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POSITION STATEMENT

Health and care of older people

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This document outlines the Australian Medical Association's position on the health and care of older people.

1. Introduction

1.1. Ageing is a normal process and does not inherently imply illness, impairment, or disability. However, most older people will, at some stage, experience a range of physical and/or psychological conditions that may result in temporary or ongoing functional impairment. Such impairment is most effectively managed by the involvement of medical practitioners and other healthcare workers.

1.2. Older Australians should be supported to age in their homes, maintaining independence and function for as long as possible. Governments must provide access to and funding for home and community aged care that meets this need.

1.3. The aged care system must be based on a universal right to high-quality, safe, and timely support. The AMA has advocated for the implementation of the key recommendations from the Royal Commission into Aged Care Safety and Quality.

1.4. Continuity of care is the cornerstone of effective healthcare for older people. The partnership between patients, families, and their general practitioner (GP) must be recognised as pivotal throughout the ageing journey — whether in community or residential aged care settings. Funding models must acknowledge the vital role GP-led teams play in delivering comprehensive care for older people.

1.5. In the face of an ageing population with a growing prevalence of complex chronic conditions, preventing disability and improving the health and care of older people must be a national priority. Changing demographics, evolving disease patterns, and increased dependency on services significantly influence the demand for the provision of health and aged care services. These demands include increased care needs, potential stays in residential aged care homes (RACHs), greater uptake of medical and allied health services, and heavier reliance on hospital-based care for acute illnesses.

1.6. Cultural safety and trauma-informed care must underpin services for Aboriginal and Torres Strait Islander older people, as required by the Aged Care Quality Standards and demonstrated through the Support at Home program, which mandates culturally safe services. The AMA supports care models that are person-led and culturally safe, acknowledging historical and

intergenerational trauma, including that experienced by Stolen Generations survivors. Wherever possible, services should support older people to live in or close to their communities and utilise Aboriginal and Torres Strait Islander assessment organisations that are connected to local knowledge and services.

2. Health systems for older Australians

2.1. Australia's ageing population is a testament to improved care and the effective management of acute and chronic illnesses over recent decades. However, increased longevity is accompanied by a rise in other population health issues, such as higher rates of comorbidity and functional impairment.

2.2. A larger ageing population requires comprehensive and multidisciplinary care, which must be adequately funded by government. Multidisciplinary teams that function effectively and receive reliable funding will support older people to remain well and functionally independent, reducing overall costs and other impacts of care.

2.3. It is essential the government supports reforms to both health and aged care services to ensure older people can readily access clinical services that help them remain well, including timely access to restorative interventions. Governments should ensure funding, workforce development, and accountability mechanisms deliver culturally safe, trauma-informed services for First Nations older people across community, residential, and hospital interfaces.

2.4. The introduction of enhanced user contributions to both home and residential aged care should be proportional, ensuring access to essential day-to-day services is affordable, regardless of individual financial circumstances. We acknowledge that many individuals face increased out-of-pocket costs for non-clinical services from aged care reforms, such as personal care assistance, meals, and domestic support. Enhanced resourcing of the healthcare sector is required to improve older people's access to health professionals outside of hospital settings.

3. Provision of clinical care

3.1. Investment in primary care is crucial to retain and increase the number of doctors working and remaining in the aged care space. The government should implement targeted increases to Medicare rebates to adequately compensate for the additional time and complexity involved in caring for older people. This consideration must account for practitioners' time spent coordinating and connecting care, beyond the time spent directly with the patient.

3.2. Policy should prioritise enhancing multidisciplinary care, acknowledging the important role of geriatricians and allied health professionals in both supporting functional recovery after illness and maintaining day-to-day function for older people. The expansion of telehealth services facilitates more collaborative consultations between GPs, other clinicians, RACH staff, and family members, but should not be a substitute for face-to-face care.

3.3. Government policy must prioritise enhanced workforce training, improved supports for staff, and clarification of escalation pathways in the context of increased use of restraint for older people. Steps must be taken to ensure aged care providers operate with care teams that possess mixed and complementary skills, and that they meet minimum quality standards to

deliver care to residents safely and efficiently. Workforce training programs should embed cultural safety and trauma-informed practice relevant to First Nations older people.

3.4. It is essential residential aged care is appropriately staffed to ensure consistent standards of care and safety. The introduction of minimum mandatory staff-resident ratios for RAHFs, which reflect the level of care needed and ensure 24-hour on-site registered nurse availability, must be maintained.

