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Royal Australian College *of* General Practitioners

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Submission to the Royal Commission into Aged Care Quality and Safety:

Mental health, oral health and allied health services (Melbourne Hearing 4)

13 August 2020

1.Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Commissioners for the opportunity to comment on the issues discussed at Melbourne Hearing 4, 15-17 July 2020.

The RACGP is Australia's largest general practice organisation, representing over 41,000 members working in or toward a career as a specialist general practitioner (GP).

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for training
- maintaining the standards for quality general practice
- supporting specialist GPs in their pursuit of excellence in patient and community service.

The RACGP supports the work undertaken by the Royal Commission and is committed to engaging with all stakeholders to improve the experiences of and outcomes for older people. Our previous submissions (January 2019, December 2019, including supplementary material, January 2020 and August 2020) and representations at public hearings have reflected upon existing issues and newly raised themes, and provide constructive recommendations to improve service delivery and patient health and wellbeing. We have also highlighted the leadership provided by the RACGP in this area, including the RACGP's aged care clinical guide (Silver Book) and the current development of Standards for general practice residential aged care.

2.Summary

While there are a number of positive recommendations, the RACGP is deeply concerned by many of the draft propositions. The RACGP considers that the logic underpinning many is flawed and does not grasp the fundamental issues and challenges that the sector faces. Rather than improving access and encouraging high-quality care, we believe they may be detrimental to the health and wellbeing of older Australians.

Most concerning is the proposed primary care model for people receiving aged services (draft proposition CH21). The RACGP considers that this proposal, as presented, contains several inappropriate and unacceptable components and may actually decrease patient access to general practice care. As such, this proposition cannot be supported. The RACGP strongly recommends a co-design process, or at minimum improved collaboration and consultation, to determine the optimal model to improve access to high-quality general practice services.

Other comments on the mental health, oral health and allied health propositions are also provided. In general, the expansion of funded services will benefit patients, however we caution that services must be both evidence-based and delivered according to individual assessed needs.

3.Process and consultation

The RACGP appreciates having received in July the draft propositions on mental health, oral health and allied health for review, which were considered at Melbourne Hearing 4. However, it is concerning that neither we, nor any of our representatives, were invited to explore and provide direct feedback on these topics at that hearing.

The RACGP is disappointed with the lack of engagement with the GP community regarding not only these draft propositions but all health needs for older people. This lack of engagement will be to the detriment of the work of the Royal Commission and consequently the health and wellbeing of older Australians.

Upon review of the draft propositions the RACGP has identified that several of the described scenarios imply significant changes for GPs, their model of service delivery and their interactions with other health professionals. These changes will necessarily impact upon the care received by people receiving aged services.

This requires meaningful and more thorough engagement with us and other stakeholders to better understand the implications of these changes across all settings, including an investigation of any potential adverse and unintended consequences. It has been identified throughout the course of this Royal Commission and other inquiries into aged care that the sector is rife with perverse incentives; it would be remiss to introduce others due to insufficient consideration of the issues at hand.

In light of the significant changes set out by the draft propositions and other findings arising from the Royal Commission, the RACGP strongly recommends further engagement and collaboration with us and the general practice profession so that the Commissioners and staff assisting may more fully understand the implications.

4.Access to GP services

It is readily acknowledged that people receiving aged services, particularly those in residential aged care facilities (RACFs), have poor access to health and medical professionals. The Royal Commission has frequently discussed the lack of access to general practice care for older patients in RACFs and in the community. As we have noted in previous submissions, there are two key barriers that must be overcome to facilitate access to these essential services:

- inadequate staffing and infrastructure in facilities
- financial penalties for GPs providing care to patients at home or in RACFs.

5.The proposed new primary care model

The principles underlying the proposed primary care model for people receiving aged services (draft proposition CH21) are sound. The underlying mechanism aligns with the RACGP's preferred model for promoting continuity and coordination of care in the community, i.e. voluntary patient enrolment, as outlined in the RACGP's *Vision for general practice and a sustainable healthcare system*.

In addition, the development of an "Aged Care Plan" may encourage collaboration between service providers and personalised services for recipients. However, it remains to be seen how this is substantively different from existing services (eg health assessments, management plans and team care arrangements in the Medicare Benefits Schedule).

If the intention is to facilitate some new, more effective and efficient process, the RACGP strongly recommends that it be co-designed with health and medical professionals that may develop, use or refer to such a plan. There may also be scope, were an appropriate improvement to existing services developed and agreed, to introduce Aged Care Plans regardless of the implementation of the proposed new primary care model.

However, the RACGP has some significant concerns with the new primary care model as presented in the draft propositions, which ultimately means we do not support the current proposal. The RACGP acknowledges that few details have been made available; to inform future deliberations, we wish to advise of certain components that cannot be supported.

As a general statement of principle, if chronic underfunding is the issue affecting the provision of services to older people, then these changes are not likely to improve the situation and may worsen access to and quality of care.

Furthermore, any proposal that seeks to create or define a separate stream of general practice providing services solely to older people is neither an appropriate solution nor acceptable to the RACGP.

