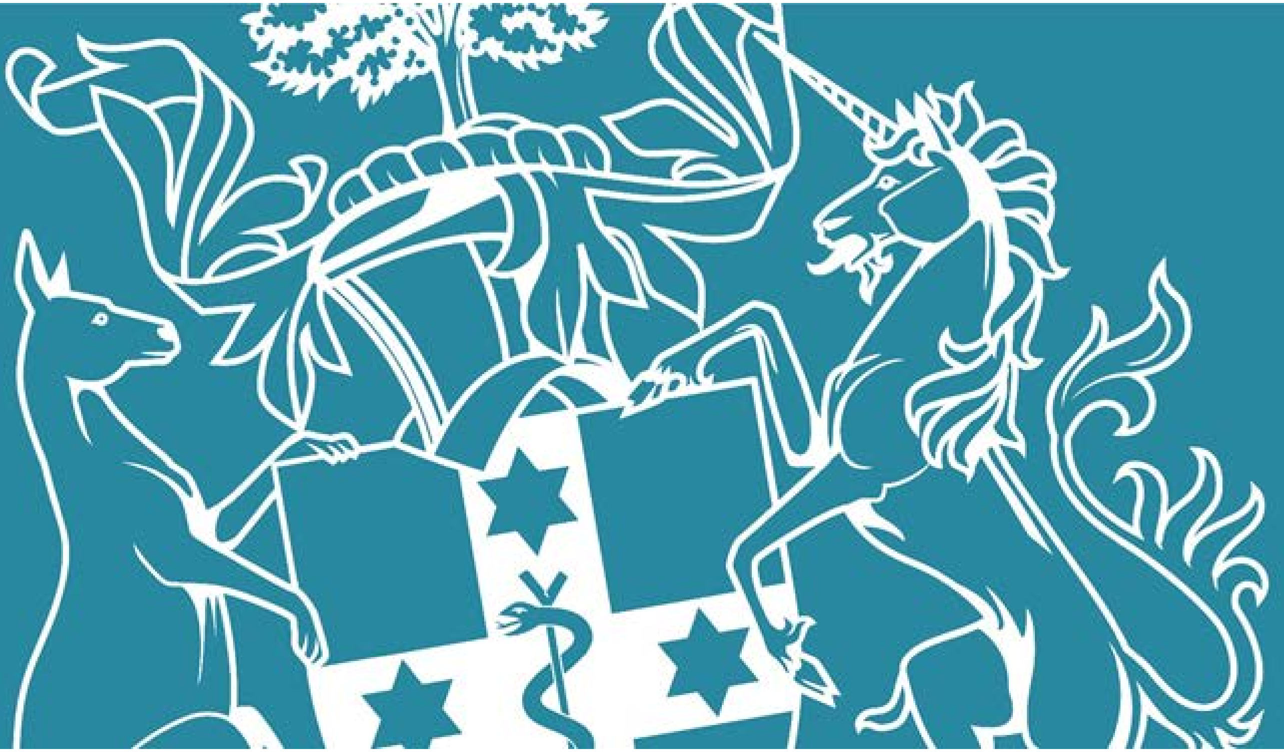
Royal Australian College *of* General Practitioners

Supporting sustainable GP-led care for older people

Position statement – October 2021



1. Position

The RACGP considers that high-quality care for older people requires:

- general practitioner (GP)-led multidisciplinary care
- recognition of the spectrum of healthcare needs and preferences of older people with diverse characteristics and experiences
- continuity of information about patients and their care
- proactive place-based community care
- residential services with sufficient capacity and capability
- collaborative engagement between all staff, family members, carers and the treating GP
- technology and physical infrastructure which is fit-for-purpose
- co-design by care providers and users of the system.

2. Recommendations

The RACGP recommends:

- greater investment in medical services for care provided both in residential aged care facilities (RACFs) and in the community through blended funding models which incorporate fee-for-service, complexity loading and recognition for high-quality care
- improved capacity and capability of clinical and non-clinical workforces, particularly in residential aged care
- Medicare supported telehealth for aged care staff, family members and carers to consult with the GP, including when the resident is not present

- voluntary patient enrolment (VPE) with a patient's GP/general practice, including people over 65 in the community, residents of aged care facilities and all Aboriginal and Torres Strait Islander people, with additional resourcing
- interoperability of information and other technology systems between aged care services, pharmacy, hospital and general practice
- increased support for GP involvement in clinical governance, clinical oversight and aged care sector reforms
- more support for Aboriginal and Torres Strait Islander leadership and participation in aged care decision-making and service delivery.

