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Transcript: AMA President, Dr Tony Bartone, Evidence to the Royal Commission on Aged Care Quality and Safety, Canberra, Monday, 9 December 2019

Subject: GP role in healthcare provision to older Australians

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MR GRAY: Commissioners, the next witnesses are Dr Anthony Bartone and Associate Professor Mark Morgan. I call those witnesses to the witness box.

COMMISSIONER PAGONE: Yes. Thank you.

MR GRAY: Thank you. Please take a seat. Dr Bartone, what's your full name?

DR BARTONE: Dr Anthony Bartone.

MR GRAY: I will ask that your most recent statement be displayed on the screen before you, WIT.1301.0001.0001. Dr Bartone, can you see there a copy of your statement dated 27 November 2019?

DR BARTONE: I certainly can.

MR GRAY: Do you wish to make any changes to the statement?

DR BARTONE: No, do I not.

MR GRAY: To the best of your knowledge and belief, are the facts in the statement true and correct, and the opinions in it opinions that you sincerely hold?

DR BARTONE: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: The statement of Dr Bartone will be exhibit 14-9.

MR GRAY: Thank you, Commissioner. For the record, the statement refers to the AMA's submission of the Royal Commission which is to be found at general tender bundle tab 25.

[Questions to Associate Professor Morgan]

MR GRAY: Dr Bartone, you're the President of the Australian Medical Association, the AMA. You were elected Federal President of the AMA in March 2018, having served as Vice President since May 2016. You're an experienced GP and a management executive. Your principal specialty interests include men's health, mental health counselling, care coordination of patients with multiple chronic illnesses and aged care. Is that all correct?

DR BARTONE: Correct.

[Questions to A/Prof Morgan]

MR GRAY: Dr Bartone and Dr Morgan, I'll just lead into the first topic I wish to raise for your comment. You may have received a document setting these out that will assist for the purpose of giving, probably best if I read that out and then I'll direct some specific questions to

you. The material before the Royal Commission suggests that the current model for the provision of primary health care to people who are in the aged care system rests primarily on the relationship between patient and general practitioner, and primarily that's a service provision model which involves remuneration on a fee for service basis through Medicare. In addition, there are practice incentive payments but primarily it relies on a fee for service approach.

It appears that this model is under strain in aged care settings. I refer in particular to the AMA's 2017 survey which you referred to in your material, Dr Bartone, including in your original statement in February, and that survey provides some evidence of the attitudes of medical practitioners about visitation of residential aged care facilities, and it makes sobering reading.

Also, the Royal Commission's staff analysis of unpublished AIHW data suggests that 46 per cent of general practitioners are not delivering services to aged care residents. So if one thinks about the principle of continuity of care, a matter that's referred to in your statements, it seems that on the basis of those data, a person transitioning from living in the community to living in a residential aged care facility would probably have roughly an equal chance of having to change general practitioners upon that transition.

Now, each of the AMA and the College respectively supports increases in the level of Medicare rebates for consultations for general practitioners providing primary health care services to residents and to others in the aged care system. In this first topic, I want to explore both the AMA's and the College's views on the question of whether addressing MBS items and the levels of rebate is, in itself, a sufficient response, or whether the model for delivering care and the way in which funding applies needs augmentation or even fundamental reform. If it does, what changes are needed?

Dr Bartone, would you like to address those topics first? Of course, you have - in the material the AMA has provided to the Royal Commission, including your statements, identified in detail arguments for the increase in MBS rebate levels, and you've pointed out that the AMA has consistently, in recent times, been seeking high increases in those items.

In addition, and augmenting that matter, if we could to the question of the funding model. What's the AMA's position on whether the funding model needs to be fundamentally reformed to perhaps involve a base fee on a capitation model as an augmentation for fee for services?

DR BARTONE: So if we look at how primary care is to be funded into the future, what we're seeing now is an increased movement or an increased understanding that fee for service alone will not support the increase in chronicity of care, the increased complexity of care and the increase in non-face-to-face care. So that increasing non-face-to-face component needs to be funded in an alternative way to the fee for service model whereby the MBS moiety only rewards time spent in front of the patient.

