1. Tell us about you

1.1 What is your full name?

1.2 What stakeholder category do you **most i**dentify with?

Professional organisation

1.3 Are you providing a submission as an individual (go to question 1.4) or on behalf of an organisation (go to question 1.5)?

Organisation

1.4 Do you identify with any special needs groups?

Choose an item.

1.5 What is your organisation's name?

Australian Medical Association

1.6 Which category does your organisation **most** identify with?

Other

1.7 Do we have your permission to publish parts of your response that are not personally identifiable?

☒Yes, publish all parts of my response except my name and email address

☐No, do not publish any part of my response

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AMA Submission to the Department of Health – Aged Care Legislated Review

The AMA has advocated for some time to secure medical and nursing care for older Australians. This is even more necessary now given that 15% of the population are over 65 years of age and this proportion continues to grow[1]. The health care needs of residents of aged care facilities are complex, with the majority of Aged Care Funding Instrument (ACFI) assessments indicating a 'high' need of care across all three assessment categories (activities of daily living, behavior, and complex health care)[2]. The complexity of multisystem medical disorders that afflict older people warrant the regular attention of medical practitioners and quality nursing care which must be taken into account when planning for the aged care workforce. General Practitioners, as the coordinators of care prevent more expensive downstream costs. Conditions, particularly chronic conditions which are more prevalent in older Australians, are less likely to result in the patient requiring hospital care if treated early by a practitioner[3,4].

The aged care sector must evolve to be able to care for older Australians while ensuring a person's access to quality medical care. For older Australians, whether living in residential aged care facilities (RACFs) or in the community, access to ongoing medical care and supervision is fundamental to ensuring they receive the best quality of care as they grow older. The same applies to people who are living independently but who are not able to attend the doctor's surgery.

In order for the aged care system to evolve we must also consider that, like the broader health system, aged care impacts upon both State and Federal Government. However, there is a lack of coordination between the two. Aged care facilities are the purview of the Commonwealth but when a health complication arises, residents are often transferred to a hospital which is the responsibility of the State Government. This means that the States often bear a financial cost resulting from issues that arise in a Commonwealth-run aged care environment.

In the response below, we address the Criteria that focuses on the issues that face aged care workers (including medical practitioners) and patients affected by the Aged Care Legislation.

[1] Department of Health (2015) *2014-15 Report on the Operation of the Aged Care Act 1997*, p 6.
[2] Australian Institute of Health and Welfare (2015) *Residential aged care and home care 2014-15 – Care needs in residential aged care.*
[3] Australian Institute of Health and Welfare (AIHW) (2014) *Australia's Health*. Canberra:. (AIHW Cat. no. AUS 178; Australia's Health Series No. 14.).
[4] NHPA (2015) *Healthy Communities: GP care for patients with chronic conditions in 2009-2013.*

Whether unmet demand for residential and home care places has been reduced

Australia's ageing population will continue to increase the demand for aged care, which in turn warrants an increase in expenditure. The number of aged care beds in Australia increased by 27% from 2005-2015, resulting in an additional 40,000 new beds[5]. However, this growth rate will not meet the demands of future growth. RSM Australia has forecast a demand of 392,000 beds by 2025, while supply in this year based on current growth is predicted to be 262,000[6]. This leaves an unmet demand for 130,000 beds, with Government funding restrictions and the time it takes to establish an aged care facility the major factors inhibiting supply[6]. As a result, patients often end up in hospital, or have extended hospital stays, as they cannot get an appropriate place in an aged care facility.

Hospitals are not an ideal environment for the older population. Patients in Emergency Departments (EDs) have a higher risk of contracting an infection and the older population are more susceptible as their immune systems are often compromised[7]. Further, they are more likely to have decreased cognitive impairment[8], which can result in anxiety and disorientation, and can increase the risk of injuries when attempting to mobilise unaided in a confused state. Pressure sores are common for elderly patients in EDs which warrants further attention from nursing staff[9]. Residents in RACFs are usually on multiple medications and there is an increased risk of incorrect dosage at the wrong time in a busy ED environment[10].

Increasing the number of residential and home care places would contribute to preventing unnecessary admissions and reduce the risk co-infection and other hospital-induced complications.

Whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model

The Australian population is continuing to age, with an expected 1.8 million people over the age of 85 in 2050[11]. However, the variance in this figure is 37%, indicating uncertainty on accurate population projections[6]. For this reason, the aged care system and providers must be flexible and adapt to the needs of the community and the makeup of the population. The types of services in demand will also change over time, as younger generations are predicted to live longer. However, it is unknown whether they will live a healthier life than the generation currently accessing aged care services. A shift in the prevalence of particular diseases will see new ones arise and interact in different ways, as we have seen a shift from the prevalence of acute disease

[5] Baldwin, R et al. (2015) *Residential Aged Care Policy in Australia – Are We Learning from Evidence*, Australian Journal of Public Administration,vol. 74, no. 2, pp. 128-141.
[6] RSM (2016) *RSM Aged Care Sustainability Review 2016*. [online http://www.rsm.global/australia/sites/default/files/media/Industry/Aged-Care/rsm_aged_care_sustainability_review_2016.pdf accessed 15.11.2016]
[7] Avci, M. et al. (2012) *Hospital acquired infections (HAI) in the elderly: comparison with the younger patients*, Archives of gerontology and geriatrics, vol. 54, no. 1, pp. 247.
[8] Deary, I.J et al (2009), *Age-associated cognitive decline*, British Medical Bulletin, vol. 92, no. 1, pp. 135-152.
[9] Baumgarten, M et al. (2006) *Pressure ulcers among elderly patients early in the hospital stay*, The journals of gerontology. Series A, Biological sciences and medical sciences, vol. 61, no. 7, pp. 749.
[10] Rothschild, J. (2010) *Medication errors recovered by emergency department pharmacists*, Ann Emerg Med, vol. 55, no. 6, pp. 513-521.
[11] Commonwealth of Australia (2010) *Australia to 2050: future challenges* [online http://archive.treasury.gov.au/igr/igr2010/Overview/pdf/IGR_2010_Overview.pdf accessed 17.11.2016]

to chronic disease as a result of success of modern medicine. For example, currently one quarter of Australian children and adolescents are overweight or obese[12]. If this trend continues, aged care services may need to focus more on health conditions that accompany obesity, such as musculoskeletal diseases and type 2 diabetes, and also carry out structural renovations to cater for larger individuals.

Primary Health Networks (PHNs) are in a prime position to conduct research into services required for their community area, and to address any gaps where the services available are insufficient to meet the needs of the community. Each PHN contains a Community Advisory Committee (to advise PHNs of community perspectives) and Clinical Councils (led by local GPs and contains health professionals). These groups should collaborate to ensure a proficient number and range of services are in their area. PHNs need to ensure flexibility in the provision and usage of services, and ensure an easy process for the movement of people between aged care facilities.

Although PHNs have a potential place in a supply-driven model, they are relatively new and no research has been undertaken to prove their effectiveness. Some PHNs perform better than others and many are overloaded with existing obligations. Coordination can be difficult as some PHNs span over great distances in rural and regional Australia. Each PHN's boundaries should be flexible and adaptable to reflect local considerations and resident flows and must follow and improve resident flows that already exist. The Government should review the operations of PHNs at regular intervals to ensure they are performing in a manner which is consistent with their broad objectives. These reviews should have strong representation from the medical profession.

The effectiveness of arrangements for protecting equity of access to aged care services for different population groups

Rural Aged Care

Rural aged care services remain limited in choice and rely on Government-based aged care facilities, as for-profit providers are increasing only in major cities[13]. A supply-driven model may not be as effective in rural areas for this reason, and in turn affect the rate of aged care facility growth in rural areas, further reducing the amount of choice and resulting in the absence of some services.

Many rural doctors are pressured to treat older patients in RACFs due to the limited number of hospital beds in rural areas. RACFs are not funded to adequately tend to the needs of ill residents and therefore the quality of care they receive can be reduced. These challenges deserve the specific attention of those undertaking the review.

The lack of services is coupled with a shortage of medical practitioners in rural and remote Australia. This is due to the lack of funding to support the recruitment and retention of doctors and health professionals, and the limited availability of education and training facilities in rural and remote areas. Funding is also required to address that rural doctors are finding it difficult to

[12] Australian Bureau of Statistics (2009) *Children who are overweight or obese* [online http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20Sep+2009 accessed 15.11.2016]

[13] Baldwin, R. et al (2015) *Residential Aged Care Policy in Australia – Are We Learning from Evidence?*, Australian Journal of Public Administration,vol. 74, no. 2, pp. 128-141.

find locum relief to maintain their Continuing Professional Development (CPD) points and find a work-life balance[14].

