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AMA submission to the Royal Commission into Aged Care Quality and Safety – Response to Consultation Paper 1 - Aged Care Program Redesign: Services for the future

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Introduction

The Australian Medical Association (AMA) welcomes the opportunity to respond to the Royal Commission into Aged Care Quality and Safety (the Royal Commission) Aged Care Program Redesign Consultation Paper 1 and to provide input into designing aged care services for the future.

The AMA has previously provided a comprehensive submission to the Royal Commission[1], that will be referenced throughout this document. In addition, the AMA President Dr Tony Bartone appeared as a witness before the Royal Commission twice.

The AMA has long been calling for reforms of the Aged Care Sector and has supported the findings of the Royal Commission's Interim Report. As noted in the previous AMA submissions, the work of the Royal Commission is seen by AMA members as an opportunity for real reform of the aged care sector, that will bring improvements and innovations so greatly needed. It is an opportunity to create an environment and a system that promotes good care for the most vulnerable members of our society into the future.

In this submission the AMA responds to the Royal Commission's proposal for the redesign of aged care services and provides the medical practitioner perspective on the proposed redesign concepts. By responding to the design questions, the AMA will outline its support or lack thereof for specific solutions, AMA's views on system navigation, role of GPs in system navigation, appropriateness of medical care for older people and how the aged care and health systems could best work together to deliver care which better meets the complex health needs of older people.

[1] Australian Medical Association (2019), *AMA Submission to the Royal Commission*

The responses to the Consultation Paper design questions reflect the views of AMA members and their experiences working in the aged care sector. In considering the proposed design, AMA members reiterate that health and aged care should be considered two parts of the same system that should be designed to optimise health and wellbeing of older people. While this consultation does not address intersections with health care, AMA members raise some of the key issues that they feel would need to be resolved to avoid further distancing of doctors from aged care.

Firstly, AMA members raised the issue of non-remunerated time and effort involved in providing medical care in RACFs, where a one-hour visit assessing patients often entails at least an additional 2-3 hours of non-remunerated work. For further detail, see pages 3 to 7 of the AMA's main submission to the Royal Commission.

Secondly, AMA members reiterated the importance of a GP-led collaborative relationship with pharmacists for the benefit of older people. Such collaborative arrangements will facilitate a reduction in polypharmacy. Medication review regulation is currently too restrictive and is hindering its effectiveness. Medication reviews should occur annually, and when there is a significant change in the older person's medication and/or medical condition. For further detail, see pages 32 to 34 of the AMA's main submission to the Royal Commission.

Design questions

1. What are your views on the principles for a new system, set out on page 4 of this paper?

The AMA supports the principles proposed by the Royal Commission in the consultation paper. Older people accessing aged care services need to be put at the centre of any future redesign of those services, including the intersection of aged care and health care.

The AMA supports the proposition of effective interfaces with other relevant care systems, particularly health and disability. The AMA is also supportive of any strategy that will enable the recruitment and retention of a skilled, professional and caring workforce. The AMA has consistently called for minimum mandated staff-resident ratios that can be adjusted according to care need, and the availability of registered nurses (RNs) 24/7 on-site at residential aged care facilities (RACFs). Additionally, and as stated in the AMA Submission to the Royal Commission from 30 September 2019, the AMA believes that accreditation and evaluation of residential aged care providers by the Aged Care Quality and Safety Commission should include staff turnover, as staff turnover is often reflective of poor governance/ management culture of RACFs and poor care culture.

2. How could we ensure that any redesign of the aged care system makes it simpler for older people to find and receive the care and supports that they need?

It is the AMA position that the aged care and health care are two parts of one system that should be set up to optimise health and wellbeing of older people. Therefore, the AMA argues that general practitioners (GPs) form a centrepiece of aged care service design, as they are involved in all stages of aged care, from entry point to the system to the end of life care. GPs perform an important role in system navigation for many older people, from connecting them

to My Aged Care to advocating for their needs once they are receiving aged care services. In order for GPs to perform this important role, the AMA maintains that they should be appropriately supported and adequately funded.

More details on the GP role in the system will be provided throughout this submission, including the role of GPs in system navigation. Also see response to question 3.

3. Information, assessment and system navigation.

What is the best model for delivery of the services at the entry point to the aged care system - considering the importance of the first contact that older people have with the system? This includes looking at services provided by phone and website as well as face-to-face services.