This effort may actually hinder access while undermining existing effective models of service delivery and important components of high-quality general practice care, such as the long-standing therapeutic relationship between a patient and their preferred GP.

5.1 New barriers to general practice access

The current proposal may inadvertently create new challenges without sufficiently addressing the issues underpinning existing problems with access.

Any additional cost and administration involved in accreditation and/or reporting against performance measures will likely deter participation. In addition, an accreditation scheme will likely introduce barriers to GPs from non-accredited practices providing care. Initiatives that increase the burden on GPs or practices, or in effect exclude the majority of GPs or practices from providing services to older people, will lead to further reductions in access to necessary and high-quality care.

The RACGP also wishes to make clear that the majority of practices are independent businesses; though the size of the business varies, a commonality is often low profitability. No business case has been made that suggests the viability of this scheme, particularly with reference to the financial sustainability of engaged practices. As a result, many GPs and practices will interpret the proposition as a risk to business viability.

5.2 Continuity of care

Continuity of care leads to improved health outcomes, increased patient satisfaction and reduced costs to funders and patients.

Older people receiving aged services, particularly those in the community but also many in RACFs, have strong, pre-existing relationships with their GP and practice, who may have known them for decades prior and will be fully aware of their circumstances, history and needs.

Any moves to disrupt pre-existing relationships upon receiving aged care services and tie additional health services to a new, accredited practice is likely to be counter-productive and lead to worse outcomes for patients. Patients must retain discretion to not enrol with an accredited aged care practice if another GP or practice better supports their wishes and needs.

5.3 Performance

The draft proposition notes that “Practices will be held to account against a range of performance indicators.” This suggests a form of performance management, which undermines patient choice and clinical decision making. By mandating and focussing on specific processes, there may be an incentive to “tick boxes” rather than provide the appropriate and necessary care[1,2].

The RACGP will not support a model that involves performance management, mandates services and assesses against inflexible conditions and rules, particularly if tied to funding. We also wish to note that many factors which influence a patient’s outcomes are beyond a GPs control and may be within the remit of other health or medical professionals and/or aged services providers. Any proposal to monitor performance requires considerable further engagement with the RACGP.

5.4 Accepting patients

The stipulation that an accredited practice “must agree to accept any person who wishes to register with them (subject to geography)” is unacceptable. This requirement to accept patients does not consider their capacity to accept new patients. It also would not allow GPs/practices adequate control of work intensity, which will lead to burn-out and consequent drop off in patient care, as well as lessen incentives to register as an accredited practice.

5.5 Funding

The proposal suggests a capitation model for funding. The RACGP assumes that these payments will be made to support enrolment processes and a base level of service (ie it is not proposed that the fee-for-service model is removed for GPs at accredited practices providing services to enrolled patients).

The RACGP does not support the removal of fee-for-service funding system(s) as it fundamentally changes the basis upon which GPs operate in this country. This may exacerbate or create new imbalances in workforce distribution or propensity to provide services. A blended model of block funding/fee-for-service could be supported but requires some consultation or co-design with the RACGP to determine the optimal model.

The proposal to reduce capitated payments when a registered patient sees another GP in another practice requires further attention and explanation. For example, it is not clear whether other GPs will be barred from providing services such as mental health care plans, annual health assessments and medication reviews to patients registered elsewhere.

As noted above, a GP from a non-accredited practice who has a long-standing relationship with a patient may be better placed to provide these and other services. This component also reduces incentives for accreditation and registration as payments may be reduced through the delivery of less complex services by another GP without prior knowledge of the accredited practice. The accredited practice, which presumably retains responsibility for the overall care of the patient, may then be burdened with the outstanding and more complex needs of the patient.

Capitation payments also potentially create a risk of underservicing high-needs individuals that exceed the top tier of need. RACGP members report that this has created issues for patient selection during the Health Care Homes trial and we recommend that the relevant experiences and outcomes of that trial, when available, are considered.

5.6 Accountability

By definition, capitation models shift financial risk from the funder (ie the Australian Government) to the provider (ie the GP/practice). The RACGP is fundamentally opposed to any model that unnecessarily shifts risk to GPs and their teams.

In addition, if it is proposed that care is shared between an RACF and GP/practice, overall responsibility for the whole health and wellbeing of the resident must be clearly defined. The allocation of any funding that is intended to support service delivery must also consider this potentially complex arrangement and range of process and patient outcomes.

Consideration must also be given to ensuring transparency and accountability for providers of aged services, particularly RACFs. A genuinely independent, external and expert provider of services, such as a GP, may be well placed to identify any concerning practices or outcomes. This potentially important source of accountability should not be undermined by any moves to tie GPs/practices to specific providers of aged services.

6.Mental health

In Australian general practice, patients receive comprehensive, whole patient care encompassing both mental and physical health needs. Unlike other settings, general practice does not draw a distinction between mind and body. Assessment and treatment of mental illness is informed by a holistic, whole-of-person approach.

The RACGP agrees that there must be greater access to mental health services in RACFs. Mental health of residents is a major issue, with 87% of people in permanent residential aged care having had at least one diagnosed mental health or behavioural condition in 2019[3].

