RACGP

Supporting sustainable general practice care for older people

Position statement – August 2026

1. Position

The Royal Australian College of General Practitioners (RACGP) calls on Australian governments to:

Address the significant disincentives to providing specialist general practitioner (GP) care in residential aged care homes (RACHs) by:

- Providing blended funding models that incorporate fee-for-service, recognition for complex high-quality care and compensate GPs for work that currently goes unfunded.
- Substantially increasing the General Practice in Aged Care Incentive (GPACI) payment made to GPs, supporting them to provide high-quality care to patients in residential aged care.
- Providing an alternative registration pathway for patients experiencing dementia so that specialist GPs can receive verbal consent from the patient's family member or other appropriate person over the phone.
- Introducing Medicare support for face-to-face and telehealth consultations to enable care coordination for a RACH patient including when they are not required to be present and consultations can take place between aged care staff, family members and carers.
- Increasing funding for long consultations (over 20 minutes) to support complex care and remove structural incentives to provide shorter consultations.
- Amending case conferencing Medicare Benefits Schedule (MBS) items to allow them to be billable where only two specialists are present, including the GP.
- Improving and investing in digital interoperability between aged care services, pharmacies, hospitals and general practices as outlined in the RACGP Position Statement Interoperability and useability requirements for general practice CISs.

Increase team capacity, capability and responsiveness when caring for older people by:

- Recognising dementia diagnoses made by specialist GPs within the wider health system, including Support at Home program eligibility and access to dementia-specific medications, to reduce unnecessary barriers to care.
- Better funding and supporting for GP case management, review and referral to non-GP specialists and credentialled aged care pharmacists to support quality use of medicines including selection, doses and deprescribing.
- Enabling independent living and aging in place by funding the integrated involvement of allied health professionals, non-GP specialists in a team-based approach.
- Promoting work in the aged care sector for rural settings to lift local workforce constraints.
- Developing formal mentoring programs and increased rotations/training placements for the future workforce to build a pipeline into aged care.
- Introducing initiatives similar to the Prevocational General Practice Placements Program to promote interest in aged care, particularly in rural settings.
- Supporting innovative models such as asynchronous eConsultation programs to enable GPs in rural areas to access timely non-GP specialist advice.
- Providing housing support for aged care workers and health professionals in rural and remote areas to address workforce shortages and improve service delivery.

Better support and trauma-informed care for older people from priority populations by:

- Ensuring aged care services are trauma informed, as per the RACGP White Book (5th Edition), focussing on whole-person care that is safe, more effective, and more responsive to the complexity of human experience.

- Providing greater investment in Aboriginal Community Controlled Health Services to provide culturally safe and trauma informed care for older Aboriginal and Torres Strait Islander people.
- Introducing more support for Aboriginal and Torres Strait Islander leadership and community participation in aged care decision-making and service delivery, aligned with the Closing the Gap priority reform areas.
- Providing support for aged care services that are tailored to the specific needs of Culturally and Linguistically Diverse (CALD) older people and Older Lesbian, Gay, Bisexual, Transgender (LGBT), Queer, Intersex, Asexual people and older people of other minority gender and sexual identities (older LGBTQIA+ people).
- Harmonising supports available through the aged care system and the National Disability Insurance Scheme (NDIS) to ensure older people receive a consistent level of disability support as they age. This includes integrating specialist GPs into NDIS processes so they can effectively care and advocate for their patients, such as remuneration for completing paperwork when a patient is not clinically required to be present.

2. Definitions

Older people: Non-indigenous people aged over 65 or Aboriginal and Torres Strait Islander people aged over 50. This definition acknowledges the impacts of colonisation and that Aboriginal and Torres Strait Islander people may experience conditions associated with ageing at a younger age due to chronic disease and health inequities throughout the lifetime may require aged care services at a younger age compared to non-indigenous people.[1]

Aged care: Care provided for an older person that accounts for the unique support needs associated with their age.

Residential aged care home: Dedicated accommodation providing a high level of care for older people.