System Navigator

The current system fails to ensure that care for an older person at an acute point, or when they require a high level of care, is optimised before decision is made on the type (Home Care Package (HCP), residential aged care facility (RACF)) of care or level of care required. In that sense, a navigator who can follow the person needing care, from the point of application to the end of their journey, would be most beneficial in the AMA's view. The navigator should be independent of aged care service providers so they can act in the best interest of the older person without potential conflicts of interest. In addition to coordinating services with aged care providers, the navigator should also communicate with the older person's usual GP when clinical care is required. Navigators should also have thorough knowledge of the aged care, disability, and health systems.

The AMA is aware that in 2018 the Aged Care System Navigator trial was initiated, and a contract was awarded. However, a year later there has been no report, no measurable impact information on the trial itself or how it benefited the consumers that the AMA is aware of. Understanding the outcomes of that trial may be beneficial to further inform the work of the Royal Commission. The system navigator need will be discussed in more detail throughout this submission, providing more insight into how the system navigation should operate in the AMA view.

The current aged care system is difficult to grasp and navigate for older people. A particular flaw is that the point of access is by telephone and through a web portal. A National Seniors' survey from 2019 showed that 59.34 per cent of older people rarely or never use internet to access Government services[2] (noting this trend may change over time). Further, often older people have hearing problems, so access by telephone is not appropriate. Accessing My Aged Care by telephone often requires waiting and being put on hold for long periods of time, which can be too burdensome for older people. For people from Culturally and Linguistically Diverse (CALD) backgrounds, using a telephone to access services, including My Aged Care, is seen as inappropriate, as CALD older people, due to insufficient English language proficiency,

[2] National Seniors (2019), Senior surfers – *Diverse levels of digital literacy among older Australians* Page 11

often lack the confidence to use the telephone for service access[3]. Clearly, older people need support when accessing and navigating the system, and that support needs to be face to face.

The role of GPs in system navigation

The AMA submission to the Royal Commission dated 30 September raises the issue that the current system, in particular My Aged Care, fails to recognise the role of the usual GP in caring for an older person. AMA members have reported that even when clinical information is communicated to My Aged Care, it fails to be forwarded to ACAT teams for assessment purposes.

According to the Streamlined Consumer Assessment for Aged Care Discussion Paper from 2018, over the years the number of referrals by health professionals has been steadily increasing, reaching approximately 56,000 referrals in the last quarter of the 2017-18 financial year[4]. Clearly, health professionals, including doctors, play an important role in connecting older people to My Aged Care, as well as navigating their patients through the entire process.

In September 2019, and following a steady and systematic AMA advocacy, the Department of Health implemented GP e-Referrals system, allowing GPs to make referrals directly from their clinical software by introducing an e-Referral option into the patients' medical records[5]. AMA members welcomed this move by the Department of Health. However, further steps must occur.

As explained in the AMA submission to the Royal Commission dated 30 September 2019, doctors should be kept informed whether their older patient is receiving the services they have been referred to in a timely manner. Some older people, such as those with cognitive impairments, require a doctor or other person to request services on their behalf because they cannot do it themselves. Without a feedback loop to the doctor or other referrer, there is a risk that the older person will not be receiving the services they need. With a feedback loop, doctors can act if a delay puts the older person's health at risk. The AMA calls for feedback loop capability within clinical software programs, in addition to the referral form being integrated within clinical software programs. This will reduce the administrative burden placed on GP practices and reduce the risk of harm if older people are not receiving the services they have been referred to. Currently, for example, the dashboard that displays the position in the queue of a patient that has been assessed for a home care package is not available to GPs. A GP must inefficiently call My Aged Care to track their patient's progress. If doctors were kept informed of the developments and progress of the aged care process for their patients, they could act when any delays or long waiting times put their patients at risk. The AMA included the following recommendation in its submission:

Recommendation 33: Greater transparency for GPs and patients to be able to view the progress of aged care assessments. This will provide GPs with confidence that their patients

[3] Federation of Ethnic Communities Councils FECCA (2017), *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* Page 13
[4] Australian Government Department of Health (2018) *Streamlined Consumer Assessment for Aged Care* Page 9
[5] Australian Government My Aged Care (2019) *For Health Professionals*

are being provided with the necessary care in a reasonable timeframe, as well as enable GPs to take action if this is not occurring.