So, therefore, non-contact time with a patient essentially, except very few occasions perhaps, is not remunerated. So with – and we're looking at the increasing complexities, as I say, and the increasing amount of non-face-to-face care. So not only in aged care but right across the whole

primary care spectrum, we're now looking at a blended payment of funding. More so than any of those other spectrums or any localities, aged care would really be a screaming example, in my opinion, of where that blended approach needs to be considered even more so.

Notwithstanding that we already have an ineffectual blended payment model between the MBS and the PIP - which is an incentive grant, you might call it, for the amount of work that you might do in an aged care facility but not directly rewarding face-to-face time - those two components together largely do not reward or completely remunerate in any way, shape, or form the activity required.

And so what we're saying is the principles are sound, the funding is woefully inadequate and needs to be reviewed and not only augmented but also improved in that relationship between the amount of work that really goes on, and I think if you go back to both my previous testimony to the Commission, the amount of work that happens after you've finished your visit at the facility is significant if not substantial, and all of that occurs outside the envelope of the MBS fee for service and the PIP grant that currently exists.

MR GRAY: What would that blended funding model look like precisely? Does the AMA have a position on how the base component of that blended funding model would be constructed?

DR BARTONE: Certainly, there is a significant amount of work being done at the moment in the primary care steering group by the Minister that is looking at a voluntary nomination payment for those – at this stage for those over 70 in the community that nominate a GP or a GP practice as their usual doctor. That kind of backbone could be – that kind of funding arrangement could be the backbone, if appropriately funded, to ensure that there was both that blended component but also a significant redress of that MBS item funding.

MR GRAY: So that's an enrolment model?

DR BARTONE: Enrolment is one part of that. Yes, there is an enrolment process, but essentially the patient or the resident would just nominate a doctor or a practice as being their regular practice or their regular doctor, and that would see those payments follow that period of nomination into the future.

MR GRAY: Would that be outcomes based?

DR BARTONE: No, at this stage the entire process is about a certain level of – what's the word I'm looking for – activity, not even activity, sort of addressing certain scopes or certain items of care ensuring that they were part of the everyday relationship between doctor and patient. In an aged care facility there would be, I would imagine, a different set of requirements but it wouldn't be –there's no scope at this stage for any outcomes based payment there.

[Questions to A/Prof Morgan]

MR GRAY: I will return to that topic in just a moment and ask both of you further questions about it. Dr Bartone, the staff of the Commission are exploring a proposition that the MBS items related to comprehensive health assessment should be amended and liberalised to make comprehensive health assessment rebateable more frequently for residential aged care

recipients, and also for people in the complex or high needs categories in home care. What would you say to a recommendation that those comprehensive health assessments should be available every six months or as needed?

DR BARTONE: There would be no objection at all. Let's understand that with aged care residents at the moment as a cohort, as a group, they are entering into facilities at a much later point in their life. They've stayed in the community for longer periods of time, supported with either their local GP and/or members of the local community care team. Because of that increasing complexity, the care that's required is becoming increasingly more complex and more nuanced. And so, anything that supports the comprehensive assessment on a more frequent basis and/or allow that to happen on a more frequent basis would be a good thing. And in essence that whole issue underpins some of the questions that you already asked today.

And I know that's not what you're asking me right at this minute, but it does need to be stressed that because of that increasing complexity we can't look at what can happen in the next six months or 12 months, we need to take a really long-term approach. But we do need to look at ensuring that continuity of care which underpins good clinical care is fostered.

So whatever the framework is, it's got to recognise that whether it be through voluntary enrolment or nomination of some other process, that blended payment model supports that the ongoing fee for service by the usual GP, supported by a multidisciplinary care team, and that's where the complexity arises. And then that multidisciplinary care team would interact where there was a need to up – upregulate the care required and prevent admission to, as Professor Morgan was saying, to emergency departments which is extremely – both – not only costly but costly in terms of time, wasted in terms of necessary intervention to clinical care.

It's very disruptive to the patient, very, very disconcerting to the patient if not – that the whole transfer procedure wastes time, and creates a lot of fear and concern by in family members and in the patient. And we need to support their care as long as possible in that facility and anything that allows that to happen has got to be a good thing.