Trauma-informed care: An approach to care that recognises the pervasive impact of trauma, integrates this understanding into all aspects of care, and seeks to avoid re-traumatisation while supporting safety, trustworthiness, choice, collaboration, empowerment and cultural respect.[2]

3. Background

Older people require unique support to maintain their independence and to account for health conditions associated with the progression of years, including multimorbidity and polypharmacy.[1] Access to general practice and aged care services support safety and health for older people while maintaining social engagement and enabling independence for those with higher support needs.

RACGP advocates for continuous, multidisciplinary, culturally safe, trauma-informed and high-quality general practice-based care for older people. The RACGP believes the continuous relationship between a patient and their GP is a cornerstone of the health system and entry into a RACH should not disrupt this. The RACGP is also a leader in the development of best practice guidelines for older people, for over 20 years the RACGP has published the RACGP Silver Book.

A GPs' broad scope of practice allows them to provide care, manage and provide advice to older people with multiple health conditions through a holistic, person centred and trauma-informed approach. Access to continuous high-quality, coordinated primary care for older people will help reduce preventable hospital presentations and free up tertiary capacity in hospitals across Australia. However, funding models need to be updated to support general practice to care for older people while maintaining business viability.

The aged care system must promote achieving and maintaining independence, and the cultivation of collaborative relationships between health professionals, patients, carers and family members to ensure the best outcomes for older people. Quality of care is greatly enhanced through technology and fit-for-purpose physical infrastructure. This includes digital systems that are interoperable with general practice software, high-quality on-site healthcare equipment and high-quality telehealth systems. Digital systems must always be complemented by face-to-face alternatives where digital literacy is a challenge for patients.

4. Discussion

4.1 The role of GPs in aged care

Overwhelmingly, people prefer to 'age in place', maintaining their independence and connections to family, friends and community. Aging in place generally requires lower-intensity support and is associated with lower levels of ill health. Specialist GPs are critical to enabling older people to achieve this. GPs provide health risk assessments, primary and secondary disease prevention, population health programs, chronic disease management, support for mental health and long-term continuous care to older people.

Continuity of care is a cornerstone of the high-quality healthcare needed to age in place and is associated with reduced potentially preventable hospitalisations and improved health outcomes.[3–5] Specialist GPs work closely with non-GP

specialists, nurses, pharmacists, allied health professionals, support workers and administrative staff to enable older people to age in place.

More than five times as many people access home support than enter residential aged care. Home care is also associated with lower health service use than RACHs.[6,7] Lumos data for NSW has found that RACH residents had: seven times the average rate of ambulance episodes; six times the average rate of unplanned hospital admissions; and, almost double the prevalence of preventable hospital admissions compared with older people ageing in the community.[8]

When patients need to transition to a RACH, it is important that they maintain access to their usual GP. General practice is built on a foundation of longitudinal and continuous care, including supporting transitions of a patient's care when they move into a RACH.[9] If a patient must change GPs (for example the patient moved into a RACH that is far away from their general practice) then clinical handover should occur between these GPs, including appropriate transfer of all medical records.

4.2 Addressing the significant disincentives to providing GP care in RACHs

High hospitalisation rates of older people in RACHs reflect ongoing issues with access to primary care and the capacity of aged care services.[10,11] Research has found that approximately one-third of hospitalisations were potentially avoidable if care had been provided earlier.[12] A cost-benefit analysis conducted by Lumos has shown that across all age groups there is a cost-benefit to spending in the primary care system. Overall, for every $1 spent in the primary care system there was $1.60 in healthcare system benefits estimated.[13]

The RACGP's Vision for general practice and a sustainable healthcare system (the 'Vision') sets out a roadmap for sustainable healthcare through a strong primary care system that provides high-quality, continuous and comprehensive care for all.