AMA members often report that their older patients who find themselves at an acute point in their lives and are mostly unaware of where to go for help or how to access aged care services. Often their main link and source of information will be their GP. In addition to being able to link them to My Aged Care, GPs enable continuity of care, which is linked with improved health outcomes for older patients[6]. GPs are familiar with their older patient's situation, their medical histories, important medical conditions that can affect their physical function, and any disabilities that their patients may have. The AMA therefore argues that in the context of the model of delivery of services at entry point, GPs should be better supported. This would be beneficial further down the track in terms of care coordination for older people entering aged care.

In the Submission to the Royal Commission dated 30 September 2019 the AMA has explained the important role the GPs perform in supporting their elderly patients both when entering aged care and when in aged care. On pages 4 to 9 the Submission elaborates on the issue of lack of remuneration for non face to face time for GPs and argues for introduction of an MBS telehealth item for telephone calls for GPs when interacting with patients accessing aged care.

The AMA urges the Royal Commission to take into consideration the fact that a lot of older people reach out for aged care services in an acute health point in their lives. Many older people may not have family members or relatives and friends who can support them through this process. Often their only chance to reaching out and obtaining services is through their GP. If that GP is then able to identify and establish a connection with the system navigator for a specific area where the older person lives, that would bring enormous benefits to the older person.

As mentioned previously, this year the Department of Health enabled the interoperability between My Aged Care and GP clinical software. Doctors are now able to submit requests for aged care assessments from their clinical software. An option that would facilitate engagement of navigators could be that when a doctor submits a request for an aged care assessment, it would automatically trigger the engagement of a system navigator in the local area. That person would then be able to connect directly with the older person and their GP, obtain all the relevant information and provide support to the older person, from the ACAT assessment to obtaining services required, to helping them once in the system and receiving services by advocating for their individual needs.

The AMA has provided other recommendations as to how the current system could be improved in the AMA Submission to the Royal Commission dated 30 September. It is the AMA's view that the current system fails to capture the information doctors hold or engage with the doctors when older people are in need of aged care services.

[6] Barker, I Steventon, A, and Deeny, S (2017) *Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data* BMJ. 356:j84

4. Entry-level support stream.

People maintain their homes and gardens, do laundry, cook meals, get themselves to appointments and attend social engagements across their whole adult lives - some people may choose to pay others to do these things - but mostly they handle them with little assistance. As people age and need support with everyday living activities, how should Government support people to meet these domestic and social needs?

The AMA argues that there are lifestyle choices and changes that if implemented can reduce a person's risk and impact of impairment and adverse health conditions in older age. They include physical activity, a healthy diet, maintaining a healthy weight, positive supportive relationships and participation, undertaking preventive health activities, and disease management. Therefore, the AMA maintains that there needs to be a focus on healthy ageing in policies and services to maintain a person's functional ability as they age. Those policies and services should better support medical practitioners, in particular GPs, to implement preventative care.

Additionally, community-based services should be better coordinated with GPs when developing programs that promote optimal health of older people. This is particularly important as we know that many older people prefer to age in their own homes and community. Therefore, adequate access to primary care and coordination with community care should be the focus of future policy development.

The AMA argues that Primary Health Networks have a role to play in designing the community services to meet the needs of the local community. They should be able to identify those needs and any gaps in available services, based on which appropriate solutions should be identified. In addition to this, early medical assessments of older people are crucial to ensure that people who want to age at home are supported and enabled to maintain their independence for as long as possible. Finally, community care services should include programs that facilitate transportation for older people, so they can access medical, health and social services and activities.

5. Investment stream.

The benefits from regular and planned respite, reablement and restorative care are well documented, but the services are in short supply. What incentives, including additional funding, could be introduced to encourage providers to offer greater and more flexible options, including major home modifications and assistive technologies, which meet the needs of the older person, carer and caring relationship?

The AMA supports care streams that are preventative and proactive. In the recently published position statement *Innovation in aged care*, the AMA argues that Australia must actively seek innovative ways to sustainably provide high quality care in the face of an ageing population with complex care needs[7]. Digital health and assistive technologies have the potential to significantly improve the aged care system through increased efficiency and coordination of

[7] Australian Medical Association (2019) *Innovation in Aged Care Position Statement*

care providers, and increased independence and health of older people. The use of assistive technologies could also be considered through the ACAT assessment. The AMA contends that monitoring technologies provide opportunities for longer independent living of older people.