3.5. Effective, real-time communication between medical practitioners and aged care providers is essential to ensure timely, high-quality care and the responsive management of residents' health needs. The AMA's 10 minimum standards for communication between health services and treating doctors — while primarily focused on GPs and other medical professionals — also provide a model of best practice for residential aged care settings.

3.6. Care finders must involve the patient's usual GP, general physician, or geriatrician in the very first instance when a referral to aged care services is made, and must communicate the outcome, the chosen provider of the care package, and the timeframe for commencement to facilitate ongoing care.

3.7. Further investigation and research are needed into the demographics and transitions of medical professionals contributing to multidisciplinary teams in the aged care sector, noting the declining trend in GP aged care visits and the ageing medical workforce. Research should also consider expenditure trends related to Australia's ageing population and the projected needs of the medical workforce.

3.8. Older people must be well-supported through multidisciplinary teams that are sufficiently resourced to ensure continuity of care. Increased investment in community-based care should be prioritised, and its scope extended to strengthen GP-led services in aged care, with the objective of reducing strain on public hospital services without diverting existing resources.

4. Dementia and psychogeriatric care

4.1. The AMA's submission into the National Dementia Action Plan 2023–2033 (NDAP) highlights the key recommendations to improving dementia management in Australia by addressing the fragmentation of care among medical, health, and aged care professionals. There must be a high degree of coordination with, and support for, general practitioners, who play a crucial role in dementia care. Structural changes are necessary to ensure sustainable GP practices, adequate time for patient consultations, and better sharing of information between care providers. Increased clinical supports for GPs should be prioritised over education to enhance dementia diagnosis and post-diagnostic care.

4.2. The AMA has criticised the NDAP for not adequately addressing these issues — particularly its failing to consider the crucial role of GPs or to introduce structural changes to support sustainable GP practices. The plan does not reflect the true capabilities of primary care in Australia and places inadequate focus on the aged care sector, where more than 50 per cent of residents live with dementia.

4.3. The NDAP's focus on education and training for GPs is insufficient, without addressing the systemic barriers that limit their ability to provide dementia care. GPs must be supported to engage further in the plan through capacity building in generalist services — supported, rather

than replaced, by specialist input. The AMA calls for greater coordination and sharing of information among care providers, which the plan does not adequately address.

4.4. With the number of people living with dementia expected to increase significantly over time, skilled dementia care must become a core component of mainstream services delivered by aged care providers in both community and RACH settings. Appropriate skills and resources to support patients with behavioural and psychological symptoms of dementia (BPSD) will be essential to deliver effective, person-centred care and minimise the use of restraint. Structuring a tiered dementia care model that differentiates approaches to managing mild, moderate, or severe BPSD could be considered to improve care delivery.

4.5. The existence of Specialist Dementia Care Program (SDCP) units for patients with very severe BPSD should not be seen as a substitute for addressing the significant capability gap that currently exists in supporting patients with a wide variety of BPSD in standard RACH settings. Dementia assessment and BPSD management should incorporate culturally safe, trauma-informed approaches, with family/community involvement in line with the person's wishes. Better education frameworks, co-led by GPs, geriatricians, psychologists, and aged care nurses, could be implemented to build broader capacity for the delivery of dementia care across RACH settings.

4.6. GPs can manage dementia in both community and RACH settings, but they need appropriate support and resources — including access to medical specialists, allied health professionals, and community services. GPs also require specialist support in palliative and end-of-life care within RACH settings, where the complexity of treatment is amplified by the growing prevalence of chronic conditions among patients.

4.7. Attention to preventative health measures in mental health and cardiovascular risk factors can reduce incidence of dementia diagnosis.

5. Quality of care

5.1. All clinicians involved in an older person's care should have greater visibility over the progress of federally-funded aged care assessments and timelines to access services. This will give treating practitioners confidence that their patients are receiving the necessary care within a reasonable timeframe, and will also enable appropriate avenues for escalation if this is not occurring.

5.2. GPs are qualified to prescribe medications which alleviate distress and acute behavioural disturbance associated with dementia. Any proposal to restrict prescribing to non-GP specialist providers is unworkable in urban areas and almost impossible in rural settings.

5.3. Quality indicators must reflect the highest clinical outcomes, and accreditation audits should prioritise quality of care over documentation compliance. Staff must ensure that the standard of care is recognised as a more essential measure of quality than the existence of paperwork.