4.2.1 Funding to support high-quality general practice care

The Royal Commission into Aged Care Quality and Safety (ACRC) found funding for GPs to provide care in RACHs is insufficient and contributes to issues around access to care in RACHs.[14] Only 9% of specialist GPs say they have worked in a residential aged care facility in the last month. This percentage has steadily declined from 12% in 2017.[15,16] Patients receiving after-hours GP care to a RACH directly contributes to reduced ambulance call outs and hospital admissions.[17]

Specialist GPs who provide care in a RACHs face significant unpaid time spent on travel, liaising with onsite RACH staff, writing scripts and communicating with families/carers. Many GPs find that visiting a RACH will incur an opportunity cost greater than the funding available for seeing patients in their practice rooms instead.[18]

After-hours aged care MBS items are also insufficient to provide after hours care at RACHs and maintain business viability. These factors are significant disincentives for GP to provide services to RACHs, particularly for early career GPs.[18]

An appropriately balanced funding model will improve access, ensure practice viability, support continuity of care, enable proactive management of comorbid health conditions, and reduce complications and avoidable hospitalisations for older persons in RACH's.

The RACGP supports blended funding models that incorporate fee-for-service, complexity loading and recognition for high-quality care. Fee for service payments must enable GPs to provide consultations of a duration that is appropriate for the care necessary, without pressure. Funding systems should support a mix of telehealth, including phone, video and face-to-face services. This ensures older people can access care from their specialist GP in a way that satisfies the needs of patients and providers while ensuring that telehealth does not replace the provision of face-to-face care.

General practice-based multidisciplinary care for older people is best achieved through the established links older people have with their usual GP. The introduction of MyMedicare has the potential to provide significant benefits for older people through improved care continuity and an innovative blended funding model.

To ensure specialist GPs are supported to sustainably provide aged care services, tasks that are currently unpaid must be acknowledged and funded. For example, GPs should be supported to provide regular and ad-hoc advice to aged care staff as well as to contribute to participate in Medication Advisory Committee meetings without being at a disadvantage. After hours MBS benefits must adequately cover the cost of care provided by GPs so that patients and aged care staff have an alternative to calling an ambulance for patients who require medical care after hours.

The GPACI's focus on ongoing care and preserving relationships with a patient's existing specialist GP is a significant opportunity to improve outcomes for older people. It has the potential to make supporting care for their patients in RACHs a core part of what GPs do, if they are sufficiently supported to take up the incentive. However, to achieve this, the payment to GPs from GPACI needs to be adequate to appropriately incentivise care provision in RACHs. The

registration process for MyMedicare needs to be streamlined and modernised due to the prevalence of dementia within RACHs.

Funding systems need to support day to day collaboration between medical professionals. The current case conferencing MBS items are only applicable where three medical specialists are present. Case conferencing items should be amended to be billable where only two specialists are present to better facilitate interprofessional collaboration in care.

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

Independent research and the ACRC identified family members and carers to be critical collaborators in the multidisciplinary care team. Engagement with this group enhances coordination across the care team, supports the patient and contributes to the delivery of high-quality care.[14,19] 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.

The high prevalence of dementia and cognitive impairment among residents in RACHs means that consent for common care interventions often needs to be obtained from family members or substitute decision makers.[20]

Advance care planning should be an accessible and supported part of caring for older people and entering a RACH. Aged care services and services designed for older people need to have workable supported decision-making processes to avoid delays and administrative burden when care is needed.

The current MyMedicare registration process must consider alternative options for consent for patients who cannot do so such as those with dementia. To reduce the administrative burden placed on GPs and general practice teams by the current cumbersome process, we recommend a streamlined and modernised registration pathway designed for such patients.

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

Currently, many RACH and GP clinical information systems are not interoperable and often do not allow remote access to patient records or medication charts. This results in records which are not consistent between locations and limits the flow of information between services. GPs are required to duplicate or re-enter these records to attempt a level of currency and a degree of synchrony to provide an accurate medical record of the patient.