It is widely understood that older people prefer to stay at home as they age. Investment in technologies that would help them live in their preferred setting and enable preventative proactive action should be the focus of investment for the Australian Government. Such investment would ensure that the aged care sector is kept up to date with broader technological developments and that mainstream developments are accessible to all those accessing aged care services, not just those who can afford them. Investment in aged care innovation should aim for improved effectiveness in the provision of health and aged care services and maximising health benefits for older people. It should enable: improved data collection, secure and appropriate distribution, storage and retrieval; better understanding of older people's needs; improved monitoring of care and quality of care; better communication between all stakeholders and enhanced information management[8].

It is the AMA view that further improvements of respite care programs are needed, along with additional government investment into respite care. The AMA has in the past called for a streamlined process to improve urgent access to respite care for older people who have not yet been assessed by an ACAT, for those who have been assessed but are awaiting a home care package, or those who have not yet entered the aged care system. Access to respite care could be streamlined by allowing GPs to approve respite care for older people in much the same way a doctor determines that a hospital admission is necessary. GPs are best informed about their patient's circumstances and requirements and are able to spot any deterioration in their health and are therefore best placed to refer their older patients to respite care.

The AMA argues that the wellness and reablement approach promoted by the Government through its recent policies[9,10] requires better integration between health and aged care systems. Doctors, particularly GPs, regularly incorporate preventive care and reablement (or rehabilitation) as part of providing holistic, long-term, health and medical care. GPs also provide the medical home for many older people; coordinating their complex care requirements, ensuring access to services and advocating on their behalf. It is imperative that older people have access to a regular GP and that an older person can access GP-referred services provided by other health professionals. The My Aged Care workforce should work with GPs in developing programs to promote the optimal health of older people before impairment develops.

In addition to the older person's usual GP, the ACAT assessors should ensure access to allied health professional services that focus on wellness and reablement - this includes psychologists, physiotherapists, speech pathologists, dieticians, and podiatrists. Older people living in RACFs can also benefit from wellness and reablement strategies, however they have difficulty accessing allied health professional services. A good example of positive practice is

[8] Australian Medical Association (2019) *Innovation in Aged Care Position Statement*
[9] Australian Government, Department of Social Services (2015) *Living Well at Home: CHSP Good Practice Guide*
[10] Australian Government, Department of Health (2018) *Review of wellness and reablement in the home care sector*

diversional therapy, for instance. AMA members are aware of instances of diversional therapy implementation that has resulted in significant benefits to their patients.

6. Care stream.

As people's needs increase and go beyond what can be managed with entry-level support or with their carer, they may need care services - personal care, as well as nursing and allied health. What are the advantages and disadvantages of developing a care stream, independent of setting?

Although the AMA in principle supports the notion presented by the Royal Commission that people in the care stream should be able to receive the care they need, when they need it, regardless of setting, the AMA has some concerns around the model proposed by the Royal Commission, especially around its implementation and possible duplication/lack of coordination between multiple services. Below are some of AMA concerns and questions regarding the feasibility and implementation concerns of the proposed model:

- Would the proposed care streams work more as levels of care need (for example, investment, then entry level, then care and health)? How would this work in practice if a person requires funding from more than one or all streams?
- Would aged care providers need to specialise in one of the three care streams? The AMA is concerned that this would not constitute person-centred care, as the older person will need to access different aged care providers for different reasons. This additional coordination and navigation might be inefficient and complex for an older person. The AMA maintains that aged care services should be holistic. Additionally, Aged Care Quality Standards put responsibilities on aged care providers to facilitate access to external services.
- Does the Royal Commission expect accommodation to be a separate service to care, delivered by separate providers? If an individual with high care needs requires nursing care 24/7, and external nurses are required, this would mean they would require multiple nurses to come in different shifts. It would be more efficient for nurses to exist in a hospital-like system (i.e. nurses attending patients in rounds). There are already declining numbers of nurses working in RACFs, due to low remuneration and because aged care providers fail to employ sufficient numbers to meet the patients' needs. There are also concerns of high turnover and increased reliance on agency nurses who do not know their patients, which affects the quality of care. The same principle would apply to personal care attendants, but probably less-so for allied health professionals because are they are not providing care 24/7.
- This proposal may have particularly detrimental effect to people living in rural and remote areas, where we know already there are not enough providers. An existing provider of aged care services could choose not to provide certain services, and then the older person may not have access to that service if it does not exist in their area, for example.
- With more separate providers for basic care needs comes more divisions of responsibility – there would need to be a lot of work into accountability and legal issues as well as a restructure of the Aged Care Quality Standards.

