in an older person's life when they most need coordinated health care to manage complex medical needs, coordination and continuity often falls apart.

The patient journey is confusing, fragmented and sub-optimal.

Aged care and health care currently operate as separate systems that enable very little or no continuity of care for older people. The Royal Commission's Interim Report articulated and evidenced "breakdowns, inconsistencies and rigidities in the way that the aged care, disability and health systems interact with each other".[7]

The hypothetical example of an older person's interaction with the aged care and health care systems in Australia (see pages 12–17) provides AMA's vision of what the patient journey should look like, juxtaposed with what currently happens.

Aged care and health care must complement each other and work together to the benefit of older people and the wider community. Now is the time to design and implement adequate health and aged care policies to meet the current and future demand and needs of our older people.

Clinical and financial outcomes

The separation between the aged care and health care systems results in inferior patient outcomes and cost inefficiencies.

Poor continuity of care leads to inferior clinical outcomes and quality of life.

GP availability and involvement and better longitudinal continuity of care lead to a reduction in avoidable hospitalisations.[8] Evidence suggests that continuity of care leads to better health outcomes and quality of life for older people with chronic disease.[9,10]

But with the current setup of the aged care system, a GP's involvement in their patient's aged care journey is limited. Aged care assessors usually have minimal or no interaction with the patient's usual GP even if the GP referred them to My Aged Care.

After a GP has referred their patient to My Aged Care, there is no feedback loop to inform the GP of the progress or outcome of the referral/ assessment. Unless they can find the time to contact the My Aged Care call centre to ask for an update, they have no view of the process or the outcomes. While the patient is waiting, their condition might deteriorate significantly, and they may require higher acuity of care and end up in hospital.

If the patient ends up in a nursing home, their GP is often limited in the care they can provide. Access to nursing homes and high-quality patient records can be difficult and involve substantial unpaid work, and sometimes a change to a different GP is imposed. Not only does this process create significant inefficiencies, but it also leads to poorer health outcomes and quality of life for the older person.

Older people end up in hospital when their condition could be managed or prevented by a GP or a Registered Nurse.

In 2017–18, 748,000 admissions in public and private hospitals were for conditions that are potentially preventable or treatable in the community, such as by a GP. Forty-six per cent of all preventable hospitalisations were for people aged 65 and over.[11]

Concerningly, in terms of patient days in hospital, potentially preventable hospitalisations as a proportion of total hospitalisations are growing rapidly. And at present, on average people who are hospitalised with a potentially preventable condition stay longer in hospital than those with non-preventable conditions.[12]

Under current aged care regulation, with the exception of State Government-run nursing homes in several states[13], there is no requirement for providers of nursing homes to employ enrolled nurses or Registered Nurses (RNs), nor is there any requirement to implement minimum staff to resident ratios. RNs are typically the only aged care provider employees that can provide frontline, timely clinical care within their scope of practice.

GPs who interact with the aged care system rely on RNs to carry out their clinical directions following a visit to the nursing home or the patient's home. Between a GP and a RN, proper continuity of care can take place, ensuring the best clinical care for older people. Older people in aged care need RNs to safely administer medicines and help prevent medical issues such as bed sores and falls leading to fractures.

With insufficient nursing staff available, and limited access to GPs, older people in nursing homes are transferred frequently to hospitals, often resulting in unnecessary prolonged stays. Nursing homes with poorer staff to resident ratios have higher rates of transfer to hospital, compared with those that have better Registered Nurse availability.[14]

Older people end up over-medicated or inappropriately medicated.

Around 53 per cent of people in nursing homes have some form of dementia, and 87 per cent have at least one diagnosed mental health or behavioural condition.[15]

The Royal Commission's Interim Report found that, in addition to the frequent use of physical restraints on residents in nursing homes, psychotropic drugs and sedatives ('chemical restraints') were overused.[16]

Medication management in aged care has continued to be one of the components of aged care quality standards that are most frequently not met.[17] This is primarily due to a lack of availability of RNs who are qualified to provide appropriate clinical care. The complexity of medical conditions now experienced within nursing homes really requires the nuanced understanding, skill and experience of a RN.

Annual and as-needed medication management reviews in collaboration with the person's usual GP and a pharmacist are essential in ensuring a patients' medication regime remains suitable for their current circumstances.

Avoidable hospital admissions for people in the aged care system are frequent and expensive.

There is a tendency for nursing homes to transfer older people to a hospital even if primary care services are more appropriate to resolve the issue[18], and even when it is not in the best interests of the resident.[19] Older people are being transferred to emergency departments (EDs) for problems that could potentially be managed in general practice, such as some injuries, skin disorders, and urinary tract infections.[20]

Various studies have attempted to quantify the extent of avoidable hospital admissions that occur from people receiving aged care services. A study of residents transferred from nursing homes to two EDs in Melbourne in 2012 found that 17.4 per cent of transfers were potentially avoidable, while a Western Australian (WA) study in 2010 found that 31 per cent of transfers from nursing homes to hospital EDs were potentially avoidable.[21] In the latter study, the most common reasons for potentially avoidable transfers were non-emergent symptoms suitable for assessment and management in the nursing home (48%); wounds where assessment and management, including suturing, could be undertaken in the nursing home (23%); and minor injury with time-critical radiology not needed (22%). Forty-five per cent of residents were returned to their nursing home without admission to hospital. The services most frequently identified as being able to potentially prevent the transfer were a GP or assessment team, radiology and acute wound care.[22]

An Australian intervention study in WA found that hospital transfers from nursing homes were reduced by 15 per cent when enhanced primary care services were provided by experienced nurses under the governance of GPs.[23]

While these studies are useful, there is no national estimate of avoidable hospital admissions from aged care. Furthermore, these studies only focused on nursing homes to the exclusion of older people living at home in the community. The AMA has undertaken original analysis, triangulating publicly available data from various sources, to estimate this.

Potential savings

Over four years (2021-22 to 2024–25), $21.2 billion could be saved from avoidable public and private hospital admissions, presentations and stays from older people in the community and in nursing homes.

The AMA estimates that 27,569 hospital admissions per year from nursing homes are potentially preventable, and that this comes at an annual cost of $312 million (figures calibrated for 2020–21). Over four years to 2024–25, with anticipated annual growth in residents of 1.5 per cent, a continuation of the trend in the proportion of patient days in hospital found to be preventable, and cost indexed to Independent Hospital Pricing Authority (IHPA) National Efficient Price growth of 2.7 per cent[24], this represents $1.4 billion that could be saved through better management of health care in nursing homes.

In addition to this, the AMA estimates that potentially preventable hospital admissions from people aged 65+ in the community represent 1.9 million patient days per year, at a cost of $3.7 billion in 2020–21.[1] Over four years to 2024–25, with patient days for the 65–84 and 85+ year old cohorts growing at 2.8 per cent and 1.5 per cent per year respectively[2], and cost indexed to IHPA National Efficient Price growth of 2.7 per cent, this represents potential savings of $18.2 billion.

Further to these potential savings, a Royal Commission research paper reported that every year there are tens of thousands of non-admitted ED presentations from nursing homes — 47,822 in 2018–19[25] (the AMA estimates 49,300 in 2020–21). These are people who present at ED with minor conditions and are sent home without admission. Costs incurred here are the cost of transport plus the costs of being triaged at the ED, which the AMA estimates totals $112 million per year in 2020–21. Over four years to 2024–25, indexed to nursing home resident population growth of 1.5 per cent, this represents potential savings of $497 million.

In addition to this, a Royal Commission research paper reported that there were 18,267 hospital re-presentations from nursing homes in 2018–19[26] (the AMA estimates 18,800 in 2020–21). These are people who re-present to ED within 30 days of an overnight hospital stay. The Royal Commission paper considers these re-presentations an indicator of poor nursing home quality. The AMA estimates that the transport cost alone of these re-presentations is $31 million in 2020–21.[3] Over four years to 2024–25, indexed to nursing home resident population growth of 1.5 per cent, this represents potential savings of at least $138 million.