Comprehensive, shared information is key to effect management and patient stability, early detection of health and wellbeing changes, medication misadventure or deterioration in older people. Without information sharing and care coordination care becomes fragmented between different service providers, leading to worse patient outcomes and increased health system costs.[21]

The aged care sector needs a fit-for-purpose, interoperable technology infrastructure to improve information sharing of information between GPs and other services for older people and was a recommendation of the ACRC.[14,22,23] My Health Record can be an excellent tool for delivering interoperability by providing shared access to pathology results and discharge summaries. The RACGP recommends that My Health Record be used in conjunction with an interoperable Clinical Information System (CIS). The RACGP supports use of the Aged Care Transfer Summary in My Health Record as a tool to facilitate better transfers of care between hospitals and RACHs.

While the RACGP encourages the use of My Health Record in RACHs, as it does in other healthcare settings, My Health Record is not a complete patient medical record and should not be relied upon as such. Practitioners must note the limitations of My Health Record as data source, with patients being able to opt out, the absence of notification functions and meaningful use between all providers is still to be achieved.

4.2.4 Supporting care of older people in rural Australia

In rural Australia many of the challenges of providing care to older people are amplified by a reduced services and workforce. Specialist GPs in small towns feel a deep sense of obligation and responsibility to the communities they serve and where they are often the only medical practitioner available. GPs in regional, rural and remote Australia know how vital they are to the wellbeing of their community often driving them to go above and beyond to fill gaps in the health system. The unacknowledged tasks like writing scripts, providing advice to nurses and aged care staff, completing paperwork and supporting family/ carers is exacerbated in small communities.

Constraints on GP scope of practice also have an amplified impact on these communities. For example, acetylcholinesterase inhibiting medications for dementia require a diagnosis by a geriatrician or neurologist. In rural areas it may be impossible to find a geriatrician or neurologist that is accessible without driving multiple hours, and there can be significant wait lists for these services. Similar challenges are also experienced in other areas such as the prescribing of adrenaline for patients at risk of anaphylactic allergic reactions.[24] When GPs lose their power to prescribe appropriate medications it leads to delays and increased cost for patients.

These challenges also extend to the RACGP's Small Town Rural General Practice Additional Rural Skills Training (ARST). Specialist GPs completing the ARST are required to provide aged care services as part of their training, exposing them to a wide range of unfunded work. There is very little funding support for community-based ARSTs, and in most cases the trainee must bear the impact of this unpaid work themselves, acting as a disincentive to purse these skills.

4.3 Increasing team capacity, capability and responsiveness when caring for older people

To meet patients' diverse needs, values and preferences, aged care services need to be adaptable to geographical, community, cultural and institutional contexts. There must be coordination and communication between the multitude of community-based services and GPs providing care to older people. Funding for these services is currently fragmented, leading to poorly integrated services that aren't accessible.

Achieving healthy ageing, ageing in place and maintaining independence requires the cooperation of various health services. These include pharmacists, physiotherapists, occupational therapists, geriatricians, specialist memory and falls clinics, plus other multidisciplinary team care members or services, working alongside general practice. Delivering the breadth of services that older people need requires an integrated, team-based approach which would require a transformation of the existing isolated funding streams. The Aged care on-site pharmacist program is an example of such a program which the RACGP principally supports. The program provides embedded allied health support while fostering collaboration amongst health professionals within the aged care sector.

The provision of proactive place-based community care must include tailored solutions to manage capacity issues in rural and remote areas. This must be more flexible in the way care is provided and consider housing support for aged care workers and health professionals servicing aged care in areas with limited housing stock in the local area.

4.3.1 Strengthening the workforce in residential aged care

The RACGP supports ACRC recommendations for increases to minimum staffing levels, requirements for 24/7 on-site registered nurses and increases to minimum care minutes.[14] However, the RACGP acknowledges the current workforce is under significant pressure, resulting in many RACHs operating well below capacity.[25] These pressures compound in rural and remote areas, where staff can struggle to afford housing and there is a smaller pool of potential staff to draw from.[25]

The day-to-day support provided by RACH staff is invaluable to the well-being of RACH residents. RACH staff are also an important part of a GP's care team for patients living in residential aged care, often implementing the GP's instructions and supporting patient care.