The AMA supports the Royal Commission's proposition around greater engagement of allied health professionals to provide services in aged care. The AMA has previously raised concerns that currently there are a number of allied health services that people in aged care, in particular residential care, do have access to. This includes but is not limited to dentists, psychologists, physiotherapists, dietitians, podiatrists, and speech pathologists.

Under the current legislation, RACFs should provide therapy services to residents, depending on their funding classification, as part of the overall RACF service provision, with no additional cost[11]. Additionally, Medicare provides limited funding for some allied health services, of up to five allied health sessions per year for eligible residents of RACFs, under a multidisciplinary care plan developed by a GP[12].

If the Royal Commission was to recommend, and the Government to introduce, this new model, and separate funding stream for community nursing and allied health services, the AMA fears that the aged care providers would further negate their legislative responsibilities. Furthermore, this could introduce additional confusion around the Medicare funded GP referred allied health services, and potentially duplication. A potential option would be to increase the number of health sessions per year under the multidisciplinary care plans developed by GPs and ensure that RACF residents can receive the same Medicare funded allied health items as the rest of the population.

7. Specialist and in reach services.

How could the aged care and health systems work together to deliver care which better meets the complex health needs of older people, including dementia care as well as palliative and end of life care? What are the best models for these forms of care?

Doctors have to be at the centre of any design models where aged care and health care intersect. In the submission to the Royal Commission, the AMA stated:

Recommendation 1: Retaining and increasing the number of doctors interested in working in the aged care space should be the focus of any future reforms in aged care if appropriate clinical care is to be provided. Investing in primary care for patients in aged care settings will save on public hospital expenditures.

As the AMA noted in the submission, any future planning will need to take into consideration the forward-looking trends of expenditures related to Australia's ageing population and the projected needs of the medical workforce. The AMA explained why GP rebates for RACF visits need to increase by at least 50 per cent to adequately compensate for the additional time and complexity of caring for patients in RACFs.

Additionally, and as the AMA President Dr Tony Bartone explained in his witness statement before the Royal Commission during the Canberra hearing, the AMA supports blended

[11] Australian Government, Federal Register of Legislation *Quality of Care Principles 2014*
[12] Australian Government, Department of Health (2017) *Chronic Disease Management - Individual Allied Health Services Under Medicare - Residential Aged Care Facilities*

payment models for GPs working in aged care. The AMA argues that while the current model of PIP and MBS is inadequate because it does not adequately compensate for the non-contact time between GPs and patients in aged care, the principle of that type of payment remains sound. The AMA is represented at the Primary Health Reform Steering Group[13] established by the Department of Health that is looking into voluntary nomination payment for patients over the age of 70 in the community that choose to nominate a GP or a GP practice as their usual doctor. The AMA expects that this kind of arrangement, if properly established and adequately funded, including the review of GP MBS funding, could be the axis of the blended payment method.

The AMA also supports, as confirmed by Dr Bartone during his witness statement, the amendment and liberalisation of rebates for comprehensive health assessments, so as to make them more frequent for older people in both residential and home care.

The AMA is supportive of the concept of multidisciplinary outreach care teams. The AMA is aware that in the states that they operate in, they have had positive results and achieved improved patient outcomes. One such example is the in-reach service operated by Brisbane North Primary Health Network (PHN), the Metro North Radar Service[14], a Nurse Navigator led service facilitating access to outreach services.

The AMA would argue that arrangements for operation of such teams should be expanded nationally, and appropriate funding procedures should be established. The AMA's view is that these teams should include non-GP specialists such as geriatricians, psychogeriatricians, and psychiatrists. 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. The AMA also argues that these teams should be complementary to the services GPs provide in RACFs and should not be performing care without coordination with the patient's usual GP. Any non-GP specialist services must work directly with, and must not replace GP services, which should be the backbone of health care provision in aged care. AMA members who work in RACFs have pointed out complex wound management as one specific area where outreach teams working in coordination with GPs would be most beneficial. AMA members report that currently these services are under-resourced.

