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AMA submission to Department of Health – Residential aged care: proposed alternative models for allocating places consultation

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Background

The AMA thanks the Department of Health for the opportunity to comment on the residential aged care: proposed alternative models for allocating places consultation. While AMA members (doctors) are not typically employed by residential aged care facilities (RACFs), many of their current and future patients reside in them. Doctors work closely with RACF residents and their families (consumers) when they interact with the health care system through hospital visits, and GP and specialist consultations. This submission does not comment on the impacts of a new model on the aged care market as this is beyond the AMA's scope. Instead, the submission focuses on the perspective of AMA members who have, in their work, experienced concerning issues with the current Aged Care Approvals Round (ACAR) and consumer-controlled home care package systems.

The fundamental issue with the aged care system is a lack of funding and resources. The current system is inefficient and does not adequately meet the needs of the older Australians at the times of their highest need. Such an inefficient aged care system then creates greater cost burden to the health system as a whole. These issues must be resolved to have an effective, safe, residential aged care funding process, regardless of the model chosen by the Commonwealth.

Model 1: Improve the ACAR and places management

The current system does not adequately meet consumer demand. While the discussion paper states that the occupancy rate is 90%[1] to 94.3%, AMA members report that there are not enough places to meet demand of older people being discharged from hospital. This is supported by 2016-17 hospital data that shows 11.4 per 1000 patient days are used by consumers waiting for a residential aged care place[2]. The AMA considers that there may be issues with the location of available places not reflecting local need, or that there are not enough local providers to take up the funding. However, there is limited publicly available data for the AMA to assess this fully.

[1] Australian Institute of Health and Welfare (2018) *Services and places in aged care*
[2] Productivity Commission (2019) *Report on Government Services 2019*: Chapter 14. Page 14.17

In the 2018-19 budget, funding for residential aged care places was transferred to home care packages because there were additional funds that were not required to meet perceived demand[3]. This does not match AMA member reports at the coal face, and so if model 1 were to be implemented, significant improvements in accurately predicting and meeting supply and demand issues must occur.

Consideration should be given to the impact model 1 may have on providers of health care services, as well as consumers' access to health care services. Aged care services have an important role in preventing older people from being admitted to hospital. If an aged care service closes and others cannot accommodate the additional demand, a hospital must pick up on the demand. Similarly, if a large RACF opens in an area, this increases demand for GP services. The discussion paper outlines that in 2018-19 around 65% of the places allocated were for the development of new aged care homes. AMA members inform of RACFs being built in certain areas without any consultation with local health care providers. Local GP practices are often expected to take new patients, which may not be possible if their books are already full. The health system is already running above capacity, and demand for GP services will only increase over time to reflect the ageing population.

Model 2: Assign residential aged care places to consumers - Overall model

The AMA does not support the proposed model 2. AMA members feel that the fundamental issue in aged care is a lack of adequate funding and resources to meet the growing demand. Re-allocating residential aged care places to consumers will not solve this problem, but to the contrary, has the potential of making it more costly, harder to administer and create greater inequality. AMA members expressed the view of this proposal as "moving deck chairs on a ship that's sinking". Furthermore, they are deeply concerned that the Government would even consider, in its own Discussion Paper outlining this policy, creation of queues to access subsidised residential aged care. AMA members know too well that by the time their patients get to the stage where they need residential aged care, their conditions are generally such that require high levels of acute care. Even considering the creation of queues for this highly vulnerable cohort to access the level of care that should be their basic human right is therefore beyond comprehension.

If places are allocated to individual consumers, there is a potential risk that some providers may exit the market, and local hospitals will be expected to take on RACF consumers from that area. This will have negative impacts on consumers, but also to the health system, with great costs associated with hospital care that will have to be covered by the state and territory governments. Further, funding security for rural, regional, and remote RACFs must be assured so consumers are able to age in their local community.

Allocating places to consumers directly is predicated on having an informed and supported consumer. Expecting someone in a frail condition and in need of acute care, possibly with cognitive impairment, to be able to research the market, find suitable accommodation and manage the funds and payments to providers in a system that is too complex to navigate is unacceptable. AMA suggests that this proposed policy needs to be considered within the context

[3] Grove, A (2018) *Aged Care Budget Review 2018-19 Index*

of the limited capacities of advocacy services in aged care, a lack of availability of aged care navigation services (which are currently only being trialled out in limited scope and number of locations) and a lack of compensation for doctors to support their patients through this process. As an illustration, AMA members frequently share their frustration with another consumer driven system of care, the NDIS. They report of patients struggling to navigate the NDIS and to access the level of care that they need, and that for most their patients accessing an NDIS package would be impossible without the access to relevant advocacy services. They fear that replicating the same system to older frail patients who frequently do not have family or carers or support people capable of supporting them through the process, will create additional disadvantage for this vulnerable group.