3. Background

3.1. Role of GPs in aged care

GPs are an essential part of the medical workforce providing care to older people (those over 65 years of age).

GPs are core to keeping people well and in their home, providing health risk assessments, primary and secondary disease prevention, population health programs such as cancer screening and immunisation, and tracking and management of chronic disease. GPs work closely with other medical specialists, nurses, allied health professionals, support workers and administrative staff to deliver services to older people.

Over 90% of older people still live in the community, and most of the aged care services provided in Australia are delivered to people in the community rather than RACFs. During 2019–20, nearly 840,000 people accessed the Commonwealth Home Support Programme, while at 30 June 2020 a total of 335,889 people were using residential aged care (permanent or respite, 189,954), home care (142,436) or transition care (3,499) in Australia.[1]

In 2018, 97.5% of people in Australia aged 65 and over saw a GP. In 2018–19, there were over 36 million Medicare claims for GP attendances for people aged 65 and over – 29% of the total 124 million claims for GP attendances. There were more than twice as many claims per person for those aged 65 and over than for those aged under 65.[2]

While the proportion of people in permanent residential aged care who saw a GP was slightly less than those receiving home care or home support, people in permanent residential aged care had just over 60% more GP visits than those receiving home care. People living in permanent residential aged care averaged almost one GP attendance per fortnight (25 during the year) in 2016–17.[1]

The GP has a key role in maintaining person-centred continuity of care over time, including supporting transition of care when a patient moves to residential aged care.[3] The transition from home-based care to RACF care requires intensive management due to the high rates of multimorbidity, further increasing the demands for comprehensive GP-led care. For older people in residential care, regular well-planned primary healthcare provided by a GP supports health and wellbeing and can reduce crisis-driven care.[4]

3.2. Hospitalisation rates of older people

High hospitalisation rates for older people, including potentially preventable hospitalisations, reflect the ongoing issues with access to and capacity of aged care services.[5,6]

In 2018–19, the most common reasons for people over 65 being admitted to hospital were cancer, musculoskeletal conditions and other factors influencing health status.[7] Hospital and emergency department data acquired from states and territories shows that, in 2018–19, 36.9% of aged care residents presented to an emergency department at least once. 31.1% of residents were admitted to a public hospital at least once, with this figure increasing to roughly 37% when private hospital admissions are included.[8]

Australian data shows aged care residents are being hospitalised for reasons that are potentially preventable. For example, in 2018–19:

- 10.5% of residents had one or more hospitalisations for a fall
- 5.4% of residents had one or more hospitalisations for a fracture
- 22.2% of the residents entering or re-entering an aged care facility from hospital had an emergency department re-presentation within 30 days.[9]

4. Discussion

4.1. Strengthening primary care is key to improving health outcomes and quality of life for older people.

The RACGP's *Vision for general practice and a sustainable healthcare system* sets out a roadmap for sustainable healthcare through a strong primary care system that provides high-quality continuous and comprehensive care for all.[10]

Older people are more likely to have multiple chronic conditions and require greater coordination of clinical and non-clinical resources.[11,12] As such, GP-led multidisciplinary care is particularly important to ensuring optimal health outcomes for older people.[3,4,5,6] However, current models of care and funding arrangements mean there are significant barriers to GPs providing care to older people, both in the community and RACFs.

Reforming models of care

GP-led care should be supported through formal links between older people and their usual GP/general practice. A system of VPE should be introduced for people over 65 in the community, residents of aged care facilities and all Aboriginal and Torres Strait Islander people. This will enhance continuity of care throughout the system, with a targeted focus on preventive activities, early intervention, chronic disease management and smooth care transitions.

Sustainable funding reforms and greater investment in aged services will enhance access to health services and ensure coordination of care across different service providers. The RACGP supports blended funding models which incorporate fee-for-service, complexity loading and recognition for high-quality care. Funding systems should support a mix of telehealth, including phone and video, and face-to-face services to ensure older people can access appropriate primary care, including those who may be housebound.[13]

The Medicare Benefits Schedule (MBS) items for attendances at RACFs and home visits should be increased to reflect the unique challenges of providing care in these circumstances. This should factor in the additional time needed for visits to patients' homes and RACFs, and the time to gather information from, collaborate with and provide care plans to a patient's various care providers. The current structure of MBS RACF items is a disincentive to see more patients in one RACF visit. This must be addressed to enable patients to maintain their relationship with their GP when they move to supported accommodation or to establish a new and ongoing relationship with a GP who provides care at their RACF.[3,6]

Further, the RACGP supports reform of incentive payments, such as the Practice Incentive Program, to incorporate a system of tiered care coordination payments to GPs for each RACF patient and person over 75 in the community. These would ensure GPs are supported to sustainably provide services to older people. All payments should be indexed annually at the rate of health inflation to recognise the rising costs of providing care.