Every year there are also a number of older people waiting in hospital for a place in a nursing home. The Australian Institute of Health and Welfare estimates that people in this situation occupied 7.2 patient days for every 1,000 patient days in hospital in 2018–2019 for major cities, or 222,000 patient days.[27] The AMA estimates this will increase to 232,000 patient days in 2020–21, at a total net annual cost of $197 million. Over four years to 2024–25, with cost indexed to IHPA National Efficient Price growth of 2.7 per cent, and assuming hospital patient day growth of 2 per cent, this represents potential savings of $887 million.

In total, the amount that could be saved over four years to 2024–25 from avoidable public and private hospital admissions, presentations and stays from older people in the community and in nursing homes is $21.2 billion.

See Appendix A for further details of how these costs were estimated.

[1] Sixty-five is used as a threshold for 'older people' because it is the closest 5 year age increment to the current age of eligibility for retirement which is 66. When calculating the cost of potentially preventable hospitalisations from older people in the community, only a proportion of those over 85 were included, in order to have the effect of excluding people who are in nursing homes. This ensured that no double counting took place. For further details see Appendix A.

[2] These growth figures are based on total patient days for all separations in hospital, not just for potentially preventable hospitalisations.

[3] Only transport costs of re-presentations have been included here. This is due to the complexities and pitfalls in estimating the extent to which each re-presentation is preventable, and the lack of details available at present on the nature of such re-presentations. Therefore, this is a very conservative estimate of the cost of re-presentations. For further details see Appendix A.

Table 1: Summary of potential savings from avoidable public and private hospital admissions, presentations and stays from older people in the community and in nursing homes.

ACTIVITY	ANNUAL WASTE 2020-21	POTENTIAL ANNUAL SAVING 2020-21 ($M)	POTENTIAL SAVING OVER FOUR YEARS TO 2024-25 ($M)
Potentially preventable hospitalisations from nursing homes	27,569 hospitalisations or 159,693 patient days	$312	$1,430
Potentially preventable hospitalisations from the community (people aged 65 and over)	379,917 hospitalisations, or 1.9 million patient days	$3,737	$18,199
Non-admitted ED presentations from nursing homes	49,300 presentations	$112	$497
Hospital re-presentations from nursing homes (transport cost only)	18,800 re-presentations	$31	$138
People waiting in hospital for a place in a nursing home	232,000 patient days	$197	$887
TOTAL		**$4,388**	**$21,150**

Home care

The aged care system is not adequately resourced to support older people to live well at home.

Many older people would prefer to live at home and could feasibly do so with the proper support.

Many older people prefer to stay in their homes and in their communities as they age. In many cases, this is possible with the right level of support, often affording a higher quality of life and greater independence.

Nursing homes are an expensive alternative to Home Care Packages (HCPs), and older people generally delay going into one until it becomes inevitable.[28] In 2019–20, the average age on entry into a nursing home was 82.5 years for men, 84.8 years for women, and the average length of stay was 35.3 months.[29]

But waiting lists for Home Care Packages are too long due to lack of government funding.

Current waiting lists for HCPs are too long — up to 28 months for the highest level HCP (Level 4).[30] Many people die waiting to access a HCP at their approved level.[31] Others suffer without proper care while waiting or are forced to move into a nursing home. Many will also frequently move in and out of hospital as their health deteriorates and their care needs are not met, or will end up living in hospital at a high expense while waiting for somewhere more appropriate to live.

The Royal Commission Interim Report stated that, while waiting on the list for a HCP, "there is a clear and present danger of declining function, inappropriate hospitalisation, carer burnout and premature institutionalisation because necessary services are not provided".[32]

Patient journey example

What older people need, and what they receive are often not the same thing. This hypothetical example of an older person's interaction with the aged care and health care systems in Australia provides AMA's vision of what the patient journey should look like, juxtaposed with what currently happens.

John is 75 years old. Since he moved to his current neighbourhood 15 years ago, his care has been provided by the same GP, resulting in a significant doctor-patient relationship. He sees his GP at least once every couple of months as John has diabetes and an ongoing heart condition, both managed by medication.

During a visit to his GP, the doctor notices some changes in John's behaviour. He does not seem groomed properly, he is a bit reticent and depressed. John's wife Margaret tells the doctor that he has been forgetting things and missing appointments.

John's GP performs a dementia test and, following a consultation with a non-GP specialist, John is diagnosed with mild cognitive impairment, caused by dementia. The GP, after discussing this with John and Margaret, refers John to My Aged Care, so that his level of need can be assessed and subsequently he can start receiving appropriate care at home. The GP correctly perceives this is important because Margaret is the same age as John.

Typical experience

After the GP submits the referral to My Aged Care, there is no further contact between the aged care system and the GP. There is no feedback loop for the GP and they are excluded from the assessment process; unless they can find the time to contact the My Aged Care call centre to ask for an update, they have no view of the process or the outcomes.

The results of the assessment are not made available in My Health Record because the clinical software is not interoperable with that of My Aged Care. This means that the GP has no visibility of where John is in the assessment process, even if John happens to end up in hospital due to health deterioration. The doctor cannot start any proactive planning and engagement with John to help facilitate and improve his aged care journey.

Ideal experience

Once the GP submits the referral, My Aged Care appoints a local independent 'Care Finder' (linked to the local Primary Health Network) who contacts John and Margaret to talk them through what is going to happen next and help them navigate the aged care system. The local assessor then gets in touch with the GP to obtain John's prior medical history and other information the GP considers relevant. The assessor uses that information to prepare for the assessment with John. After they perform the assessment, the results are uploaded to My Aged Care. Through the feedback loop in the clinical software, the GP gets a notification about the assessment and is able to go into My Aged Care and view the findings of the assessment. The GP contacts the assessor if there are any concerns.

Because My Aged Care is now interoperable with My Health Record, the results of the assessment are also available in My Health Record. This means that the GP knows what John has been assessed for, can contact him while they are deciding what aged care provider to choose, and can follow up with him to ensure that his situation in the meantime does not deteriorate to the point that he ends up in hospital.

Patient journey example

The assessor decides that John needs a level 3 Home Care Package. The GP is not informed of the outcome of the assessment. John and Margaret spend hours on the My Aged Care website identifying and researching aged care providers in their area. The process is particularly difficult for them because neither John nor Margaret are well versed in the use of computers and online tools. Furthermore, there is no good way of comparing the quality of the providers because there is no rating on the website.

Once John has identified his home care provider, together they develop an Aged Care Plan which outlines John's care needs, the types of services needed to meet those needs, who will provide the services and when/how. The GP is not contacted to contribute to the Aged Care Plan because there is no requirement for them to be involved. No Advance Care Directive is developed for John because it is not mandatory, and so the people involved in John's care are in the dark about his needs, values and preferences for his care now and into the future, when he may become unable to consistently make decisions for himself.

John starts to struggle more with his cognitive functioning and mental health. John does not have anyone to help him navigate the system. He has forgotten that he is eligible for allied health services and does not know who he can contact for help. He starts to feel frustrated and isolated.

Through the feedback alert, the GP sees that John has been assigned a level 3 Home Care Package. The GP contacts John and Margaret to check if they have been informed of the outcome of the assessment. The Care Finder contacts John and Margaret to help them select the most suitable home care provider.

Once John is linked to his home care provider by his Care Finder, the GP, in coordination with the provider, and if the GP deems necessary, a geriatrician, develop an Aged Care Plan for John. The Aged Care Plan includes both medical care that John needs to be receiving and social and other care that will help improve his condition. The GP also encourages John to develop his Advance Care Directive that the GP then uploads to My Aged Care/My Health Record. The Advance Care Directive contains all the needs, values and preferences for John's future care and details of a substitute decision-maker.

The Aged Care Plan includes exercise physiology sessions two times a week, a cognitive therapy session once a week with a psychologist/speech therapist, as well as social group meetings with a local community organisation (Men's Shed) that the GP believes would be beneficial for John's mental health and slowing the progress of dementia. The Care Finder helps John find the providers of these services and enrol with them.

Patient journey example

John continues to live at home with his wife for a number of years. He keeps his regular appointments with his GP who is able to monitor his condition and review his Aged Care Plan accordingly. John's home care package also includes transport services for when John needs to visit his GP.

John's condition starts to slowly deteriorate as his dementia progresses.