A system in which the outreach services work in coordination with the patient's usual GP will achieve its best value once proper shared clinical online systems are established, that are RACGP standards compliant. This should facilitate improved communication and exchange of information is functioning and may prevent any unwanted loss of patient's information. This is important because older people frequently move from RACFs to emergency departments and then to hospital. Outreach teams are another actor that is added to an 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.

[13] Australian Government, Department of Health (2019) *Media Release: Primary Health Reform Working Group Established*

[14] PHN Brisbane North (2018) Media Release: *Metro North Radar Service Now Available*

The AMA supports and has been calling for the interoperability between My Aged Care and My Health Record. Once established, that interoperability would enable the use by clinicians, RACFs, Assessors (if they are clinicians) and Navigators (again if they are clinicians) as a method of backup of communication across aged care.

8. Caring for people with diverse needs and in all parts of Australia has to be core business - not an afterthought. How should the design of the future aged care system take into account the needs of diverse groups and in regional and remote locations?

The AMA welcomed the MYEFO announcement[15] that the Government will provide $10 million over four years from 2019-20 to create a dedicated network of Aged Care System Navigators to assist people from CALD backgrounds to access the aged care system.

The AMA is also aware of the current undertakings by the Department of Health to reform the Aged Care Funding Instrument (ACFI). The proposed new model of funding, the Australian National Aged Care Classification (AN-ACC), that is being considered to replace ACFI has multiple features that will lead to the improvement of the system and that the AMA supports. However, the AMA believes that this new model could be improved by recognition of special needs groups when designing this model, through introducing cost variability for special needs groups. This would be beneficial, for example, for CALD older people living with dementia, who often lose their secondary acquired language skills, and revert back to their original language[16,17].

What the AMA has observed throughout the Royal Commission hearings is that people living with dementia in RACFs are often sedated because providers are not able to manage their distress. For people of CALD background who have lost their English language skills the distress may be even greater as they are unable to communicate the cause, any health issues, or any pain they may be feeling.

This presents two options: they are either transferred to hospital or they are prescribed medication to manage their behaviour. Indeed, the recent *Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge* indicates that in NSW the most common reason for avoidable hospitalisations is behaviour management (78 per cent)[18]. The report found that "primarily the lack of RACF ability to meet the cultural needs of older people from culturally and linguistically diverse (CALD) backgrounds in relation to the provision of good quality care and hospital avoidance" are considered as key reasons for inadequate care. The report also notes that CALD older people "can often be labelled as a difficult resident or patient, which may be simply because they are not being listened to or understood and therefore can become frustrated".

[15] Australian Government *Mid-Year Economic and Fiscal Outlook MYEFO 2019-20* (2019) Page 232
[16] Department of Health (2019) *Actions to Support Older Culturally and Linguistically Diverse Older People* Page 5
[17] Royal Commission into Aged Care Quality and Safety (2019) *Transcript of Proceedings 6.5.19R1* Page 1151
[18] NSW Aged Care Round Table (2019) *Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge* Page 11

Interpretation, or employing workers of the same CALD background, should be the way to manage this issue, and that funding has to come from somewhere. Currently, funding for interpreting services in aged care setting is limited to agreement negotiation, understanding of care plans and monthly financial statements. The cost of involvement of interpreters for other purposes has to be borne by the consumer[19,20]. The AMA calls for this new model to recognise the variability of care costs related to special needs groups.

Hospital transfers of older people are costly to the health system. The Government wants to reduce inappropriate prescribing of antipsychotics. Consequently, CALD patients with dementia could be caught in this gap, which could potentially make them the target of discrimination when entering aged care. The RACF providers might not want to take them on, because of the risk associated with managing their behaviour.

9. Financing aged care.

What are the strengths and weaknesses of the current financing arrangements and any alternative options that exist to better prepare Australia and older Australians for the increasing cost of aged care?

The AMA has addressed the issue of aged care funding in the AMA Submission to Royal Commission dated 30 September[21].

The AMA would however like to highlight once again that without GP involvement and provision of care for older people in the aged care system, that care will be inadequate, insufficient and will lead to worse health outcomes for older people. In AMA's view, one of the key issues is the health system underfunding of GPs to provide the important service in aged care. So, unless there are significant reforms to GP funding, any reform of the financing of aged care will not be as effective as possible in producing better health outcomes to older people and concerns around their care will continue.