MR GRAY: Can I ask you about the composition of such a multidisciplinary care team? Who would be on it?

DR BARTONE: Well, we would look at all the usual wraparound services that you would expect. Now, some of those will be provided by the facility and some won't. But anything that, either both in face-to-face or in a telehealth case conferencing-type environment, could improve the patient's journey has got to be a good thing.

So, dietitians are not regularly available sometimes in some aged care facilities. Social - psychologists, psychiatrists, the whole breadth of the medical specialty treatment profession would be able to be brought in and wrapped around that as well. So it's about tailoring the care required to the individual resident's needs.

MR GRAY: And there would be utility, I suggest, in a team of that kind having access to specialised clinical expertise that's usually only available in the hospital setting, if that were

called for and if there was a possibility of avoiding a hospitalisation as a result of that advice and assistance being provided in the aged care setting?

DR BARTONE: Certainly, where the access and the availability of an outreach-type service is one type of model that I'm very familiar with, where you can bring in localised non-GP specialised care from the hospital environment into maintaining and managing that resident without having to transfer them to hospital is obviously a very good and very obvious clinical example of how that could work.

MR GRAY: I will ask you both about that in just a moment, but before I move to that, would another member of the multidisciplinary team, subject to workforce supply issues, be nurse practitioners with specialty in caring for older Australians?

DR BARTONE: I'll make a couple of comments about that. First of all, the nurse practitioner model has a defined scope of practice, usually under supervision or delegation with a supervising medical practitioner. They work really well in acute clinical environments such as emergency departments or hospital departments where there are an abundance of other medical specialist professionals present. And allow them to – to exercise their scope of practice to within their scope but at all times ensuring that their continuity and that they've done – that breadth of care is available in case of complex needs that progress outside that.

And that's what we've got to remember. As a model of care, we need to remember that nurse practitioners cannot substitute entirely for an appropriately trained medical workforce. By working with a supervising medical practitioner, there is a role or a scope but usually within a designated formulary of medications that they are able to prescribe or tests that they're able to order or conditions that they – or a diagnosis they're allowed to perform.

MR GRAY: Should they have more liberal access to rebateable items under MBS? For example, should they be able to at least participate in or perhaps make comprehensive health assessments?

DR BARTONE: So I'm a bit confused as to what is – whether – what's the problem we're trying to solve? We're trying to solve access to an appropriately trained medical workforce to perform the duty. So if we're saying that that is no longer an option and we're looking to put in an alternative standard of care, then perhaps that, you know, your premise would be appropriate. But we've got to recognise that it's only in collaboration will this – will they really fully exert their benefit, their true worth. So having independent access to the MBS is only going to fragment care and increase duplication and increase unintended outcomes.

Working collaboratively as part of the one team therefore then we can really increase both the outcomes, both the care and both the immediacy of treatment provided.

MR GRAY: The next topic I want to raise for further comment, you've already begun to comment on it, is the idea of – that transition to – access to that specialist expertise that might most typically really only be available in a hospital setting for people in residential aged care, and it seems the data would seem to suggest that they're probably being transferred to hospital to access that specialist clinical expertise in more cases than might be warranted. Now - - -

COMMISSIONER PAGONE: Perhaps just before we do go to that, sorry to let you continue to the end of your description of the next topic, but I wanted to make sure that it wasn't going to be dealt with by what I was going to ask.

Dr Bartone, and I suppose also Professor Morgan, there are all sorts of reasons why a medical profession may not be as actively involved in the aged care setting as one might like, and there are all sorts of ways in which one might encourage greater participation. But if I'm understanding what's being said, there's kind of an irreducible minimum that needs to be dealt with and that is that GPs or doctors, whether they're GPs or specialists doesn't really matter, need to be compensated for that non-remunerated proportion of the activity that currently is undertaken in the context of the aged care setting.