Typical experience

Whenever John's situation deteriorates to the point that he needs additional care, and Margaret needs some time off from being a full time carer, the GP has no choice but to refer him to the hospital, because eligibility, availability and access for respite care is difficult.

Ideal experience

Whenever John's situation deteriorates to the point that he needs additional care, the GP is able to refer John directly to residential respite care (part of the aged care system), preferably the same place each time so that there is familiarity with the carer staff, and without needing an additional assessment. In respite care, John gets the care he needs for a limited period of time, that helps him improve his condition, stay at home for longer and keeps him out of hospital. Respite care also allows Margaret to have the desired break from caring for John.

Patient journey example

John is now 80 and even though he is on the highest level Home Care Package this is no longer sufficient for his needs. His wife, who is also his carer, is no longer able to cope with the demands of caring for John. The GP advises that it would be best for the family if John went into a nursing home. The GP submits a referral to My Aged Care for another assessment for John.

Typical experience

After the GP submits the referral to My Aged Care, there is no further contact between the aged care system and the GP. There is no feedback loop for the GP who has a very limited view of the process or the outcomes. Once John has identified a nursing home, they develop a new Aged Care Plan. The GP is not contacted to contribute to the Aged Care Plan because there is no requirement for them to be involved. The nursing home does not upload the Aged Care Plan to My Health Record as they are very busy and it is not mandatory. As John's dementia has progressed, and there is no Advance Care Directive in place, it is challenging to determine how to align his medical needs with his values and preferences for the future as these are unknown.

John's GP has a busy practice with many overheads and cannot afford to make trips to visit patients in nursing homes which inevitably involves a lot of unpaid 'non-contact' time. The nursing home engages a new GP for John, who has no prior knowledge of his medical needs and can only access a limited medical history through My Health Record. Residing in the nursing home and losing access to supports and activities he previously had, John's dementia starts to deteriorate to the point that he becomes aggressive when his needs are not being met.

Ideal experience

Once the assessment has been completed, the GP and the Care Finder are notified. The Care Finder gets in touch with the GP and John (and his wife) to identify the most suitable accommodation. Once John and Margaret select the most suitable nursing home for John, his GP is able to develop a new Aged Care Plan for John. This plan is developed based on John's Advance Care Directive and his previously expressed wishes, that are all well known to his GP and his wife.

John continues to see his usual GP who has a good understanding of John as an individual, and a long history of managing his diabetes, heart condition and dementia.

To ensure that John is on the optimal medication regime for his changing health situation, John's GP initiates a thorough home medication management review in collaboration with the general practice pharmacist.

Patient journey example

Staff call on the new GP to prescribe medication to manage John's behaviour. Because John has dementia, he struggles to communicate his medical history to his new GP, such as successes and failures of different medication regimes he has tried. The newly prescribed medication stops John from being aggressive, but it also results in him being mostly bound to his bed or chair. He develops escalation of behaviours due to an undiagnosed urinary tract infection. The nursing home manager and the Personal Care Attendant do not have the medical experience to deal with John's symptoms and they decide to call an ambulance and transfer him to the local hospital emergency department. He is admitted and spends five days being extensively investigated and then treated for his urinary tract infection. The hospital doctors also develop a new medication regime before sending John back to the nursing home.

Registered Nurses working at the nursing home collaborate with the GP to develop the Aged Care Plan. The plan is stored in My Health Record and nurses are able to access it from the nursing home. Registered Nurses are also able to upload information that is relevant for John's GP into the My Health Record (such as any incidences of agitation, any use of antipsychotic medication, changes in his health condition, etc). Registered Nurses are able to call the GP whenever they need to, when John's condition deteriorates to the point they believe he may need hospitalisation. The GP is then able to visit the nursing home, assess the situation and determine the best course of care for John. If John's regular GP is not available to visit, a pre-arranged agreement of care between the regular GP and the aged care provider outlines contact details for an alternative GP to attend to John.

Patient journey example

After a hospitalisation that was instigated by the GP because of a seriously worsening health condition, John returns to the nursing home. The GP, in coordination with the geriatrician at the hospital, determines that the best option for John would be to start palliative care that can be provided by his nursing home.

Typical experience

The nursing home does not have the capacity and refuses to provide palliative care for John. They don't employ a sufficient number of nurses who are trained in palliative care provision and claim that their model of care is not conducive to palliative care. As a result, John is transferred to hospital while his wife has to search for another nursing home that can provide palliative care. As an alternative, John can be taken back to his home where he can be visited by palliative care services.

John is transferred repeatedly between his nursing home and the local hospital, causing further distress and agitation for him and his family. Eventually he dies in hospital.

Ideal experience

Communication of palliative care delivery between the GP and the nursing staff at the nursing home is regular. The GP also instigates the involvement of the visiting palliative care service that the local hospital provides. Information between the three stakeholders is shared via My Health Record. The prescribed palliative medication is administered on time by Registered Nurses who are available on site in the nursing home 24/7.

John lives the rest of his life in the nursing home getting the care that he needs with familiar carers.

SOLUTION

Investment and action

The Government is taking action through the Royal Commission, but it does not go far enough.

The Government should take steps now to improve the quality and continuity of health care in the aged care system.

With the scale of the problem growing and the system already struggling, the Government should use the momentum from the Royal Commission to implement substantial and comprehensive reform of the aged care system.

What is missing from the current direction of reforms is a plan to ensure that the health care and aged care systems work together and complement each other in the future. The AMA provides this plan here in the recommendations that follow.

While there are savings in making these improvements, the Government ultimately needs to invest more in the aged care system.

Enabling greater access to GPs and RNs in the community and nursing homes will improve health and wellbeing for older people. Investing in aged care will also create savings in costly hospital transfers and unnecessarily long hospital stays. But ultimately, it will likely be a net cost to provide proper health care in an aged care setting and the Government should invest in this care as a matter of principle to uphold basic human rights, and not with the expectation of breaking even.

Governments will have to give thought to how this necessary care will be funded, whether it be a tax, an increase to the Medicare levy, or some other mechanism. While recognising that most recipients of aged care services will have made substantial financial contributions over many years as taxpayers, given the scale of investment needed, people who are able to make financial contributions should be asked to do so, with a safety net put in place for those are not.

Recommendations

The AMA recommends taking the following actions to improve the quality and continuity of health care in the aged care system.

General practice

Position GPs at the centre of health care provision in aged care to deliver continuity of care, better health outcomes and savings.

GPs are not supported to deliver health care in aged care settings. The following section presents specific barriers and solutions to this. As outlined above, the potential cost of avoidable hospital admissions from aged care is substantial.

GP visits to patients in nursing homes are financially disincentivised.

Under the current set up of the Medicare Benefits Schedule (MBS) system for GPs in aged care, there is minimal incentive for GPs to leave their often busy practices to travel to see an aged care patient.

Nursing home and private home attendances by a doctor for older people are rebated through the MBS. A doctor may choose to 'bulk-bill' a consultation, in which case the older person has no out-of-pocket expenses. Alternatively, the doctor may charge a private fee, where the older person incurs an out-of-pocket cost (the difference between the private fee and the amount rebated to the patient for the service by the government through the MBS rebate).

Nationally, almost 100 per cent of GP (non-referred) attendances to older people in nursing homes are bulk-billed.[33] This means that older people are receiving GP services for no out-of-pocket cost, and GPs choose to accept the level of the MBS rebate as full payment for their services.

The AMA has received overwhelming reports from its GP members that MBS rebates do not adequately compensate for time and care spent with an older patient in a nursing home and other activities that are required to support the patient (i.e. non-contact time) such as paperwork and discussing treatment plans with relatives and nursing home staff.

GPs provide a substantial amount of non-remunerated, non-contact time when looking after their older patients (see Table 2).