AMA concerns around the new residential aged care funding model, the Australian National Aged Care Classification (AN-ACC), are explained in the submission to the Department of Health[22]. The AMA acknowledged that this significant reform would need to be improved over time as unknown risks emerge. For this reason, the AMA regards the AN-ACC model as a positive first step to improving the funding of the aged care sector in order to improve the quality of care older people receive. The AMA cautioned that Cost per National Weighted Activity Unit (NWAU) prices must be adequate, sufficiently indexed, and adjusted for staff wages growth so quality care is not compromised by a lack of funding. The AMA urged the Department to consider the existing issues under the hospital NWAU system when considering and developing the AN-ACC model context.

[19] Centre for Cultural Diversity in Ageing Practice Guide: Accessing Interpreter Services
[20] Australian Government, My Aged Care Interpreting support for service providers - Home Care Packages Programme
[21] Australian Medical Association (2019), *AMA Submission to the Royal Commission* Pages 4-9, 26
[22] Australian Medical Association (2019) *AMA submission to the Department of Health – proposal for a new residential aged care funding model.*

10. Quality regulation.

How would the community be assured that the services provided under this model are delivered to a high standard of quality and safety?

The AMA is aware that prior to the introduction of the new Aged Care Quality Standards (the Standards) from 1 July 2019, there used to be separate standards for different types of aged care provided, i.e. home care, CHSP, residential aged care. The reason behind the introduction of the single quality standards for all providers of aged care services was so that the system aligns with the objectives of the broader Government's policy that is based on principles of ageing in place, achieving consumer directed care and market based competition. The 2016 Aged Care Roadmap produced by the Aged Care Sector Committee stated that new standards are required because increased consumer choice is needed, that will enable "increased market competition (that) will provide incentives to providers to respond to consumer needs and expectations, and drive competition in quality"[23]. The Consultation Paper by the Royal Commission now, three years later, seems to be portraying quite a different picture.

In the submission to the Royal Commission dated 30 September, the AMA expressed the view that even though the recently introduced Standards include important principles such as dignity, respect and engagement of older people through obtaining their feedback on the services they receive, the AMA believed that the Standards were high level, subjective and potentially vague. More details can be found on pages 23-25 of the AMA submission. The AMA also provided this recommendation:

Recommendation 18: More specific Aged Care Quality Standards, including a Medical Access Standard should be developed for RACFs that help facilitate access to doctor services and high-quality clinical care.

While the idea behind allocating funds to older people rather than providers is noble in its intent and is based on principle of consumer directed care, the AMA has some concerns around it in the current aged care setting, particularly in relation to residential aged care. In our submission to the Department of Health consultation on Residential aged care: proposed alternative models for allocating places, the AMA expressed concerns of its members around this new proposed model:

"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 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"[24].

[23] Aged Care Sector Committee (2016) *Aged Care Roadmap* Page 13
[24] Australian Medical Association (2019) *AMA Submission to the Department of Health – Residential Aged Care: proposed alternative models for allocating places consultation* Page 2

If funding is to be allocated directly to consumers, there must be services available for those consumers to use, such as advocacy and system navigation, that would have to be independent of the aged care providers and working in the best interest of their clients/older people.

Conclusion

The AMA is supportive of any model that will enable holistic care for older people, avoiding fragmentation and enabling continuity of care. In the AMA's view, aged care and health care should be treated as two parts of the same system that should aim to improve health and wellbeing of older people as they age and come to need specific services. For too long, GPs at the centre of the healthcare of older Australians, in the community or RACFs have felt marginalised, and sidelined from the Aged Care system in which their patients reside. In addition, they have had their ability to provide high quality care continually eroded from a funding perspective.

The AMA is supportive of the principles of design of the new aged care system, as proposed by the Royal Commission. The AMA's main concern, as explained in the submission is around the proposed new model of personal care, nursing care and allied health, within the three-tiered care streams. The AMA fears that as envisaged at the moment, this would create duplication and potential conflict between different providers of services (RACF, HCP, restorative care), or lead to avoidance of provision of services that aged care providers are expected to provide to consumers under the current law.

The AMA remains open to working with the Royal Commission in the future to develop the best possible model of care for our older people.

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