Older Australians should have access to aged care services in their own community instead of moving to a neighbouring town that is potentially hundreds of kilometers away from their home. Providing access to more remote communities would reduce the cost and travel times for families and friends to visit, thus improving the wellbeing of the resident. Further, the GP-patient relationship is undermined when the patient has to move from their community and as a result disrupts continuity of care. The familiarity a GP has with their patient, coupled with knowing the patients' history is essential to providing quality of care and may reduce the prevalence of referring patients to the ED. To ensure rural and remote areas are not left behind in this supply-driven system, the Government should conduct research into the value of investing in aged care for rural and remote areas.

Culturally and Linguistically Diverse (CALD) Individuals

Australia has seen a rise in the number of migrants. In 2013, 32% of the Australian population (5.8 million people) were born overseas[15]. Projections for 2021 suggest that the older population will comprise 30% of people born in a country other than Australia[16]. This presents a major challenge to incorporate different cultures into Aged Care, and communicate with individuals who may have low levels of English literacy.

In the case of Aboriginal and Torres-Strait Islander populations, it is important to ensure RACFs are culturally aware and informed, similar to the cultural understanding seen in Aboriginal Community-controlled Health Service. This will ensure smooth transition between the health system and the aged care provider.

The goals outlined in the *National Ageing and Aged Care Strategy* are not being met. Our members have recently highlighted the communication difficulties both with CALD staff and residents of RACFs, and more awareness of the services and training available to staff is required if CALD residents are to receive equitable aged care.

The effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers

While the *Aged Care (Living Longer Living Better) Bill 2013* and related Bills create a framework for providing aged care subsidies, they make no provision to secure medical and nursing care for older Australians by integrating clinical care into the aged care services.

Medical Practitioners

In the same way that medical practitioners are an integral part of the hospital workforce, medical practitioners and other health practitioners comprising the general practitioner-led team are an integral part of the aged care workforce, particularly in residential aged care. They are central to

[14] Australian Medical Association (2016) *AMA Rural Health Issues Survey Report – Rural Doctors have their say*.
[15] Australian Bureau of Statistics (2013) *Characteristics of Recent Migrants* [online http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/6250.0/ accessed 23/11/2016]]
[16] Department of Social Services (2015) *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*

the provision of quality care for older people. However, there are several significant barriers that limit the amount of medical care a medical practitioner can provide. These include:

1. Poor access to properly equipped clinical treating rooms. Treatment usually has to be provided in a shared room where there is a lack of privacy for the patient and no equipment for the treating doctor, limiting the medical treatment that can be provided in that setting.
2. An absence of information technology infrastructure (IT) to facilitate access to electronic patient records and medication management, which promotes a reliance on using time-consuming paper files. This includes software that is user-friendly and appropriate to the needs of general practitioners, improved electronic interface between pharmacy services and aged care facilities records, and/or support for remote access to the practitioner's medical records. The software should also not require multiple logins in order to increase efficiency. A larger investment in IT could see better communication between the care team, faster access to hospital discharge summaries, fewer medication errors, and better access to Advance Care Directives.
3. The My Aged Care Gateway should be interoperable with clinical software. The My Aged Care Gateway referral form needs to be integrated into general practice clinical software so that the form can be auto-populated, attached to the patient record, and securely sent.
4. A strong financial disincentive for the medical practitioners to leave their surgery, with all its attendant costs, to provide services in aged care facilities.
5. Limited MBS support for telehealth services often means that the doctor needs to present at the facility or not be paid.
6. A growing tendency to build facilities in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by medical practitioners away from their surgeries. This also forces people to move further away from their community and reduces the likelihood of retaining their usual GP, which in turn breaks continuity of care.
7. A lack of access to registered nurses with whom to co-ordinate care. Nursing services are currently provided in a variety of ways, and a lack of adequate nursing services impacts negatively on the timeliness and quality of care for residents.
8. A number of AMA members identified a practical impediment to working in aged care facilities being the consistent lack of formal arrangements for doctors to be provided with after-hours access to the facility (including the provision of codes).
9. An increasing use by aged care facilities of agency staff who are not familiar with residents which compromises continuity of care.