Table 2: Example of the total time involved for GP attendances at nursing homes (first patient).[34]

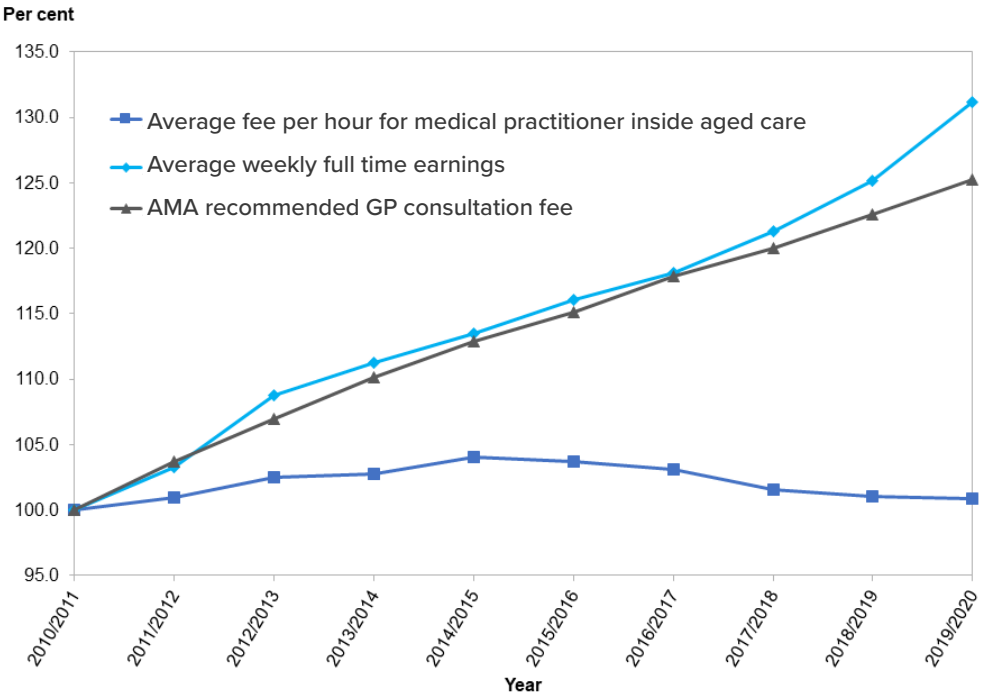
ACTION	TIME (MINUTES)
Travel time	20
Finding a car park	5
Finding a staff member (preferably a registered nurse) and discussing the patient's needs and history	5
Finding the patient	5
Level B attendance (although can be longer noting older patients are on average, more complex)	14
Filling out prescriptions and paperwork	5
Finding the registered nurse (if available) to provide a clinically reliable handover	5
Travel time back to the practice	20
Talking to relatives and the RACF staff over the phone or at the RACF	5
Entering patient records into clinical practice software	5
TOTAL	**89**

The AMA Aged Care Survey of its members conducted in 2017 showed that most GPs intended to decrease their visits to nursing homes in the future – to either visit current patients but not take new patients, decrease the number of visits, or stop visiting nursing homes entirely.[35]

This should be concerning to the Government, especially since the Royal Commission Final Report noted that there are already problems accessing general practitioners in aged care, including GPs not visiting, not visiting enough, or not spending enough time there.[36]

Over time the MBS rebates for medical practitioners working in aged care have depreciated compared to Average Weekly Earnings, and the AMA's recommended GP consultation fee. See Figure 1 below. This reflects the situation with MBS rebates across the board, where lack of indexation erodes the value of rebates.

Figure 1: Depreciation of medical practitioner fees in aged care since 2010/11 (100.0 = 2010/11)



The Government must revisit the incentives for GPs to attend nursing homes, encouraging new doctors to get into, and stay in, aged care as demand continues to grow.

The AMA calls for the MBS rebates to increase by at least 50 per cent to adequately compensate for the additional time and complexity involved compared to a GP consultation in their own rooms.

Using publicly available data, the AMA has estimated the annual cost to the government of increasing the relevant MBS rebates by 50 per cent to be $145 million in 2021–22. Over four years to 2024–25, with an anticipated annual growth rate of claims of 4.2 per cent, this would cost $643 million. This reasonably small investment is easily justifiable by the billions of dollars of potential savings outlined above, and should have immediate and measurable impacts.

See Appendix B for details of how this cost was estimated.

Recommendation 1: Increase Medicare rebates for nursing home attendances by GPs by 50 per cent to compensate for the additional time and complexity involved in comparison to a GP consultation in their own rooms.

The above example in Table 2 of non-contact time includes phone calls from nursing home staff and relatives concerning the patient. GPs may provide medical advice during this phone call, including after hours. The AMA calls for the introduction of MBS telehealth items enabling GPs to engage with nursing home staff and relatives. This will reduce barriers to accessing medical services for older people, including after hours, and may lead to a reduction of hospital transfers from nursing homes.

Recommendation 2: Introduce MBS telehealth items for phone calls between the GP, nursing home staff and relatives of nursing home residents.

Access to patients and their records in nursing homes is poor.

Nursing homes should facilitate access to particular resources to ensure GPs can provide a quality medical service to their patients. This includes:

a. clinically-equipped and available doctor treatment rooms that enable patient privacy and an appropriate working environment;

b. provided all privacy measures are met, the ability to access patient files through a contemporary eHealth system that is interoperable with clinical software, My Aged Care, My Health Record, and nursing home software to increase communication and efficiency;

c. access to the actual nursing home, through the use of swipe cards, access codes, and car parking facilities;

d. access to a Registered Nurse to carry out a reliable clinical handover;

e. facilitating access to mobile x-ray and ultrasound services, as well as medication reviews;

f. ensuring that older people have timely access to allied health professionals.

Nursing home support to facilitate access to doctor services should be standardised. The AMA has been advocating for a Medical Access Aged Care Quality Standard comprising the above factors for some time. Having a medical access standard would ensure there are adequate minimum protocols, and the necessary equipment and facilities to provide primary care services, to incentivise medical practitioners to visit nursing homes. The medical access standard would also guide nursing homes to ensure older people receive the appropriate medical treatment they need.

Recommendation 3: Introduce a Medical Access Aged Care Quality Standard for nursing homes.

People struggle to navigate a complex system and to get the care they need.

The Royal Commission characterised the aged care system as a "complex, confusing, bureaucratic maze".[37] People entering aged care typically have limited knowledge of its workings, processes and paperwork.[38] Older people and their carers need support to navigate this complex system to find and access the care they need.

Care Finders are needed to support older people through the whole aged care journey to ensure continuity of care. They should have a thorough knowledge of the aged care, disability, and health systems and coordinate services with aged care providers. They should also regularly communicate with the older person's usual GP and coordinate with the GP to optimise care for the older person while they are in the process of obtaining aged care services. This will give GPs confidence that their patients are being provided with the necessary care in a reasonable timeframe. Care Finders should be independent of aged care providers so that they can act fully in the older person's best interest.

The AMA is pleased to see that the Royal Commission final report recommended the introduction of Care Finders to support older people to navigate the aged care system.

Recommendation 4: Introduce Care Finders who work closely with GPs to coordinate both health and aged care services.

People need greater access to specialist teams in the community, in coordination with GPs.

Hospital outreach teams are one part of the strategy to provide high-quality care in nursing homes while reducing the demand on EDs. This involves small teams of specialists usually based in a hospital providing relatively simple clinical procedures in-home.

The AMA calls for the operation of hospital aged care outreach teams to be expanded nationally, and appropriate funding procedures to be established, without cost shifting between State and Federal Governments. The expansion of multi-disciplinary hospital outreach teams is recommended by the final report of the Royal Commission.

Outreach teams should include non-GP specialists such as, but not limited to, geriatricians, psycho-geriatricians, psychiatrists, endocrinologists and dermatologists. The AMA believes that the composition of such teams should be based on individual patient needs and indicative clinical situation at the time of acute care need.

Any non-GP specialist services and outreach teams must work collaboratively with, but not replace, GP services, which should be the backbone of health care provision in aged care. Outreach teams should be complementary to the services GPs provide in nursing homes and should be providing care in coordination with the patient's usual GP to ensure that that quality coordinated care is received by the residents.

A system in which the outreach services work in coordination with the patient's usual GP will achieve its best value once proper shared online clinical systems are established which are Royal Australian College of General Practitioners (RACGP) standards compliant. Adequate interoperable clinical systems would facilitate improved communication and exchange of information and may prevent any unwanted loss of patients' information. While largely beneficial to the patient, outreach teams are another stakeholder that is added to already complex communication. Having a clinical online system that facilitates these transitions, and at the same time is accessible to the patient's usual GP, will enable continuity of care and lead to improved health outcomes for older people.