Assuming that is right, and please tell me if I'm not right, but assuming that is right, then can you see some mechanism of getting the irreducible minimum dealt with by identifying those elements of, say, the supervision of others or the travel time spent travelling, or the time spent on the telehealth service? Is that something that is something that's worth looking at from our point of view? I understand that each of your organisations may have different positions but ours is not so limited. You can start, Dr Bartone; I did address you first.

DR BARTONE: Certainly the introduction of telehealth item numbers to – for aged care residents is something that could occur forthwith.

COMMISSIONER PAGONE: Immediately.

DR BARTONE: Immediately, absolutely, and could really ensure more effective and timely intervention and an assuredness by an increasing larger proportion of the general practitioner workforce. There's no doubt about that.

In terms of having that delegation or that working in collaboration with teams, that would also then circumvent some of the travelling time and the repeat visitations required. Now, often you only just leave the facility, or you've just got back to your practice premises and you receive a call about something that's occurred, and that ability to delegate that or to have either a telehealth option would immediately solve that problem and reduce the need to go back to the aged care facility that night or the next morning.

That's what we need to encourage, more efficiency and more efficient ways of utilising the scarce resources that the GP has to his or her availability.

COMMISSIONER PAGONE: So just before I let Professor Morgan add to that, so we've thought of three examples where GPs could receive additional compensation for that part of the aged care service that isn't currently being met. One is to add to the Medicare items an item for telehealth which, as you say, could happen overnight, if somebody added it on the list. The second one is to delegate and presumably have some form of compensation to the doctor for that part of the care and responsibility that goes with supervision, I presume is the second area that you've looked at. The third is presumably to compensate for the travel and administrative time. Now, they're three. Have you got anything else to add to the list?

DR BARTONE: Those three certainly would form the basis of an easily and clearly targeted set of incentives to increase, but also things that increase the collaboration and the communication I think are things that I've already addressed, perhaps not as quickly, but certainly just by ensuring that the – there was more communication between the facility and the practice would certainly also increase that.

But the last thing I'll add to that list is just a care coordinator for even the sickest or the more acute care requiring residents, working as part of that team. So, perhaps another complexity to that care coordination model, or that multidisciplinary care team by having the ability to fund in the – an optionality of a care coordinator which could be upscaled or downscaled according to the resident's needs.

COMMISSIONER PAGONE: From the doctor's point of view, that's really just one of the sub-items of care and responsibility for somebody else?

DR BARTONE: Well, presumably it could go with the facility but also sometimes the doctor's own team of clinic staff could as part of that provide those services where they're not available, and that could be compensated through the practice-based processes.

[Questions to A/Prof Morgan]

MR GRAY: Dr Bartone, I will ask the same range of questions of you. Do you wish me to go back to the first one about multidisciplinary outreach teams; should they be scaled up and replicated with sustained recurrent funding on the national health reform basis?

DR BARTONE: Certainly what is occurring at the moment is patchy, is haphazard, is subject to the local funding envelopes and availability of local hospitals. Yes, one of the drivers perhaps is to try and minimise unnecessary ED presentations, and that might be the only driver for some, but we need to remember whatever model we put in, it's about what does this mean for the resident, the patient, and making sure it's patient centred. So, whatever the model that we implement, it's got to be patient centred. I agree that there should be some more systemic funding of this service, rather than just hospital by hospital or facility by facility. So there should be some more overarching State or Territory support for that.

But clearly, whether it's an integrated model, whether it's a referral model, or whether it's a hybrid of the two, there are three things that need to be remembered in that whole process. There needs to be someone in charge or someone loosely pointed to – you know, to look after the needs of coordinating all of those resources, and that 99 times out of 100 will be the patient's usual or the resident's usual GP.

And that is a complex process, but whether it be by phone or whether it be by telehealth or whether it be by secure messaging, it's going to require significant coordination of all of that, including some face-to-face attendance. But then the facility and the staff, the trained staff at the facility will be brought to bear into that, as well as the outreach team, as well as the regular GP. So that whole process is a complicated and very, very skilled solution to even a more complex task, and that is of transferring the patient to the facility for care that could be easily –

that could be delivered at the local aged care service. And I'm sorry, the next part of your question?