5.4. Ongoing aged care standards should enhance and improve delivery of care, promote efficiency, and be practical. Standard guidelines should be clear, concise, and specific, so aged care providers completely understand their responsibilities. The administrative process required to meet aged care standards should not restrict staff capacity to provide quality care to older

people. The aged care quality standards should include a Medical Access Standard for RACHs to assist with facilitating access to doctor services and high-quality clinical care.

6. Consent and decision-making

6.1. The AMA supports the use of advance care directives (ACDs), where appropriate, and advocates for standardised, fit-for-purpose documentation in community aged care settings to ensure timely and appropriate care for older people. Providers should prioritise routine advance care planning discussions to understand the views of higher-needs patients, as well as older people accessing aged care services. The AMA emphasises the importance of prioritising advance care planning discussions, with ACDs formalised in written form where patients have the capacity to do so, and made readily available to all care providers. The process of developing an ACD does not need to be detailed if the person does not wish it to be, but appropriate record keeping is essential to ensure patients' wishes are respected.

6.2. Older people have the right to make their own informed healthcare decisions, including the right to accept or reject advice regarding treatments and procedures. However, where an older person has limited, impaired, or fluctuating decision-making capacity, they should be supported to participate in decision-making consistent with their level of capacity at the time. The views of family or a legally recognised substitute decision-maker should be sought to help ascertain the wishes of the older person.

6.3. National, state, and territory governments must review policy and legislative provisions regarding restrictive practice substitute decision-makers (RPSDMs) under the Aged Care Act, to support timely decision making while ensuring adherence to legal requirements. Providers should be prepared and informed when authorised informed consent arrangements are delegated, to ensure continuity of care and enable prompt decision-making on behalf of vulnerable patients.

6.4. The new *Aged Care Act 2024* (Cth) aims to promote older people's right to be supported in making decisions for their care through the introduction of Supported Decision Making (SDM). The federal SDM provisions should be viewed as expanding upon and complementing — rather than contradicting — existing SDM pathways established under state and territory guardianship legislation. SDM processes should be culturally safe, recognising communication preferences and cultural obligations as expressed by the person. Clarity in decision-making is essential to prevent uncertainty that may pose risks to older people or cause significant delays in care.

7. Access to aged care services

7.1. The AMA supports the framework for streamlined consumer assessment for aged care services. The older person's usual GP must be able to provide input into the assessment, ideally through the GP's clinical software systems, to support the prompt delivery of appropriate care where clinically indicated and consented to by the patient. Improved, streamlined assessment for patient access to aged care specialists — including geriatric, palliative, and psychogeriatric care services — would help with ensuring the assessment process retains a health focus and is supported by an appropriately qualified clinical workforce.

7.2. The AMA emphasises the importance of providing an unbiased assessment of the needs of older people. Safeguards should be established within the assessment framework to ensure

commercial conflicts of interest are mitigated during both the tendering and subsequent assessment processes. Measures should also be implemented to avoid regulatory bottlenecks that may arise from repeat assessments within the multi-levelled approval process under the *Aged Care Act 2024* (Cth), to ensure there are no undue delays in older people receiving the care they need.

8. Elder abuse

8.1. Elder abuse includes physical, psychological, sexual, emotional, material or financial abuse, neglect, or abandonment, and may be intentional or unintentional. It violates basic legal and human rights. Older people should be able to live with dignity and security and be free from abuse.

8.2. Education and training programs on the recognition, intervention, and management of elder abuse should be available to all health professionals involved in the care of older people. Identification and response pathways for elder abuse must be culturally safe and trauma-informed.

8.3. Medical practitioners, especially GPs, play a pivotal role in the recognition, assessment, understanding, and management of elder abuse, supported by effective and accessible reporting mechanisms when required.

8.4. A coordinated response following the reporting of elder abuse is essential to ensure effective identification, management, and prevention. GPs should coordinate the process of testing multidisciplinary approaches, and evaluating the impact of screening and interventions. To support this, funding should prioritise innovative service models that include rigorous evaluation strategies to measure their effectiveness in addressing elder abuse.

See also:

AMA Position Statement on Use of Restrictive Practices in Residential Aged Care Facilities 2023
AMA Position Statement on Medical Care of Older People 2020
AMA Position Statement on Palliative Care in the Aged Care Setting 2020
AMA Submission to the Department of Health and Aged Care Consultation 2022
AMA Submission — National Dementia Action Plan 2023–33

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