Recommendation 5: Introduce hospital aged care outreach teams in all local health networks, in coordination with a patient's usual GP.

State health services must retain the aged care assessment function and work in coordination with GPs.

The Royal Commission has recommended streamlining aged care assessment into a single assessment process. The AMA supports a single assessment process. However, at the moment, it is unclear whether the new streamlined service will continue to operate within the State health services/hospitals or be privatised.

Streamlined consumer assessments for aged care should be high quality, comprehensive, independent, consistent, efficient, effective, enable timely access to aged care services and be outcomes-focused.

Despite the chronic underfunding of Australia's public hospitals, many hospital-based Aged Care Assessment Teams (ACATs) work well. Taking assessment processes away from ACATs will risk losing the expertise of public hospitals and geriatricians in aged care assessments. The AMA calls for changes to assessments that are based on parts of the existing model that work well. The new streamlined model should be based on ACAT rather than the current Regional Assessment Service (RAS). The assessment system needs adequate resourcing, standard Key Performance Indicators (KPIs), and a good connection with the public health system and its services.

Medical expertise is needed in aged care assessments, and any new framework devised should recognise this. Current ACAT services provide baseline clinical data for subsequent clinical monitoring and evaluation of patient outcomes. This feature should be preserved in any new model. The AMA would also like to see the new model of care capture the information available to older people's usual GPs, who under the current system are cut off from contributing to their patients' assessments beyond the referral to My Aged Care.

Recommendation 6: Ensure that Aged Care Assessment remains with State health services which involve medical specialists, coordinating and collecting information from the older person's usual GP.

Nursing home staffing

Ensure the right numbers and skill mix of staff in nursing homes.

The staffing numbers and skill mix are not optimal in nursing homes. Evidence presented to the Royal Commission revealed that often the staffing levels and skill mix are not sufficient to support quality outcomes for residents.[39] Often there are too few staff for the number of residents, and/or staff are low-skilled and unable to provide health care. The Royal Commission Final Report identified that:

> Too often, there is not enough staff, particularly nurses, in home and residential aged care. In addition, the mix of staff who provide aged care is not matched to need. Inadequate staffing levels, skill mix and training are principal causes of substandard care in the current system.[40]

The AMA Aged Care Survey of its members conducted in 2017 gave a clear message from doctors about the need for more nurses in nursing homes. The majority of respondents prioritised 'access to nurses and other health professionals' as the most 'urgent' and 'extremely urgent' method to improve access to medical care in nursing homes.[41]

AMA members have been reporting for some time that there is, on occasion, no nurse available for medical practitioners to carry out a clinical handover, and no nurse available to administer certain medications after hours in nursing homes. This poses a serious risk to the health of patients living in nursing homes.

When asked if there were adequate processes in place to ensure a reliable clinical handover, over a third of doctors responded 'occasionally/ sometimes', 'rarely' or 'never'. When asked what level of expertise was required for the respondent to conduct a professionally responsible handover for their patients' care, 85 per cent listed a nurse, with the majority of respondents listing a Registered Nurse.[42]

The Royal Commission research into staffing levels in nursing homes found that more than half of all Australian aged care residents (57.6%) are in nursing homes that have one or two star ('unacceptable') staffing levels. Of the remaining 42.4 per cent of residents, 27.0 per cent are in homes that have three stars ('acceptable'), 14.1 per cent have four stars ('good') and 1.3 per cent are in homes with five stars ('best practice'). The threshold for 'acceptable care' was a minimum of 30 minutes of RN time and 215 minutes of total care time (RNs and other care workers) per resident per day.[43]

The Department of Health does not mandate minimum staffing levels for nursing homes, though minimum standards are in place for Victorian and Queensland public sector nursing homes.[44] While the Aged Care Quality Standards require all aged care services to have a sufficient, skilled and qualified workforce, it does not specify what sufficient, skilled, or qualified is. Vague quality standards allow aged care providers to make up their own definitions, and the resulting staff and skills mix typically does not meet the needs of residents.

Minimum staff to resident ratios in aged care should be mandated by the Federal Government. The AMA calls for a model that would see all nursing homes reach a staffing level that is closer to a five star rating. The Royal Commission research paper identified that this would mean at least 242–264 care minutes per resident per day, with 44–63 minutes of care by a RN. For all nursing homes with three stars or lower to achieve four stars, total staffing levels in those nursing homes would need to increase by 78 minutes (47.0%), including 14 minutes (43.8%) of RN time.[45] The Royal Commission has acknowledged the importance of making changes in this area, and as such has recommended minimum standards for staff time in its final report.

Recommendation 7: Mandate minimum staff-to-resident ratios in nursing homes.

As part of improved staff to resident ratios, RNs should be available round the clock to provide skilled health care within their scope of practice. Experienced nurses can provide appropriate and skilled care within the nursing home, which in conjunction with GP oversight, can prevent transfers to hospitals.

As mentioned above, nursing homes with poorer staff to resident ratios have higher rates of transfer to hospital, compared with those that have better Registered Nurse availability.[46] Government-run nursing homes have lower emergency department re-admissions, for both long term and short term residents.[47] The Royal Commission's research also demonstrated that medication-related events that result in hospital admissions are lowest in government-run nursing homes.[48] On average, nurses in government-run nursing homes worked 119 minutes per day per resident compared to 39 in not for profit and for profit nursing homes.[49]

The number of RNs available on site in nursing homes during the night (to ensure 24-hour availability) should be determined by the residents' level of needs.

The AMA is pleased to see that the Royal Commission recommended in its final report a transition towards having at least one RN on-site at all times by 2024, but we believe this transition can and should happen earlier, in 2021.

Recommendation 8: Mandate 24/7 on site Registered Nurse availability in nursing homes, and according to the level of residents' needs.

Personal care attendants (PCAs) spend proportionally more time caring for older people than any other staff type[50], which makes them a crucial component to the aged care workforce and a crucial component in influencing safety and quality issues.

At the moment, PCAs are not equipped to provide basic health care. The Aged Care Workforce Strategy Taskforce identified significant health-specific training gaps in areas such as basic care (nutrition and hydration), oral health, mental health, dementia, palliative care and end-of-life care, and medication management.[51] There is no requirement for aged care providers to ensure that their PCA employees receive training or professional development for the above, or any, care skills.

Other professions that have the responsibility to care for people have mandatory minimum qualifications and are regulated. RNs, doctors and other health professionals are regulated under the Australian Health Practitioner Regulation Agency (AHPRA). While the AMA does not believe that PCAs should be registered by AHPRA, the AMA has consistently called for a mandatory minimum qualification for PCAs and registration by a regulatory body. Their qualifications should include basic health care skills as well as:

- Strategies to prevent deterioration in health, such as exercise programs, adequate nutrition and hydration;
- Strategies to reduce distress in dementia patients;
- Intervention and management of elder abuse;
- Engaging with Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander older people;
- Palliative care skills;
- Mental health skills;
- Strategies to address other common health issues that older people face; and
- Basic life support.

The Royal Commission has recognised the importance of making a change in this area and has recommended minimum qualifications for personal care attendants in its final report.

As the regulator of the aged care sector, the Federal Government should ensure adequate funding for the training of PCAs and make the training mandatory. Without this in place, providers may choose not to invest in training, but still impose professional development and training requirements on their staff. Currently, PCAs can be expected to carry out training during their working hours but lack time to do so. Alternatively, they may be expected to attend training in their own time and/or at their own cost.[52] If training is left up to individual providers, risks associated with this include shorter, less costly courses that do not provide sufficient training, higher turnover of staff, de-incentivisation of the workforce, and lack of opportunities for career progression for staff that are motivated to work in the aged care sector.

Recommendation 9: Mandate a minimum qualification for personal care attendants that includes basic health care, and continuous training of the aged care workforce with specific funding attached for training.

Technology

Invest in tools and technology to improve health care in aged care.

No consistently used patient record leaves health care professionals in the dark about their patients' needs.