MR GRAY: Well, it was, there was – the next element was how does the interface with the primary health care practitioner work, but I think you've answered that. So you've advocated - - -

DR BARTONE: So, yes, and that's - - -

MR GRAY: - - - for the care coordination role to be - - -

DR BARTONE: And that – yes, and - - -

MR GRAY: - - - with that practitioner.

DR BARTONE: The centrality of the GP to that solution and to coordinating that is vital and paramount to ensuring both - no fragmentation or duplication or things just going through the cracks but that is a really elegant and very, very robustly resourced model of a much more upskilled solution to the problem.

MR GRAY: And finally, talking about specialists, particularly the specialist component in such teams, as a fallback or as a supplement, what's going to be the utility of looking at the MBS items available to them, including perhaps an expansion of the ability for them to provide rebateable services in the nature of telehealth advice?

DR BARTONE: All of those additional item numbers, including the telehealth item numbers for non-GP specialists, would obviously improve and augment the envelope of services that you could provide to the resident during his or her time of need.

MR GRAY: I want to now go to a question that's specifically about publications of the College. So I really direct these questions - - -

COMMISSIONER BRIGGS: Could I just ask a question.

MR GRAY: Yes, I'm sorry, Commissioner.

COMMISSIONER BRIGGS: I'm sorry, my microphone is not quite working properly. I think I'm getting it now. The question of specialist doctors has been a cause of some discussion over today, and the sad reflection on this is that people in residential aged care have lower access to specialists, more generally, than anyone else in the community. And this is a shocking state of affairs. And it seems the only way they can access specialist services is to be hospitalised. Has either of your organisations - I suppose I should look directly at you, Dr Bartone, from the AMA side because you cover specialists; have you been thinking about what might specifically encourage specialists to act in this field or do we take it as a fait accompli that they aren't going to visit residential aged care facilities, so the people concerned either need to go to a hospital or they need to have transport that takes them to specialist offices to get the kind of investigatory and preventative care that other members of the community are entitled to?

DR BARTONE: In some parts of the country, some models where the "outpatient clinic", in inverted commas, from the local hospital for that said specialty was held in the aged care facility. Now, that could be a model which, if funded appropriately, could work quite well, certainly where there is a significant need or patient requirement.

But the telehealth option is also a very valid way when working in collaboration with the usual regular GP to provide services well and above what is currently available, and certainly would minimise or obviate the need for any inappropriate transportation of patients to the hospital. And, certainly, it's only when things get exceedingly more complex that you have to actually look at that transport requirement.

COMMISSIONER BRIGGS: How common are the specialist outreach services that you speak of?

DR BARTONE: Obviously they vary between State and Territory as well as rural and regional as well as urban and semi – and semiurban. It comes down to the local facility and the – and the degree or the foresight that that clinical care team inside the facility has, I mean, at the hospital to provide that service and work with the community.

It does require a liaison, a GP liaison-type arrangement by the facility with the local GPs. That certainly isn't a reason why it can't occur, but often is a reason why unfortunately, if we look at hospitals, they've become more and more isolated, more and more separated from the communities they serve, and they've become distanced from their primary care services that they, in terms both of communication and accessing and working with that. There is certainly no doubt in my mind that both the primary care team and the hospital could really work more cooperatively if allowed to provide services more at the point of care of the resident.

COMMISSIONER BRIGGS: Is there anything that would force that to occur; and I mean significantly incentivise it to occur?

DR BARTONE: The problem is, of course, that we have a Federal and a State funder, so funding different sides of the equation. COAG and the COAG health processes - through the Health Ministers' forum there is certainly a forum whereby all the people are around the table, and it could be made to be a significant point of responsibility in addressing this area because it is about increasing patient care, patient outcomes and efficiency of scarce health resources.

COMMISSIONER BRIGGS: Thanks, Dr Bartone.

MR GRAY: Before I go to those College publications, I do want to follow up a couple of the points that have been raised in discussion around the team's topic and the coordination topic, and also the remuneration topic.

Dr Bartone, I'll direct these questions principally to you and we will see if Dr Morgan wants to add anything or any different views. The first point is that there seems to be, in the evidence before the Royal Commission, a suggestion of a degree of disinterestedness on the part of primary health practitioners when it comes to visiting residential aged care facilities. It is not 100 per cent explicable just by reference to remuneration issues. That's the first point.