4.3.2 Supporting the medical workforce

Workforce pressures arising from limited resourcing, funding constraints, and suboptimal service design risk reducing GP participation in aged care. This decision underscores systemic barriers rather than the choices of individual practitioners. More doctors must be supported and trained to provide services to older people, with targeted efforts and funding directed to promoting interest in aged care, including for rural settings, to lift local workforce constraints. For example, funding travel expenses and formal mentoring programs with GPs currently providing aged care services or geriatricians.

A similar model to the Prevocational General Practice Placements Program could be developed to support the future workforce in aged care settings. Increasing the number of rotations and training placements for the future workforce in RACHs will strengthen their confidence and understanding of the aged care setting and working as part of a primary care multidisciplinary team.

The RACGP supports innovative models of care, such as those which would allow rural GPs to have greater access to non-GP specialists to support patient care. The Masters Hospital eConsultation program is an excellent example one, providing a channel for GPs to receive asynchronous advice from a non-GP specialist. The eConsultation program reduced the turnaround for patients receiving non-GP specialist advice by 18 days for category 1 presentations, and over 350 days less for category 3 presentations.[26]

Aged care staff and RACH owners/operators have capacity to support the medical workforce by making it easier and more efficient to visit a RACH. Measures such as dedicated parking and consultation rooms for visiting GPs, access to RACH records and interoperability with general practice record system and access to secure messaging and VPN access to general practice records can save GPs a lot of time and make the process of providing care in a RACH much more efficient. The RACGP Standards for general practice residential aged care focus on this clinical and systemic interface, setting out the minimum requirements for GPs to provide safe, high-quality care in RACH's.

4.3.3 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 RACHs.

GPs are highly skilled in medication management for older people, including antipsychotic medicines. Polypharmacy is highly prevalent in older Australians with close to two-thirds of Australians aged over 75 years regularly taking five or more medicines.[27] While at times polypharmacy is clinically necessary, it is associated with adverse drug reactions, drug noncompliance, fatal drug events, emergency department presentations, malnutrition, and increased rates of hospital admission and readmission after discharge.[28]. Patients experience the best outcomes when their GP is involved throughout their care journey and are integrated with secondary and non-GP specialist care.[10,29]

The RACGP proposes greater funding to support GP case management, review and supervision with referral to geriatricians and psychiatrists as required to support the quality use of medicines. The RACGP additionally supports increasing the capability of multidisciplinary teams to provide care to older people in RACHs.

4.3.4 Dementia system supports

Dementia is a significant and growing health issue amongst Australians with an estimated 425,000 Australians living with dementia in 2024.[30] In 2024 dementia was the leading cause of death in Australia accounting for over 17,500 death or 9.4% of deaths.[31] Dementia creates communication difficulties for patients and often requires others, such as aged care staff or family members, to be present at episodes of care, requiring longer consultations. As patients may struggle to remember medical advice or information given to them, accurate and reliable information sharing is of paramount importance in dementia care.

Despite the prevalence of dementia amongst patients, currently a dementia diagnosis will only be recognised under the Integrated Assessment Tool used for assessments under the Support at Home program if made by a geriatrician or neurologist.[32] This requirement also exists to access some dementia specific medications such as acetylcholinesterase inhibitors. Such requirements create unnecessary barriers to patients receiving the support they need. Specialist GP diagnosis of dementia should be recognised in the wider health system to enable patients to more easily access support for this condition.

4.4 Better support and trauma-informed care for older people from priority populations

There is strong evidence to indicate that for many individuals, exposure to trauma, violence and abuse plays a major role in shaping physical and mental health across the life course.[33]

Quality general practice care is trauma informed. The generalist, whole-person approach recognises that health and illness are shaped not only by biological processes, but by other determinants such as lived experience, relationships, and social context. It requires a clinically grounded understanding of the acute and chronic physiological impacts of threat and how these manifest across the lifespan. This perspective informs every aspect of care.[2]