An appropriately balanced funding model will improve access to primary care by ensuring general practice sustainability and increasing the number of GPs providing care to older people. This will support proactive management of comorbid health conditions and reduce avoidable complications and hospitalisations for this group.

Supporting aged care staff, family members and carers to engage with GPs regarding care

The delivery of responsive and appropriate care for older people requires a collaborative and engaged multidisciplinary team with clinical and non-clinical expertise.[14] Professional consultations between GPs and other health staff, including nurses, are clinically necessary, facilitate the GP's ongoing treatment of the patient and assist RACF staff to meet their duty of care for the patient.

Research also identifies family members and carers as critical members of the multidisciplinary care team for older people, and engagement with this group enhances the sharing of information across the care team and the delivery of high-quality care.[15] Introducing MBS support for telehealth consultations between GPs, aged care staff and family members/carers, including when the resident is not present, will support care that is responsive to the changing circumstances and condition of the resident.

Improvements to infrastructure to enhance primary care sector engagement with aged care services

Fit-for-purpose technology infrastructure in the aged care sector will improve sharing of information about care between GPs and other services for older people.[16,17] Continuity of information is key to early identification of changes in the health and wellbeing of older people and proactive management of chronic health conditions.

Currently, many RACF and GP clinical information systems are not interoperable and often do not allow remote access to patient records or medication charts. This limits the flow of information between services and means GPs can be required to duplicate administrative work at their consulting rooms to ensure essential details are captured in a patient's medical record.

Investing in technology system reform to ensure interoperability would bridge information gaps between separate care events and support care that is responsive to the changing needs of the patient. This is critical for older people who may have complex care needs and engage with multiple service providers, as well as those in rural and remote areas who may face greater barriers to sharing of information between providers.[18]

Further efficiencies could be delivered through modernising medication management for RACFs (including through electronic medication charts), streamlining procedures for prescribing and supporting the use of Secure Message Delivery as the preferred method of electronic communication.

Appropriate physical infrastructure is also critical to ensuring high-quality of life for older people, specifically in RACFs. The RACGP encourages RACFs to have a dedicated, safe and private environment such as a consultation room to protect residents and support the delivery of high-quality care.[14]

4.2. Increasing capacity and capability of services to improve responsiveness to the needs of older people

Capacity of the system to provide proactive place-based community care

Aged care services need to be adaptable to geographical, community, cultural and institutional contexts to meet peoples' diverse needs and preferences. There must be coordination and communication between the multitude of community-based services and GPs providing care to older people.

An aged care system that provides proactive place-based services has the potential to significantly improve health outcomes and quality of life for older people. However, the increasing demand for aged care services in Australia means people do not always have timely access to appropriate local care and support.

The RACGP supports increasing the capacity of primary care services to enable continued independent living. Achieving and maintaining independence requires a multidisciplinary approach that not only focusses on the physical and mental health status of the older person, but also on social, cultural and economic factors.[14]

The provision of proactive place-based community care must include tailored aged care solutions to manage capacity issues in rural and remote areas. The importance of strong system capacity to enable continuity of care in rural and remote areas is detailed in the RACGP Position Statement on GP-led aged care in rural Australia.

The aged care system currently lacks capacity to provide place-based, culturally appropriate care for Aboriginal and Torres Strait Islander peoples. The RACGP Silver Book highlights how culturally appropriate care must reflect the importance of family and relationships, connection to place and country, and a trauma-informed approach.[14] For Aboriginal and Torres Strait Islander peoples, focus should be placed on needs-based assessments rather than age-based cut-offs. The RACGP supports funding local options for culturally appropriate aged care.

Strengthening the workforce in residential aged care

Staffing levels and workforce skills remain a significant barrier to the provision of GP-led care in RACFs, with resourcing issues often exacerbated in rural and remote areas. Lack of adequate clinical staffing and training leads to poor understanding and implementation of care recommended by GPs, with consequent unavoidable complications for older people and more demands on GPs.

RACF staff need to be well educated and trained in many core areas of aged care, including medication management, falls prevention, pressure sore and wound care, dementia care, and social and emotional wellbeing, before they commence working in RACFs.

Cultural safety training, particularly around providing care for Aboriginal and Torres Strait Islander peoples, must be made compulsory throughout all residential aged care and should include an understanding of context and a tailoring of practice with face-to-face training, and regular follow-up and refreshment of training.[14,19] Staff should have a robust understanding of trauma-informed care and be able to utilise its principles to promote healing, recovery and wellness.