In the AMA Member 2015 Aged Care Survey, 41.2% of respondents reported spending longer away from their surgeries to visit RACFs, seeing more patients per visit but the time spent with each patient remaining the same (average 16.1 minutes, compared to the 2012 survey). 79.6% of doctors had given the reason for increased patient visits as there was no other medical practitioner available to provide the service.

The respondents outlined four major issues affecting aged care:

- 56% were displeased that MBS rebates for attendance do not properly compensate for time away from surgeries, with 39.3% of respondents calling for a 50% increase in the rebate
- 50% called for improved availability of suitably trained and experienced nurses
- 40% called for improved IT facilities

- 40% called for specific financial support (in addition to Medicare payments) for retainer arrangements between aged care providers and medical practitioners.

The current policy settings do not support GPs working after hours, neither does it acknowledge the benefits of continuity of care. Our members report that continuity of care goes generally unacknowledged in many RACFs and a resident's management plan is not well known. This creates an environment where the default step for RACF staff may be to refer to patient to an ED. The AMA Member 2015 Aged Care Survey showed that non-contact time (such as responding to phone calls and faxes from RACF staff and patient relatives) with patients has also increased. One concept worth considering is an MBS item for phone consultations with a nurse or carer from a RACF to incentivise doctors to be on call after hours. This would in turn increase the number of doctors who make themselves available out of normal business hours. In addition, the care of patients' regular GP would avoid unnecessary referrals to the ED.

The complexity of multisystem medical disorders that afflict older people warrant the regular attention of medical practitioners and quality nursing care, which in turn warrants consideration in the context of aged care reforms. Results from the AMA Member 2015 Aged Care Survey conclude this is not occurring and the lack of both financial and staff support from the government to provide quality aged care services must be addressed.

Appropriate support for medical services, including limited forms of pharmacology and pathology, in aged care facilities will improve residents' access to medical care, and can reduce unnecessary pressure for, and counter-productive utilisation of, acute services. Investment in medical services in aged care facilities will lead to a more efficient health system.

The Government should consider the merits of different models of providing medical care services within aged care facilities. Currently, many residents have minimal choice in deciding who their GP will be once they enter a RACF. Patients should be able to decide whether they stay with their existing GP, or transition to the in-house GP. Alternate models should expand the opportunities for medical practitioners working in an aged care facility and support practitioners to provide ongoing medical care. This has the potential to reduce unnecessary transfers to more expensive forms of care such as hospitals.

There is some anecdotal evidence that an increasing number of RACFs are using Nurse Practitioners instead of GPs to tend to residents. This will fragment care and result in the duplication of services to patients. It is critical that any such services are provided in collaboration with the patient's usual GP, detailed in a collaborative agreement that specifies the role of the nurse practitioner and how they will work and communicate with the patient's usual GP.

It is important there is clear regulation and understanding around the use of Nurse Practitioners to ensure this method of relieving workforce pressures does not undermine the medical quality of care that medical practitioners provide, change the scope of practice, or subject residents to over-servicing.

Nurses

Sufficient numbers of registered nurses should be on site to manage patient care between doctors' visits. There has been a shift in the composition of the aged care workforce across Australia in

recent years (Table 1), and whilst the increase in personal care attendants is welcome, the decline in the proportion of registered nurses and enrolled nurses needs to be reversed to ensure residents are provided with timely and appropriate clinical care[17]. A recent survey identified low staffing levels in residential aged care as the main cause of missed care (e.g. not responding to bed calls within five minutes, checking vital signs etc.)[18].

Table 1: Full-time equivalent direct care nurses and personal care attendants in the residential aged care workforce: 2003, 2007 and 2012 (estimated Full Time Equivalent)*[19].