GPs engage with patients in ways that are sensitive to the possibility of trauma, attuned to patterns of threat, and respectful of the adaptive nature of behavioural and relational responses. Trauma-informed general practice therefore integrates relational awareness with clinical reasoning. It shapes how problems are framed, how interventions are selected and how care is delivered over time. By maintaining vigilance for the enduring effects of threat while avoiding re-traumatisation, GPs provide care that is safer, more effective, and more responsive to the complexity of human experience.[2]

4.4.1 Caring for Aboriginal and Torres Strait Islander older people

Elders and older Aboriginal and Torres Strait Islander people are diverse in terms of their health needs and expectations about care. Many were born into a segregated society and were subject to discriminatory government policies which are in the living memory of many today.[34] Consistency in access to culturally affirming and trauma-informed programs must be prioritised so that it is the norm for all Aboriginal and Torres Strait Islander older adults across the country, and enables improved access and quality of care.[35] Formulating a holistic approach that is culturally responsive to the healthy ageing needs of Aboriginal and Torres Strait Islander peoples is essential.[36]

Mainstream health services, including general practice, have a responsibility to address barriers for older people to receive care. Older Aboriginal and Torres Strait Islander people who are members of the Stolen Generations may require additional supports. Culturally safe and trauma-informed care is critical in the development of trust and respect between individuals, communities and care providers. Cultural safety training must be compulsory throughout residential aged care and should include an understanding of context and a tailoring of practice with face-to-face training, with regular follow-up and refreshment of training.[37] Staff should have a robust understanding of trauma-informed care to promote healing, recovery and wellness. Staff must be supported to understand Aboriginal and Torres Strait Islander health as being shaped by cultural, social, and historical determinants, including connection to country, culture, language, kinship, and self-determination, alongside the impacts of colonisation and racism.[38] These determinants also encompass access to culturally safe and strengths-based care and the broader social and economic conditions that influence health across the life course, including in aged care. Closing the Gap requires dedicated action that is led by Aboriginal and Torres Strait Islander peoples and focused on addressing these underlying determinants rather than solely biomedical outcomes.[39]

As recommended by the ACRC, opportunities for community-led initiatives should be strengthened with adequate funding and resources. The RACGP supports funding and service design of aged care for Aboriginal and Torres Strait Islander people to be led by Aboriginal and Torres Strait Islander people in line with the Closing the Gap Priority reforms. This includes maximising opportunities for older Aboriginal and Torres Strait Islander people to remain on, and maintain connection with, their Country and community in line with the ACRC recommendations.[14]

For further guidance see the NACCHO-RACGP Health of older people topic in the *National guide to preventive healthcare for Aboriginal and Torres Strait Islander people*.

The RACGP position statement on racism in the healthcare system calls on governments to implement the Australian Human Rights Commission's *National Anti-Racism Framework*, develop a clear definition of racism in health, and co-design health policy with patients and healthcare providers from culturally and racially marginalised backgrounds.

4.4.2 Caring for older LGBTQIA+ people

Older LGBTQIA+ people may have spent their lives developing communities and families where they feel safe, understood and recognised. Entering residential aged care can mean patients are leaving these communities and entering an environment that they may fear to be heteronormative and may not recognise their identities and relationships.[40–43] Lesbian, gay and transgender people must be supported to maintain their connection to their communities, and RACHs should work to facilitate this connection.[37,41,43] Services that have implemented measures to improve the safety of older LGBTQIA+ people should ensure these measures are publicised to support awareness.[40,43,44]

Older LGBT people also carry with them the experiences of having an LGBT identity during a time when their sexuality and/or gender identity was criminalised and pathologised.[40,42,44–46] This history of discrimination can lead to older LGBT people, living alone, losing contact with family, being socially isolated, and having a higher reliance on RACHs with limited people to advocate for them.[41–43,45]

There is currently a lack of high-quality, academic evidence regarding the experiences of older LGBTQIA+ people accessing home care services or living in residential aged care.[44,47] Further, there is a paucity of data regarding the experiences of older people who identify as intersex, queer, asexual or hold a sexual and/ or gender identity other than gay, lesbian or transgender.[40,42,44] As Australia's population ages, a greater number of lesbian, gay, bisexual, transgender, intersex people and those of other minority gender and sexual identities will need additional care as they age.[42] Research is needed to inform best practice and ensure older LGBTQIA+ people receive inclusive informed care as expected by mainstream Australia.