The second point is that in terms of the traditional role of the general practitioner being to coordinate all the care of the patient, whatever setting they may live in, that model seems to have come under strain and to have broken down in a number of situations that have been in evidence before the Royal Commission, perhaps because of confusion as to who really has the role in coordinating care; is it the GP, is it the facility? Perhaps for some other reason. Whatever the reason, is it now time to revisit who should be the coordinator of care and to open the debate up to the possibility that that role should be squarely placed on a designated person who may not necessarily be the general practitioner. What do you say to those points?

DR BARTONE: In response to your assertion that GPs are disinterested, I find that disappointing that that assertion has been made. The disinterest, as you refer to, is about the frustration, the lack of clinical satisfaction, the lack of due processes being available and being followed in terms of the care that's required to be expended or enveloped around that patient. It's about that everything takes a lot longer, takes a lot more effort, and a lot more opportunities for things to go through the, you know, to go through to the keeper because unless you double down, triple down, and ensure that you've exerted even more than what you would normally do, there is a, you know, there's something might have been overlooked, you need to – everything from communication at the moment to the – the record-keeping to the – having to print out additional scripts in that process, and then the recording of the IT incompatibility at the facility with your IT at the surgery, with the fact that you've only just left the facility and you get a phone call to go back.

They're the things that are frustrating and concerning and problematic in terms of ensuring that your expectations of the quality of care that you want to impart for your patient, for your resident that's in there, is why more and more doctors are deciding that no, this – I have a surgery full of patients that also require my attention.

This is a much more efficient and a much more appropriate use of my time because there's the problem of when does – you know, you go to the facility, you think you're going to finish at 6, you're still there at 7, you ring up your home and say you're not going to be home before 8. You're about to get into your car at 8 and there's another – something else has happened and you're there still at 9. That story just happens far too frequently, far too often to be other than a reflection of the process failure that is currently occurring, and that underpins, not just the remuneration, because that can be addressed overnight but the remuneration aside will not address any of those other issues.

[Questions to A/Prof Morgan]

MR GRAY: I'll now ask about the College publications I mentioned.

COMMISSIONER PAGONE: Just before you do, Mr Gray, Dr Bartone, forgive me for going back to your answer to Mr Gray a moment ago, but as you were giving it, about it wasn't a matter of compensation but frustration, I was trying to grapple with the content of the frustration and the content of the cause of the frustration. And some of the content I suppose I can work out by myself. Some of them I can't, and if you're saying that it's not a frustration

that can be helped by remuneration, what is the answer to the problem that otherwise sounds most uncaring?

DR BARTONE: To think that there is a one solution or a one lever that can be manipulated to fix this problem is really the point behind my answer. There are many, many things which need to be addressed. Over the fullness of time, processes which can be measured, which can be documented, researched, collated and data improvement – data used to quality improve the outcomes over a course of time.

Remuneration obviously would be welcome, but that alone isn't going to create the robust increase in the workforce required to ensure that we have a fully skilled and appropriately trained workforce to deal with the increasing amount of aged care residents that are going to be in need of care. So everything - from the systems in the facilities to examine the patients in the facility, to the interoperability of IT systems, to the communication, to the remuneration, to the processes being coordinated, and having that integration between not only just the practice and the facility but having the facility being part of the overall health system because it isn't at the moment - is part of those, all those levers that need to be looked at.

COMMISSIONER PAGONE: I can understand that aspect of your answer and, in a sense, that runs throughout what we're required to do as Royal Commissioners. But you remember what started the answer was Mr Gray's question about - the way he put it, was a lack of – or disinterestedness. Now, putting to one side whether that's the best description or not and whether your response would have been different had instead of "disinterested" he might have used the word "dispirited" or "frustrated" or that it seemed like too big an effort for the reward, that was the context in which you said, no, it's not money that causes this disinterest, but something else.

DR BARTONE: And I'm sorry if I've created a a misunderstanding, but what I was trying to say was that I was taking exception to the word "disinterest".