Broader adoption of digital technology by the aged care sector should be encouraged and ensured by the Government. Use of My Health Record in aged care should be expanded to all nursing homes, and interoperability should be ensured between My Health Record, clinical information systems of GPs and My Aged Care. Once established, that interoperability would enable the use by clinicians, nursing homes, assessors (if they are clinicians) and Care Finders (again if they are clinicians) as a method of communication across aged care. It would also enable doctors to easily access information about their patient, such as the results of their ACAT assessment.

The AMA is pleased to see that interoperability between My Health Record, aged care and health care systems is a recommendation of the final report of the Royal Commission.

The AMA warns that the success of implementing the My Health Record in nursing homes will depend on a number of factors, including:

- Applying the standards of conformance set by the Australian Digital Health Agency for the residential age care clinical information system;
- The timeliness of achieving full conformance with the standards, and the ease of My Health Record use via the clinical information system (CIS);
- The level of resourcing to train age care staff in My Health Record use; and
- The ease of writing and uploading clinical information about a person in a nursing home, into the My Health Record on the CIS in the nursing home.

Recommendation 10: Ensure interoperability between GP clinical and aged care software systems, including My Aged Care and My Health Record.

Home care

Properly resource aged care so that people get timely access to home care packages.

The lack of funding for Home Care Packages restricts choice and quality of life for older people.

In 2019–20, median elapsed times for a person to access a HCP ranged from 6 months for a Level 1 package to 28 months for a Level 4 package.[53]

The Government should clear the existing backlog of around 99,268 people waiting for a HCP at their approved level[54] and ensure that anyone who is assessed as needing a HCP has access to one within a maximum of three months after the assessment.

The AMA is pleased to see that the Royal Commission final report supported this position, by recommending that the Government clear the HCP waiting list and ensure that approval is provided within one month of the assessment date.

By enabling older people to receive care at their level of need, the Government will ensure reduced numbers of hospital transfers of older people and avoid their prolonged hospital stays.

Using publicly available data, the AMA has estimated the annual cost to the government to reduce the waiting list to 5 per cent, with everyone on a package at the right level of need, to be $316 million in 2020–21.[4] This is in addition to the promise of 195,597 HCPs by June 2021, already announced by the Government.[55] Over four years, with anticipated growth in cost of 2.7 per cent and growth in population aged 65+ of 2.9 per cent, this represents a cost of $1.4 billion. The 5 per cent is to allow for some minor transition time onto and off the list, as there will always be new people being added to the list.

See Appendix C for details of how this cost was estimated.

Recommendation 11: Ensure that Home Care Packages are available to all those who need them, at the level of their need and a maximum of three months following the assessment.

[4] This has been calculated using data reported for the quarter ending September 2020.

SUMMARY OF RECOMMENDATIONS

Now is the time to design and implement well-funded health and aged care policies to meet the future demand and needs of our older people.

What is missing from the current direction of reforms is a plan to ensure that the health care and aged care systems work together and complement each other in the future. The AMA has provided this plan here in the recommendations outlined:

1. Increase Medicare rebates for nursing home attendances by GPs by 50 per cent to compensate for the additional time and complexity involved in comparison to a GP consultation in their own rooms.
2. Introduce MBS telehealth items for phone calls between the GP, nursing home staff and relatives.
3. Introduce a Medical Access Aged Care Quality Standard for nursing homes.
4. Introduce Care Finders who work closely with GPs to coordinate both health and aged care services.
5. Introduce hospital aged care outreach teams in all local health networks, in coordination with a patient's usual GP.
6. Ensure that Aged Care Assessment remains with State health services which involve medical specialists, coordinating and collecting information from the older person's usual GP.
7. Mandate minimum staff-to-resident ratios in nursing homes.
8. Mandate 24/7 on site Registered Nurse availability in nursing homes, and according to the level of residents' needs.
9. Mandate a minimum qualification for personal care attendants that includes basic health care, and continuous training of the aged care workforce with specific funding attached for training.
10. Ensure interoperability between GP clinical and aged care software systems, including My Aged Care and My Health Record.
11. Ensure that Home Care Packages are available to all those who need them, at the level of their need and a maximum of three months following the assessment.

APPENDICES

Appendix A: Modelled cost estimate of avoidable hospital admissions, presentations and stays from older people in the community and in nursing homes.

Potentially Preventable Hospital (PPH) admissions from aged care (both community and nursing homes)

- Estimated number – admissions from nursing homes: 27,569 hospitalisations or 159,693 patient days in 2020–21
- Estimated annual cost – admissions from nursing homes: $312 million in 2020–21
- Cost over 4 years to 2024–25 of admissions from nursing homes: $1,430 million ($1.4 billion)
- Estimated number – admissions from community (65+): 379,917 hospitalisations or 1.9 million patient days in 2020–21
- Estimated annual cost – admissions from community (65+): $3,737 million ($3.7 billion) in 2020–21
- Cost over 4 years to 2024–25 of admissions from community (65+): $18,199 million ($18.2 billion)

Based on data from:

- Australian Institute of Health and Welfare (2019). *Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18*.[56]
- Aged Care residents by age:
  - Aged Care Financing Authority (2020). *Eighth report on the Funding and Financing of the Aged Care Industry*.[57]
  - Australian Bureau of Statistics (2020). *National, state and territory population;* Australian Bureau of Statistics. *Population Projections Australia, population by single year of age, Australia*.[58]

The Australian Institute of Health and Welfare (AIHW) reports data on all hospital admissions for conditions which potentially could have been prevented – Potentially Preventable Hospitalisations (PPHs). These are conditions which could have been prevented in the first place, such as through vaccination, or those in which hospitalisation could have been prevented through better management in primary care, such as with a range of chronic diseases.

The trend in these admissions has been growing since the data series began in 2012–13. In 2012–13 577,000 admissions were deemed as potentially preventable—2.5 episodes per 100 people. This increased to 748,000 admissions in 2017–18, or 3.0 episodes per 100 people. The most recent data published is from 2017–18.

To estimate PPHs for older people, we divided the AIHW data up using reported PPH episodes by five year age cohort, and grouped it into 0–64, 65–84 and 85+ years. 85+ years is the age cohort which most closely aligns with the common age of nursing home residents. Nursing home residents make up approximately 29% of this entire age cohort. In turn, 60% of nursing home residents are aged 85 and over. The 65–84 year old cohort is the one likely to contain most of the Home Care Package recipients. It also contains some people in nursing homes, but this proportion is very small, at approximately 3%.

The number of PPH episodes and patient days in hospital by each broad age cohort was then calculated for each financial year 2012–13 to 2017–18. Using this, we estimated the trend in PPHs over a five year period by age group.

In addition, a trend was also estimated for the total number of patient days per hospital separation for each specific age cohort. The average length of stay has been declining which offsets to some degree the growth in separations. This is driven in history by improvements in technology which enable patients to stay a shorter time in hospital for a given condition. The overall effect of this is to reduce patient days per separation. We took this into account when projecting forward the number of patient days.

Some of the underlying trends are strong in the historical data. To produce a more conservative projection, these have been assumed to continue at only half the previous rate. This includes the growth in the proportion of patient days and separations which are estimated to be potentially preventable. For example, while the proportion of potentially preventable patient days for 65–84 year olds has increased from 10.0% of all patient days for that cohort in 2012–13 to 11.3% in 2017–18, our projections have it continuing to increase but at a slower pace, to 12.1% by 2024–25.

Stepping out of PPHs, we looked at total hospital separations to examine the hospital sector as a whole. The total hospital separations are growing at a steady rate. Therefore they were projected based on the historical trend, which has seen growth of 3.7% per annum. This growth in total separations is likely to continue with the population aged 65+ growing by 2.9% per annum.

The proportion of these separations attributed to each age group was then projected for both the 65–84 year olds (39% in 2024–25) and the 85+ year olds (7.1% in 2024–25). The remaining proportion was attributed to the 0–64 year olds (53.5% in 2024–25).

Up to this point of the analysis we have calculated the number of PPHs for the general population separated by our defined aged cohorts. Our last step was to estimate the share of PPHs belonging to older people living in nursing homes and in the community.