Proposition M1: Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care

The RACGP has long highlighted the inequality of the current restrictions, which prevent aged care residents from receiving the mental health care they require and deserve and to which the rest of the population is entitled. Mental health treatment plans prepared by GPs for patients living in RACFs should be funded through the MBS and any funding restrictions should be removed.

Proposition M2: Fund mental health assessments and mental health treatment plans by a psychiatrist

The RACGP has serious concerns regarding the suggestion that introducing psychiatrist mental health treatment plan items negates the need for funding of these plans prepared by GPs.

The majority of mental health care delivered to residents in RACFs is provided by GPs, however this proposal suggests their exclusion. It fails to acknowledge that the majority of residents have multi-morbidities, both physical and mental, which must be considered in total. In this environment, treatment plans prepared by discrete providers can lead to polypharmacy, discordant guidance, increased care costs and, overall, reduced healthcare system capacity and worse patient health outcomes.

It is important for GPs to be included in the assessment, planning and review of residents who often have complex needs. The resident's regular GP must be supported to integrate the clinical advice of other medical specialists into the patient's overall care plan. To structure care otherwise will fragment the primary care of older people further, which is presumably not the intention of these propositions.

The availability of the psychiatry workforce is also highly variable and limited in many parts of Australia, with psycho-geriatricians particularly few in numbers. Restricting mental health care assessment and planning items to psychiatrists, who will likely need to visit the aged care facility, will be a significant barrier to care in this context.

The creation of psychiatrist MBS items for the completion of an assessment, generation of a plan and review at three month intervals will only benefit residents living in areas where there is capacity for this to happen.. It is also important to note many older person aged care teams are publicly funded services which are not eligible for MBS rebates.

Proposition M3: Increase funding for psychologists providing psychological services to people living in residential aged care

The proposal to expand the availability of subsidised MBS psychology sessions is welcome but an evidence based approach should be used in determining the appropriate number of psychology sessions. For example, evidence should be provided to support raising the limit to 15 psychological sessions each six months. While residents with communication and cognitive difficulties may require more psychological sessions, the 'dose' of psychology input does not necessarily follow the rule 'more is better'[4].

Proposition M8: Peer workforce

The RACGP has concerns with the proposal for the use of a mental health peer workforce to cover gaps in provision of mental healthcare to older patients.

While we recognise their value and are supportive of efforts to build and use a peer workforce in the Australian health system, many conditions such as major depression, anxiety, dementia and psychosis are beyond the scope of the peer workforce and require clinical expertise. Evidence is needed to understand the potential of a peer workforce in these settings before recommendations can be made.

7.Allied health

Allied health is an essential component of care to maximise the health and wellbeing of older people. The delivery of high-quality allied health services can reduce risks (eg falls prevention), improve quality of life and sustain independence, helping people to stay in their homes and communities. However, access to these services is currently inconsistent and inadequate, particularly for patients in RACFs.

The RACGP is broadly supportive of the intentions and actions contained within the original (A1-4) and revised (A5) draft propositions on allied health. In particular, the proposal to expand the availability of subsidised MBS allied health visits from a total of 5 per year based on assessed need is welcome.

The RACGP wishes to note some reservations and provide some further suggestions on how to improve access to and the delivery of allied health services, highlighting that:

- the proposal to specify the minimum interval between allied health appointments is clinically inappropriate. Patients tend to move from acute intervention to acute intervention as crises occur, demonstrating the need for short term intensification of treatments
- counsel assisting has suggested that a resident of an RACF requires a minimum of 22 minutes of allied health care per day. The RACGP instead recommends that needs assessment and the agreed goals of treatment guide the 'dose' of allied health care delivered
- there is insufficient attention given to the consultation-liaison roles of allied health and the scope of allied health to supervise care assistants and nurses to effectively administer interventions (for example, walking with a resident). The RACGP recommends that this be further investigated and considered.

In addition, while the proposal to separate regular maintenance allied health provisions from infrequent/episodic allied health needs is broadly acceptable, we note that this will be complex to administer in the context of wide scale unmet need.

The RACGP recommends that regular allied health services should, as far as possible, be managed by supervised hand-over of functions to generalist nurses and personal care workers. Funding must be made available for upskilling, supervision of and consultation-liaison for such generalist care providers.

8. Oral health

Oral health is a longstanding concern and the RACGP agrees that increased, and improved, access to oral care for those receiving aged services must be a focus. However, we caution that there is a need to ration dental services in an open and transparent way to avoid issues that developed with Australia's previous Chronic Disease Dental Scheme.[5]

9. Other propositions on the interface between the aged care and healthcare systems

The RACGP agrees that improved definitions of roles and responsibilities regarding the healthcare needs of residents in RACFs, including acceptance and recognition of the agreed distinctions and duties, is required (propositions CH18, M7, D3, A5). This must cover all healthcare services in order to be effective.

The introduction of care coordinator roles for those with high needs may be beneficial (proposition CH17). The RACGP cautions that previous evidence[6,7,8] and experiences demonstrate that care coordinators only enhance care when they have some level of control over individualised plans, or when they are imbedded within the primary care team.

10. References

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