The research that does exist describes the importance of adequate staff training and proactive inclusivity measures that support older lesbian, gay and transgender people feel safe to disclose their sexual and/or gender identity.[40,45]. Results from a very small survey indicated the need for privacy for transgender people, such as private rooms and bathrooms and a desire to be treated professionally regardless of their transgender identity.[45]

4.4.3 Caring for Culturally and Linguistically Diverse older people

Culturally and Linguistically Diverse (CALD), describes people born overseas or who have one or both parents born overseas and who may speak languages other than English as their primary language. This group is highly diverse and therefore their needs can vary considerably. For example, refugees require care that is culturally responsive, language-appropriate, along with trust-building approaches that recognise the cumulative impacts of displacement, loss, and migration while minimising re-traumatisation.

CALD people can have a higher prevalence of chronic health conditions and face numerous barriers to accessing aged care services.[48] CALD older people can also have unique cultural, social and spiritual needs. CALD people deserve RACHs that are culturally tailored towards their needs to ensure they receive appropriate care.[49] Making translated information available to support CALD communities understand how to access safe, culturally appropriate and affordable services must be prioritised. While cultural awareness training is strongly recommended for all staff working in residential aged care, there remains a need amongst CALD communities for services that are not just aware of their cultural needs but actively built around them.

Communication challenges such as language barriers can be a major challenge in caring for older CALD people.[50] The Australian aged care system needs to offer services that are tailored to specific needs of CALD communities, including the ability to speak in the resident's language(s) other than English or have interpreters readily available. While the Australian Government's Translating and Interpreting Service (TIS) is available for GPs and allied health practitioners, translation may be needed on a day-to-day basis by personal care workers and other aged care staff, requiring the RACH to have access to their own interpreting service.

4.4.4 Aged care and disability services

It is common for people to develop disabilities as they age, with 52.3% of Australians over 65 having a disability.[51]

In Australia, disability and aged care services come from different insurance (funding) schemes and processed and paid separately. While aged care and disability services can provide similar types of care, aged care services often don't provide the same level of individualised support and disability services often don't support patients with the impacts of ageing.[52] Older people can be eligible for support through both aged care and disability services, however, the intersection of these schemes is extremely complex and challenging to navigate, especially for people with compromised cognition, low digital literacy or internet access.[52]

While it is important that there are not duplicative or fragmented services provided to patients, it is unacceptable for older people to be eligible for less disability support as they age rather than more. People receiving aged care supports should receive living supports equivalent to those they would receive under the NDIS so they can achieve the same outcomes.[14,53]

Navigating the intersections between health, disability and ageing is made unnecessarily complex by the inconsistent involvement of GPs. Currently, GP involvement in the NDIS is sporadic and their status as medical specialists is not formally recognised by the National Disability Insurance Agency (NDIA). Opportunities for GPs to provide clinical input often depends on a patient's ability to self-advocate, and the extent to which NDIS planners understand the GP's role. Where GPs do contribute to NDIS processes, Medicare rebates are not payable if the patient is not present, despite there being no clinical reason for patients to be present while forms and reports are completed. The NDIS must acknowledge the expertise GPs bring to disability care and integrate GPs into NDIS processes so they can effectively care and advocate for their patients.

5. Other resources

Standards for general practice residential aged care (1st edition)

RACGP aged care clinical guide (Silver Book)

RACGP guideline Abuse and violence: working with our patients in general practice (White Book)

National guide to preventive healthcare for Aboriginal and Torres Strait Islander people, 4th Edition

RACGP Position Statement on Interoperability and usability requirements for general practice CISs

RACGP Position Statement on Seamless exchange of information between aged care and general practice.

Understanding trauma fact sheet for aged care [Healing Foundation]

Understanding trauma fact sheet for GP services [Healing Foundation]

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