(i) Nursing homes

The proportion of potentially preventable and non-preventable separations from nursing home residents is not known or estimated by any national data source. The AIHW PPH series does not record a flag for admissions from a nursing home. We therefore attribute them in the same proportion as all other hospitalisations allowing for the age cohort. A recent research paper[59] as part of the work done for the Royal Commission concluded that hospitalisations from nursing homes occur at a faster rate than for the general population over 65, but once you adjust for the age profile within nursing homes they are admitted to hospital at only 74% of the rate of the general population. We have labelled this a Nursing Home Adjustment Factor.

This includes both public and private admissions. The Royal Commission paper gives a higher rate of public hospitalisation for nursing home residents than the general population but a much lower rate of private hospitalisation. We have used the combined public and private hospitalisation rate to simplify the analysis but also as a conservative assumption as we cannot estimate the cost differential between public and private using publicly available data.

We apportioned PPHs per the proportion of the population aged 65–84 and 85+ which resides in a nursing home. This is approximately 3% for 65–84 year olds and 29% for 85+ year olds in 2017–18. The trend in the proportion of people within each aged cohort which reside in a nursing home is also projected given the growth in nursing home residents is slower than that of the population aged 65–84 and 85+. This is in part due to the growth of Home Care Packages.

The impact of this slower growth of nursing home residents is a lower proportion of total PPHs which are attributable to nursing home residents over time. That is, by 2024–25 nursing home residents make up only 26% of the 85+ cohort from 29% at present. The change in share of patient days attributed to nursing home residents in the projections is driven by resident growth, continuing at approximately 1.5% per annum.

The cost of each patient day was estimated by allocating the total cost of all patient days against the total cost of hospital separations. While the Independent Hospital Pricing Authority (IHPA) calculates hospital costs based on separations rather than patient days, the patient day metric has been used as the patients in our nursing home cohort are much older and spend a much greater than average number of patient days per separation. To project the cost of each patient day, we have utilised the most recent IHPA price determination of 2.7% per annum growth which is used to bring IHPA activity based pricing from the latest data in 2018–19 to 2021–22 prices. This is a conservative cost assumption given it is deemed to be the growth in efficient price after allowing for all cost saving measures.

(ii) Community

At present there is no flag within the data on PPHs to suggest what care arrangements patients are utilising (if any), such as nursing homes, Home Care Packages or Commonwealth Home Support Program (CHSP). Therefore, it is problematic to try to estimate PPHs only for people in the community that are already receiving aged care services. Consequently, we have estimated the cost of PPHs for everyone in the community over 65. This is useful because it illustrates the potential benefits of greater investment in primary care among this older age group.

Sixty-five is used as a threshold for 'older people' because it is the closest 5 year age increment to the current age of eligibility for retirement which is 66.[60] When calculating the cost of PPHs from older people in the community, only a proportion of those over 85 were included, in order to have the effect of excluding people who are in nursing homes. This ensured that no double counting took place. As we approximated that 29% of 85+ year olds are in nursing homes, and attributed PPHs in this same proportion, 71% of PPHs for over 85s were assumed to come from the community.

As the Home Care Package and other support programs grow, the number of people receiving support from one or more government programs will also grow. The likely demographic utilising these programs is in this 65+ age group.

Non-admitted ED presentations from nursing homes

- Estimated number: 49,300 in 2020–21
- Estimated annual cost: $112 million in 2020–21
- Cost over 4 years to 2024–25: $497 million

Based on data from:

- Royal Commission into Aged Care Quality and Safety (2021). *Hospitalisations in Australian Aged Care: 2014/15–2018/19*. Research Paper 18.[61]

'Non-admitted ED presentations' means when patients are taken to the Emergency Department of hospitals, mostly by ambulance, and returned to their nursing home without further treatment. In this section we look at the cost of transporting, assessing and not admitting a patient, then returning them to the nursing home.

The cost consists of three parts, the ambulance call fee, the cost of triage and discharge at the hospital (using the IHPA estimate of non-admitted ED presentations), and a further 'patient transport' fee to return them to the nursing home.

The ambulance to the hospital is the most expensive part of a non-admitted ED presentation. While it varies state to state, the weighted average cost of an ambulance can be calculated by using broad population weights for each state and the indicative cost of an emergency ambulance ride. The weighted average of the states is approximately $1,050 in 2018–19.

The cost of triage and discharge, according to the latest IHPA data on non-admitted ED presentations in 2017–18, is $561. Expected growth is at the current IHPA price determination efficient price indexation of 2.7%.

The transport of patients back to the nursing home takes different forms depending on the state but all states have a non-emergency transport method for use on such occasions. The weighted cost of these transport fees is approximately $500 in 2018–19.

When projecting the costs of people visiting the ED from a nursing home we needed to make some assumptions about how some parameters estimated from the data change over time. It is assumed that ED presentations will continue at the current rate of total nursing home patient days out to 2024–25 as estimated by the Royal Commission. Total nursing home patient days are assumed to grow at the current historic trend of 1.5% (average of the past 5 years). Costs per patient day are assumed to continue to grow in-line with broader hospital prices of 2.7% from the latest IHPA price determination.

Hospital re-presentations from nursing homes

- Estimated number: 18,800 in 2020–21
- Estimated annual cost (transport only): $31 million in 2020–21
- Cost over 4 years to 2024–25: $138 million

Based on data from:

- Royal Commission into Aged Care Quality and Safety (2021). *Hospitalisations in Australian Aged Care: 2014/15–2018/19*. Research Paper 18.[62]

Re-presentations are when people re-present to ED within 30 days of an overnight hospital stay. The Royal Commission paper considers these to be an indicator of poor nursing home quality.

These costs are calculated in the same way as non-admitted ED presentations. Only transport costs of re-presentations have been included here, due to the complexities and pitfalls in estimating the extent to which each re-presentation is preventable, and the lack of details available at present on the nature of such re-presentations. The cost is likely substantial, far in excess of the transport figures presented here. Therefore, this is a very conservative estimate of the cost of re-presentations.

When projecting the costs of people re-presenting to hospital we needed to make some assumptions about how some parameters estimated from the data change over time. It is assumed that re-presentations will continue at the current rate of resident days out to 2024–25 as estimated by the Royal Commission. Total resident days are assumed to grow at the current historic trend of 1.5% consistent with growth assumptions throughout the report based on population growth and growth within Home Care Packages. Costs per transport are assumed to continue to grow in-line with broader hospital prices of 2.7% from the latest IHPA price determination.

People waiting in hospital for a place in a nursing home

- Estimated number: 232,000 patient days in 2020–21
- Estimated annual cost: $197 million in 2020–21
- Cost over 4 years to 2024–25: $887 million

Based on data from:

- AIHW reporting of waste under National Hospital Reform Agreement.[63]

When calculating this cost, we estimated only the additional cost above what the alternative would be if they were not waiting in hospital. We assumed that the alternative for these people would be a form of transitional care. To cost this, we used the existing Transitional Care Program which aims at this same cohort. The Productivity Commission recently costed this program in 2020 as part of their "Report on Government Services".[64] The total cost is reported as are the number of admissions and the average length of stay. The cost is the numerator and the denominator is the number of admissions times the average length of stay. This simple cost per day metric is appropriate for this type of program as it is by design temporary, so all capital and labour are apportioned equally across all residents on a per day basis. The potential saving is therefore the difference in the cost of administering the Transitional Care Program compared with the cost of each bed day in a hospital. There are additional non-monetary costs of 'bed blocking' by people remaining in an acute setting when they no longer require acute treatment. This additional cost has not been accounted for, but it still contributes to inefficiencies in the hospital and health care systems.

The 'Major Cities' rate (7.2 patient days for every 1,000 patient days in hospital) has been used for the entire country due to problems delivering services in remote locations. Programs for care in remote locations are often combined, due to the limited availability of staff and facilities, meaning that older people may stay in hospital for long periods of time because there is no other alternative facility in the area. This means the average rate for all of Australia is dragged up by these remote locations. Rather than use this elevated rate, we chose to make a conservative estimate and so have used the lower rate based on capital city hospitals.