We further support measures to ensure enhanced training for clinical and non-clinical staff for the delivery of quality and safe care in regional, rural and remote Australia.

Managing prescribing in residential aged care

The under-resourcing and fragmented nature of the current aged care system does not support high-quality medication management that meets the complex health needs of many older people. This is a particular concern for those with the behavioural and psychological symptoms of dementia in RACFs.

GPs are highly skilled in medication management for older people, including for antipsychotic medications. They are readily available to lead and coordinate prescribing, and they undertake continued professional development to ensure their skills and practices align with the latest medical evidence. GPs are particularly well-placed to manage any comorbidities or complex medication needs given their ongoing relationships with their patients and shorter wait times than other specialists.[3]

It is expected the introduction of VPE for older people, as well as measures to eliminate barriers for GPs to provide care to RACF residents, will help to improve continuity of care and reduce inappropriate prescribing in this sector. Research suggests facilitating continuity of GP-led care for new RACF residents is particularly important for preventing inappropriate initiation of psychotropic medications.[3]

To support high-quality medication management, the RACGP has proposed greater funding to support GP case management, review and supervision with referral to geriatricians and psychiatrists as required. The RACGP additionally supports increasing the capability of multidisciplinary teams to provide care to older people in RACFs.

Supporting the medical workforce

The medical workforce is under increasing pressure to provide services to the rapidly increasing proportion of older people in Australia. Supporting doctors, including GPs, to provide services to older people requires a range of measures targeting new models of care and funding reforms, improving the capacity and capability of the broader aged care workforce and increasing exposure to aged care for junior doctors.

It is vital that more doctors are supported and trained to provide services to older people, with targeted efforts directed to promoting interest in aged care in rural settings to lift local workforce constraints. A similar model to the Prevocational General Practice Placements Program could be developed to support a medical workforce pipeline into aged care settings. Increasing the number of rotations and training placements for junior doctors in aged care facilities will strengthen their understanding of the aged care setting and working as part of a primary care multidisciplinary team. It would also contribute to building team-based support for GPs already working at these facilities.

Training for the medical workforce should address the unique issues and challenges in aged care, including specific training on the behavioural and psychological symptoms of dementia.

4.3. Co-design is essential to ensuring services are suited to those accessing and delivering them

Supporting consumer and carer involvement in service design and delivery

Embedding co-design in the aged care sector will help build a more patient-centred system.[20,21] The RACGP supports patients taking on an active role in identifying, implementing and evaluating improvements to healthcare services. Where possible, patients and carers should be supported as partners in healthcare design and delivery. The Working with aged care consumers resource, produced by the Aged Care Quality and Safety Commission, outlines a range of best practice strategies and tools to engage with consumers and their representatives in this sector.[22]

GP involvement in the design of clinical care protocols

As the main source of medical care to older people, GPs have valuable insight into best-practice design of aged care services and overarching sector reform. Involving GPs in the design, trial and implementation of changes to clinical protocols, team care arrangements, implementation of new technology, and models of care and funding will contribute to their acceptability and effectiveness. This should occur at a local, state and federal level, including GP representation in organisations such as the Aged Care Quality and Safety Commission, and with appropriate remuneration. Members are directed to the RACGP information sheet on GP representation for more information on representative opportunities.[23]

Good clinical governance has the potential to reduce negative health outcomes by focussing on prevention and management rather than escalation to acute settings, especially referrals to ambulance and hospital emergency departments in after-hours periods. Including GPs in shared clinical governance and clinical oversight will contribute to improved clinical management, greater efficiencies in the care provided and improved engagement of GPs working at RACFs.

Aboriginal and Torres Strait Islander-led services

The RACGP acknowledges the cultural and practical knowledge within the Aboriginal and Torres Strait Islander health sector, especially the concepts of cultural determination of health, self-determination and community control, as essential to improving the health and wellbeing of older Aboriginal and Torres Strait Islander peoples.[24,25]

We endorse policies that support Aboriginal and Torres Strait Islander peoples to make decisions about, and take responsibility for, their own health and wellbeing. This includes financial and political support for Aboriginal and Torres Strait Islander–led initiatives, and evidence-based engagement and consultation practices. Consistent with the National Partnership Agreement on Closing the Gap, aged care resources should be directed to community-controlled organisations for Aboriginal and Torres Strait Islander peoples.[26]

The RACGP further supports different models of care appropriate to Aboriginal and Torres Strait Islander peoples. Structures that embed shared decision-making and accountability for Aboriginal and Torres Strait Islander peoples are needed within the aged care sector to ensure effective long-term outcomes for individuals and communities.

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