Occupation	2003	2007	2012
Nurse Practitioner	n/a	n/a	190 (0.2)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)
Allied Health Assistants and Professional	5,776 (7.6)	5,204 (6.6)	5,026 (5.3)
Total number of employees (FTE) (%)	76,006 (100)	78,849 (100)	94,823 (100)

** data in this table was extracted from The Aged Care Workforce, 2012 – Final Report: Table 3.3*

The absence of specific nurse to patient ratios in the accreditation standards has allowed the shift in proportions. This has placed additional pressure on nursing and medical practitioners and has most likely led to increased transfers to hospitals. The Government must ensure that the number of aged care facilities is not restricted due to a workforce shortage. This is critical to the success of the aged care system.

The AMA strongly believes that there must be specific accreditation standards around access to medical services, in a similar fashion to the existing standard on access to clinical care and specialised nursing care. To this end, the AMA supports calls by the Australian Nursing and Midwifery Federation for the provision of a minimum number of registered and enrolled nursing staff, to meet the assessed care needs of all residents.

Education and training for RACF staff

It has been reported to the AMA that many aged care staff do not have to appropriate training to properly handle the major issues facing the elderly, such as behavioural conditions, falls prevention, pressure sore prevention, and pain management. We have been informed that this can lead to an increase in medication use.

Some of our members are concerned that aged care staff are requesting sedation of residents so they are easier to handle. Restraints such as sedation should only be prescribed where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. They should always be considered a last resort. Providing care should ensure the

[17] King, D. et al - Commonwealth Department of Health and Ageing (2012) *The Aged Care Workforce, 2012 – Final Report*, Flinders University, p 22.
[18] Henderson, J et al (2016), *Missed care in residential aged care in Australia: An exploratory study*, Collegian,
[19] King, D. et al - Commonwealth Department of Health and Ageing (2012), *The Aged Care Workforce, 2012 – Final Report*, Flinders University, Table: 3.3.

safety, wellbeing and dignity of the patient and ensure a medical practitioner assesses the patient for any underlying behavioural conditions. Aged care staff should be properly trained on the ethical, medical and legal issues that can arise from using a restraint, and also educated on ways to improve the aged care environment through ensuring a friendly physical space, and through social and staffing structures.

The effectiveness of arrangements for facilitating access to aged care services

My Aged Care System

The My Aged Care Gateway was supposed to streamline access to needed services for patients. Instead it has complicated access by requiring all patients to undergo either a Regional Assessment Service (RAS) or Aged Care Assessment Team (ACAT) assessment in order to access support services. An assessment bottleneck has been created and is causing delay in elderly patients' access to support and medical care. In addition, direct referrals to service providers for required services are being blocked by the bureaucratic requirement for an assessment.

The My Aged Care website is easy to navigate for most patients. However, the number of complaints from AMA members and patients about the administrative process of the My Aged Care System is extremely high. Complaints include:

- Over a week to inform a patient they were ineligible for home support required to redress their infected wound and that their application required further processing. This process was a stream of back and forth phone calls between the patient, the referring doctor, and the My Aged Care call centre.
- The lack of communication in the new My Aged Care HACC application process and increased administrative burden on doctors and practice staff.
- Waiting times on the My Aged Care contact centre of 90 minutes for a referral
- Several website malfunctions
- The My Aged Care contact centre not following up with a patient's doctor when an attempted call to the patient has had no response.
- The contact centre failed to act on information supplied on the application form about a hearing-impaired patient unable to answer phone calls.

For the My Aged Care system to work properly, it must be simple and efficient. Reports from our members indicate this is not the case, and previously simple processes have become complex and time consuming, leaving patients in need of urgent care left at home waiting.

Aged Care Assessment Team (ACAT)

Another example of how the medical profession's contribution to aged care can be better incorporated is the area of respite care. Demand for respite services is likely to increase as the trend towards community care increases and the carer base diminishes. The need for respite care usually occurs when the carer has become unwell and/or is temporarily unable to provide care. In these situations it is often very difficult to access respite care.

Approval for respite care depends on a formal ACAT assessment. Difficulty in accessing an ACAT assessment means it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the patient to hospital in order to give the carer

some relief. This causes great distress for patients and their carers and increases the risk of delivering respite care that is inappropriate both in timing and in the nature of the care given. Admitting the patient is also expensive and further overpopulates the public hospital system.

A streamlined process is required to improve access to respite care for people who have not yet been assessed by an ACAT or who have not yet entered the aged care system. GPs who work in aged care know their patient's circumstances and requirements. In these circumstances, access to respite care could be streamlined by allowing GPs to approve respite care for older people in need of urgent respite care in much the same way a doctor determines that a hospital admission is necessary.