COMMISSIONER PAGONE: I understand that.

DR BARTONE: And that, really, whatever adjective you want to put there, or description, you certainly need to understand that there are many reasons behind it. But, at the end of the day, as Professor Morgan has already outlined, there are still an enormous number of GPs dedicating their time and their services to the care of their patients in aged care facilities, and will continue to do so, notwithstanding what happens in that remuneration space to a large degree in the immediate future.

But how far can you stretch, you know, can you, you know, pull that lever and hope for the goodwill of the practitioner, especially as an ageing workforce, which is the bulk of a lot of those medical practitioners visiting facilities, reaches the age of retirement, and there's not the replacement coming through because of all the other reasons that we've outlined, including remuneration.

COMMISSIONER BRIGGS: Yes. I wondered if it's okay with you, Commissioner Pagone, have you finished your question?

COMMISSIONER PAGONE: I have, yes.

COMMISSIONER BRIGGS: I've been pondering for some time the issue you raised, Dr Bartone. I'm very conscious of what appears to be the case, namely, that there are quite a lot of older doctors who are attending to older people in residential aged care and marrying that with the issue about the increasing complexity of care and it does seem to have increased dramatically in the time. And we've even heard suggestions in some of the witness – in one of the witness statements today that formerly these people may have been in almost subacute settings in the 70s and 80s, for example.

So there's a real issue about the capability and the size of the medical workforce that supports these groups, and some of the suggestions we've had is that in medical training programs, young people should – young doctor trainees should have placements in aged care. I don't know whether that would work to increase the interest, but there's the broader question of whether or not younger doctors with the experience they have, have the capabilities to deal with this kind of complexity of care need. Do you want to comment on that or let us know what you've been thinking these issues, and perhaps you too, Professor Morgan?

DR BARTONE: I might leave the training question to Professor Morgan.

COMMISSIONER BRIGGS: Yes.

DR BARTONE: Because that's actually the RACGP. But in terms of the – using the aged care facilities as training venues, I would suggest that that would be an excellent opportunity, both for some pilot programs or some scaled-up opportunities to have that kind of training. It seems to me that there is an enormous amount of clinical experiential learning that could occur in an aged care facility, and would be only part of the rounded requirement around the training that would impact in the development of a young GP.

We need to understand that – and Professor Morgan will speak further to this, no doubt, but the training that goes to produce the breadth of capability and skills required to be a GP are becoming wider and wider all the time, and so another venue such as an aged care setting would be an excellent opportunity to actually improve on the training capabilities.

[Questions to A/Prof Morgan]

COMMISSIONER BRIGGS: Perhaps the College and, indeed, the AMA might consider coming back to us to address this – the issues to address these needs specifically because fundamentally we are dealing with a much more complex health issue for elderly people than we have experienced before, because frankly they used to die earlier. I think that's fundamentally what's going on here. So the management of these complex conditions affects the health system, it affects the aged care system and it affects the community more generally with the downstream impacts on families who witness these concerns with considerable concern and in some cases frustration or horror that they can't seem to get the supports that people need. So we would welcome you coming back with further submissions in this regard.

COMMISSIONER PAGONE: And when you do, for the benefit of at least me, who has no background in medical matters except my own ailments over time, you need to explain or make clear how it is that a deepening knowledge of medical practitioners in aged care is the relevant inquiry as distinct from the conditions which in old age one might have. Being old is not a medical condition. Dementia might be, or glaucoma might be or various forms of cancer might be. But how the College might do more in the context of perhaps additional training for practitioners entering into the aged care space is a particular kind of inquiry that is different from becoming an expert in dementia and the other conditions that are likely to be seen in that context.

[Questions to A/Prof Morgan]

MR GRAY: Thank you. Commissioners, if that's a convenient time and if these witnesses could please be excused?

COMMISSIONER PAGONE: Yes. Thank you both for coming to assist the Commission. You more than most, or more than many anyway, I'm sure, understand the significance of the work of the Commission and that your assistance in that regard has been very helpful, both to us and to the public as well as to your members, so thank you for coming and thank you for sharing your views.

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10 December 2019

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