When projecting the costs of people waiting for a place in a nursing home, we needed to make some assumptions about how some parameters estimated from the data change over time. It is assumed that waiting days will be a constant share of total patient days out to 2024–25 as estimated from the data. Total patient days are assumed to grow at the current historic trend of 2% (average of the past 5 years). Costs per patient day are assumed to grow in-line with broader hospital prices of 2.7% from the latest IHPA price determination.

Appendix B: Modelled cost estimate of increasing MBS rebate for GP attendances at nursing homes.

- Estimated annual cost: $145 million in 2021–22
- Cost over 4 years to 2024–25: $643 million

Based on data from:

- Services Australia: Medicare Item Reports for all MBS item numbers pertaining to aged care (5010,5028,5049,5067,5260,5263,5265,5267,90001,90002,90020,90035,90043,90051,90092,90093,90095,90096,90183,90188,90202,90212) 2010–11 to 2019–20.

Rebates for services provided by all medical practitioners in nursing homes are billed through the Medicare Benefits Schedule (MBS) under individual items. There are specific item numbers depending on:

- whether the service is provided by a GP or other medical specialist;
- when the services are provided (in hours or after hours);
- how long the service is (level A 0–5 minutes, through level D, 45 minutes or longer in hours and 40 minutes after hours); and
- whether services are provided in a rural or remote setting.

A special item number 90001 or 90002 is paid as a 'flag-fall' for in hours attendances depending on whether the doctor is a GP or other specialist.

The flag-fall was introduced in March 2019 and was supposed to lift compensation for medical specialists attending nursing homes by $98m over four years according to government costings.

Recent data for 2019–20 shows the average fee for each hour of service has fallen by 0.6% from the last full year prior to the introduction of the flag-fall, 2017–18.

As the MBS fees have failed to keep pace with either the AMA's recommended GP non-surgical consult fee or Average Weekly Earnings for a long time, the estimated increase in fees to bring the aged care items to an appropriate fee is deemed to be 50% by doctors. This is to compensate them for the unpaid time appropriately as well as meet the general fee increase over time.

When costing this figure out across the forward estimates, the rate of growth in services per resident was conservatively estimated at half the recent trend (2014–15 to 2018–19) of 5.4%, which equates to 2.7%. The number of residents is also conservatively estimated to increase by only 1.5% despite the population aged over 85 growing by 2.4% per annum to 2024–25, according to the Australian Bureau of Statistics population series B projections. Combined, these two sources of growth amount to an estimated annual growth in services to 2024–25 of 4.2%.

In addition, it is assumed that the price of all MBS fees is going to be indexed by the Government on 1 July 2021, 2022, etc... in the usual manner, at the assumed rate of 1.5% per annum.

The forward estimate costing was measured by applying the 50% increase to the entirety of the schedule of the aged care MBS item fees. The recent MBS claims data which was used to measure the growth is also used as the base for future projected claiming behaviour by consulting medical practitioners. The implementation date of the fee increase was costed based on 1 July 2021 start date and then indexed in the usual manner afterwards. That assumes no further behaviour change in the pattern of service delivery, such as a shift towards after hours attendances or number of visits per flag-fall.

The additional cost across the forward estimates is calculated as the residual of the proposed fee increase and the baseline continuation of standard indexation of existing fees. This equates to $145 million in 2021–22 or $643 million across the forward estimates.

This estimated cost is not particularly sensitive to the anticipated growth in demand for aged care, although faster growth in either places or the frequency with which residents see a doctor would increase the cost in-line with that further growth. That is, a 1% increase in services would result in a 1% increase in the additional cost of the proposed 50% fee increase.

Appendix C: Modelled cost estimate of everyone receiving a Home Care Package at their level of need.

- Estimated annual cost: $316 million in 2020–21
- Cost over 4 years to 2024–25: $1,397 million ($1.4 billion)

Based on data from:

- Department of Health (2020). *Home Care Packages Program Data Report 1st Quarter 2020–2021.*[65]

The method to estimate the cost of giving everyone a Home Care Package (HCP) who is waiting for one is complex. There are several distinct groups to consider and within those groups the cost for individuals will vary markedly. Significant effort has been made to factor in the current and future contributions by government and residents using all information available about those approved for, but not yet receiving a HCP, or receiving a package below their needs.

According to the recent reported data (September 2020), the waiting list for people not receiving their required level of Home Care Package is 99,268 people. This is split into four distinct groups:

1. Those receiving no formal government funded care at all: 1,443 clients;
2. Those receiving only access to the Commonwealth Home Support Program (CHSP): 72,778 clients;
3. Those receiving an interim HCP below their approved level: 25,047 clients; and
4. Residents approved for HCP but will ultimately enter a nursing home: a currently unknown proportion from the cohorts of all the above.

The model to calculate the cost of funding additional packages accounts for what the government currently spends, what residents spend, and how much additional funds need to be spent. For example, if a person is receiving a level 3 HCP but has been assessed as needing a level 4 HCP, we included only the additional cost of bringing that person up to their level of need, not the total cost of the level 4 HCP. Similarly, we accounted for the fact that a cohort of people contribute financially to their aged care package, and so this was excluded from the overall cost figure so as to only represent additional costs needed.

The government currently provides CHSP to the majority of people waiting on the list. This would equate to approximately $240 million across the 72,778 clients served by only CHSP.

Of the residents already approved and receiving a HCP or waiting for one, those residents would also be expected to pay fees toward the cost of their care depending on their means. For those fully supported clients, usually those receiving a full pension, the fees are limited to the basic fee which varies based on package level. For most clients the basic daily fee is approximately $10. In addition, part pensioners (an approximation as exact fees vary a small amount for each person) can be asked to pay $15.43 per day and self-funded retirees $30.86 per day.

While the fee structure depends on the individual circumstances of the client, for our modelling purposes we have broken up those waiting for an appropriate HCP into these three cohorts. The proportion of people in each of these cohorts is approximated using the proportion of full-pensioners, part-pensioners and self-funded retirees as published by Challenger[66] using Australian Bureau of Statistics and Australian Taxation Office data. Of those age eligible retirees, 42% are full pensioners, 30% part-pensioners and 28% self-funded retirees. The trend in the number of full pensioners is declining according to this research although for the purposes of this model it is kept constant across the forward estimates. This fee contribution for the extra packages (and level of need) we estimate would be an additional HCP recipient fee contribution of $177 million in 2021–22.

In addition, we factored in packages already released but not yet operational, an increase between September 2020 and June 2021 of 42,782 packages above population growth, or 45,778 packages in total.

There are two final adjustments we factored in. The main one is the number of people that are approved for a Home Care Package but will not take it up because a nursing home place is a better fit for their clinical needs. This will be a small proportion, but certainly above zero per cent. After asking a handful of GPs who see patients receiving government aged care services, an approximation of 10% was made of the proportion of patients approved for HCPs who end up instead in nursing homes. This reduces the number of packages needed in the HCP program by approximately 25,000. This reduces the cost burden on the HCP program by $412 million in 2021–22. Although this is valid for the present calculation, it does not save the government any money as these patients are likely to cost more money through the nursing home program instead.

The final adjustment is for the number of people waiting to get a package arranged with an appropriate HCP provider. Even when funding is made available, there will always be a time delay between when a package is accepted and when funding begins. This has been assumed to represent approximately 5% of the size of the HCP program. In comparison to the assumption that every person on the queue is given money the instant an ACAT approval is granted, by a simple calculation allowing for a 5% waiting list equates to a reduction in cost of $206 million.

Therefore, after making all these significant adjustments, the total amount of additional government funding required in 2020–21 to reduce the queue size to approximately 5% of total package recipients would be $316 million. This funding includes the cost of bringing all those waiting in the queue that ultimately receive a HCP up to the level they are approved for. If you were to also include all people that may have gone into nursing homes instead of receiving a HCP, that figure would be much higher at $728 million in 2021. However, an assumption that no-one approved for a HCP goes into a nursing home as an alternative is not plausible.

Over the four year forward estimates to 2024–25, including growth in the overall program already factored into the baseline government costing, the cost of the additional packages is $1.4 billion allowing for per package cost growth of 2.7% and growth in packages to match growth in the population aged 65+ of 2.9%.

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