Furthermore, AMA members are deeply concerned that Government would even consider establishment of a queue for this highly vulnerable cohort, especially after the developments around the Home Care Packages program over the last several years. As of June 2019 there were almost 120,000 people waiting for a home care package[4]. More than 16,000 people died between June 2017-18 waiting for a home care package[5]. This is unacceptable.

Consumer-controlled funding should reflect demand and ensure timely access to care. In considering any change, it will be important to ensure that a cue for people needing to access residential care due to their higher care needs is not created, as it would then put additional pressure on the health system. A change in the system should not be implemented without also addressing the waiting times for home care packages. With the current wait times, implementation of a completely new access system to residential care risks creation of even further backlogs and wait times for already vulnerable consumers.

Regardless of the model adopted, aged care navigation support will need to be substantially increased. Home care package consumers have felt unsupported, overwhelmed, and confused about the change to a consumer-controlled market, which further delayed their care[6]. While a listed major benefit of model 2 is that consumers have more choice and control over their residential aged care place, the AMA argues that there is too little publicly available information about RACFs for consumers to be able to make informed choices. COTA's 2018 survey revealed important information around consumer choice and preferences in aged care. Information on My Aged Care is lacking, with many providers leaving information fields blank. Consumers want more information about staff quality (skills and qualifications) and quantity to make more informed choices[7]. The AMA welcomes the mandatory reporting of Quality Indicators, but when and how the data will be published for consumers to compare RACFs in not known. Further, AMA supported the principles behind the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018* in its submission[8] to the parliamentary inquiry.

[4] Department of Health (2019) *Home care packages program data report 4th quarter 2018-19*
[5] Royal Commission into Aged Care Quality and Safety *Transcript of Proceedings – 22 march 2019* page 1098
[6] Australian Medical Association (2017) *AMA submission to the Department of Health: Future reform – an integrated care at home program to support older Australians* Page 1
[7] COTA (2018) Project report: measuring quality and consumer choice in aged care
[8] Australian Medical Association (2018) *AMA submission to the Standing Committee on Health, Aged Care and Sport – Inquiry into the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018*

If model 2 is to be implemented, urgency should be the key factor determining a person's priority. Doctor referrals should influence the prioritisation process. The patient's usual GP will be aware of their patient's health and complexity of their health care and aged care needs. Referrals from other specialists such as geriatricians and psychogeriatricians should also be included in the prioritisation criteria. An assessment of needs at a given time represents a snapshot of that person at that time and the most likely scenario is a progressive upscaling of needs. While a consumer may be put at a lower level of priority when assessed, their situation may change and deteriorate rapidly, which may not be reflected by their position on the queue. There should be an appropriate mechanism enabled to their GP or other practising specialist to be able to push forward their application if deterioration occurs. Similarly, if a consumer on the queue is admitted to hospital, that should trigger their prioritisation. Appropriate arrangements should be established to share information between the two systems. In that sense, connecting My Aged Care with My Health Record would be beneficial, provided all privacy and security measures are met.

Date of approval is important too, but if the creation of this system leads to establishment of queues and waiting lists, date of approval stops being relevant for reasons explained above.

Conclusion

The fundamental issue in aged care is a lack of adequate funding and resources to meet growing demand. In this submission, the AMA has highlighted some major issues with the ACAR and home care package systems that need to be resolved moving forward. Where ACAR places are allocated, significant improvements in accurately predicting and meeting supply and demand issues must occur. More consideration needs to be given regarding capacity of health care services in an area before a new RACF is built. The AMA does not support a consumer-controlled model. However, if implemented, it must be adequately funded to ensure that long waiting times, as seen in the home care package prioritisation queue, does not occur. This is essential to ensure consumer health and safety. If a consumer-controlled model is implemented the consumer's doctor should be given a greater say in determining their place on the prioritisation queue. Finally, there must be more publicly available information so consumers can make an informed choice about their care, and aged care navigation services must be improved.

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