Although there are 'first clinical contact' timeframe guidelines (High urgency: 2 calendar days, medium: 3–4 calendar days, and low: 15–36 calendar days[20]), our members are reporting delays longer than these outlined periods. While 47.8% of respondents in the 2015 AMA Member 2015 Aged Care Survey reported a wait for initial assessment by ACAT was less than one month, 38.8% had to wait 1-3 months. States who had the longest ACAT waiting times were New South Wales, South Australia and Queensland. The current aged care assessment arrangements fall short on efficiency and responsiveness to the care needs of older people.

The effectiveness of the aged care assessment process can be improved by including the patient's usual medical practitioner in the assessment arrangements. Our members tell us aged care assessment currently makes little use of the information doctors can provide about their patients. Medical practitioners form long-term relationships with their patients. An older person's usual doctor, be they a GP or geriatrician can bring his or her background knowledge of the whole person and their current circumstances to the assessment process. This information would ensure the person's assessment results in them receiving the care that is most appropriate for them, be it in the community or RACF. It would also reduce the assessment time, which would allow people to access services more quickly.

Other comments

Palliative Care

Our community needs to be educated about the reality of death and dying. Similarly, health care professionals need to be upskilled and supported to provide quality palliative care. There should be training in palliative care and grief and bereavement counselling available to all health practitioners, to support both patients and their family members.

Acute medical care in Australia prioritises treating disease and preserving life. This acute model of care does not necessarily respect the needs of patients living with life limiting illnesses and can impose additional unnecessary pain and distress without necessarily delivering desirable outcomes. A palliative approach in aged care settings recognises that healthcare should not be based on diagnosis alone. The aim of a palliative approach is to maximise quality of life through appropriate needs-based care. This approach provides a positive methodology for reducing an individual's symptoms and distress.

[20] Department of Social Services (2015) *My Aged Care Guidance for Assessors*.

The majority of Australians want to die in their own home[21]. In many occasions, home is an aged-care facility (i.e. not the hospital). Where possible, the patient should be cared for in the environment of their choice, including the RACF. Currently, there is a lack of resources to respect this choice. Supporting end of life care and advanced care plans will provide residents with good quality patient-centered care that is a collaboration between the patient and the health care team. This care should be facilitated and coordinated by their medical practitioner.

There is emerging data to suggest that community-based care for the last three months of an individual's life is significantly cheaper than if they were to die in hospital ($6,000 compared to an average hospital admission cost of $19,000 per patient)[22]. These substantial savings, coupled with the ability to respect a person's choice in their place of death, argues that more should be invested in providing good quality palliative care in the home.

By remaining in the RACF, residents are able to receive care in a familiar setting, reducing confusion and the anxiety that results from transfers to hospitals. Appropriate integration of the general practitioner in the facility will improve outcomes for residents through better clinical management, improved continuity of care and reduced readmissions. Hospital in the home-type services provided by a Local Health Directorate can also support treatment in an aged care facility rather than transfer the patient to a hospital.

Conclusion

The aged care system needs to evolve in order to accommodate Australia's increasing ageing population, with the majority of issues in the lack of aged care staff and the absence of recognition in the role of the medical practitioner in effective aged care. Aged care providers should have arrangements in place to ensure that residents' needs for medical care are identified and that they receive ongoing access to medical care appropriate to their needs and that they age in place. This will include, but is not limited to:

- ensuring adequate numbers of appropriately skilled nurses are employed;
- having management practices in place to ensure residents who require medical attention from a doctor are identified quickly, and that doctors are contacted;
- providing doctors with access to properly equipped clinical treatment rooms that afford patient privacy; and
- providing doctors with access to information technology infrastructure, and patient records.

With support from PHNs, the Government needs to closely monitor the trends and needs of the ageing population to ensure a flexible and efficient supply-driven system and to ensure that rural aged care facilities are not left behind under this model.

December 2016

[21] Foreman et al (2006) *Factors predictive of preferred place of death in the general population of South Australia*, Palliative Medicine, vol. 20, no. 4, pp. 447-453.
[22] Swerissen, H and Duckett, S (2014) *Dying Well*, Grattan Insititute, Melbourne