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

December 2019

About The Royal Australasian College of Physicians (RACP)

The Royal Australasian College of Physicians (RACP) trains, educates and advocates on behalf of more than 17,000 physicians and 8,000 trainee physicians across Australia and New Zealand. The RACP represents a broad range of medical specialties who work at both the individual and population level and at all stages of the lifecycle from infancy and childhood through adolescence and adulthood to old age and the end of life, neurology; oncology; public health medicine; occupational and environmental medicine; palliative.

Physicians with a specific interest in older people include geriatricians, general and acute physicians, neurologists, palliative care physicians, rehabilitation medicine physicians, though these are not the only physicians that might be involved in the care of older persons at different times:

- **Geriatricians**. Geriatricians are specialists in understanding the needs and challenges of an ageing population. They are trained to identify and assess decline or the need for decline preventing strategies in an older person. Such strategies are critical to minimising or reversing any negative impact on function.

  Geriatricians take a multidisciplinary team approach to healthcare for older persons, always endeavouring to work with GPs and other health professionals such as nurses, physiotherapists, occupational therapists, speech pathologists, dieticians, psychologists, social workers and pharmacists. Geriatricians promote and prolong older persons' capacity to safely remain at home. Their role and appreciation of the impact and complexity of multi-morbid conditions on older persons should be considered central to supporting carers and patient decision-making.

  Geriatricians contribute to the care of older people across the care continuum; from Memory Clinics and community care at home, through emergency, acute and subacute care, including rehabilitation of older Australians.

- **General and acute physicians.** General and acute physicians treat elderly patients with acute illness and are also specialists in multimorbidity and the management of chronic disease. Patients may be residents of aged care facilities or transitioning from hospital to an aged care facility from hospital. General and acute physicians can also provide care to adults with intellectual and or physical disability, including adults with congenital or acquired brain or physical disability and those with neurodegenerative conditions affecting them in childhood or early to middle aged adulthood. Adult patients with intellectual or physical disabilities may need to be treated in the different residential and care contexts (aged care facilities, as part of younger families, with ageing parents, in group homes, in supported accommodation).

- **Neurologists.** Neurologists are involved in the diagnosis of dementia, including determining the probable underlying cause in younger people (Huntington disease, Frontotemporal dementia and Alzheimer disease) and older persons. Neurologists will see disorders that present in other ways and evolve to include dementia as a major feature e.g. Parkinson's disease, Huntington disease. They are involved in addressing safety issues (such as driving) and recommendations for NDIS or My Aged Care registration.

- **Rehabilitation medicine physicians.** Rehabilitation medicine physicians diagnose, assess and manage individuals with disability or functional decline due to injury, illness, chronic disease or ageing and work together with these people to achieve their optimal level of functional ability, social participation and quality of life. They are trained in the rehabilitation management of older people including those who have impaired function due to frailty and geriatric syndromes, debility and deconditioning, and chronic diseases or other complex health conditions. They are also trained in the rehabilitation management of all people with severe and permanent disability who may reside in aged care facilities, including younger individuals. Further, retention in and return to work rehabilitation programs are an important part of care of older persons with longer work requirements.

RACP submission to the Royal Commission into Aged Care Quality and Safety

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute to this Royal Commission into Aged Care Quality and Safety. The College represents expertise in condition complexity and age-related health care; geriatric medicine, palliative medicine; sleep medicine; internal medicine; and prevalent condition related specialties such as cardiology, neurology, endocrinology, rheumatology, neurology and oncology.

The stated aims of the Australian aged care system are to promote the wellbeing and independence of older people (and their carers), by enabling them to stay in their own homes or by assisting them in residential care[1]. The strategy to achieve this aim is for Government to subsidise aged care services that are:

- accessible — including timely and affordable
- appropriate to meet the needs of older persons — person-centred, with an emphasis on integrated care, ageing in place and restorative approaches (restorative care refers to a philosophy of care that supports individuals to maintain and restore function, intended to prolong independence, and is distinct form rehabilitation[2]).
- high quality.

There are many aspects of aged care that consultant physicians consider do not meet these objectives.

The infrastructure of the aged care system is not resourced to safely and effectively meet present and future demand. This demand will come from well-documented projections of the increasing proportion of people aged over 65 (noting that Aboriginal and Torres Strait Islander people require aged care services earlier). This demand will be compounded by the prevalence of chronic conditions within population (including the young people now who will require health care services in the future as older persons) and that there may be fewer carers available (due to incapacity or pressure to work longer on potential carers). We already observe more people delaying seeking care due to cost factors, and if this trend continues then this could mean a higher demand for acute and secondary care at a later stage of condition progression, which is of higher risk to an older person.

The goal for the College, representing essential physician services for the aged, is to improve the consistency of delivering high quality, safe and best practice care for the aged and ageing in Australia.

Our key messages are about:

- Ensuring all aged care services are highly responsive and timely to the needs of older persons and their carers/trusted persons because this can be critical to health, and can mean less intense, longer term and costly treatment later.

- Scaling up the use of existing resources within the health system such as telehealth, especially where timely care and clinician expertise can be achieved.

- Reducing the cost to consumers of support care (specifically low level home care) because this can positively impact health care requirements.

- Improving models of service provision for Aboriginal and Torres Strait Islander people (emphasising cultural competence) including addressing regional gaps and reducing pressure on overstretched resources.

- Driving proactive, preventative and restorative care that includes assessment, management and documentation of older person needs irrespective of point of care (such as impairments and experience of pain, pharmaceutical oversight), and building in protections for the vulnerable (against risk of abuse and being taken advantage of).

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[1] Productivity Commission 2019 Report on Government Services (Chapter 14 Aged Care)

[2] Resnick B, Boltz M, Galik E, Pretzer-Aboff I. Restorative care nursing for older adults: a guide for all care settings. 2nd ed. New York: Springer; 2012

- Establishing purpose designed models and pathways of care that engage appropriately skilled teams (where team work is of benefit) or connect health professionals, that are able to communicate from different locations or portals.

- Providing safe, high quality medical and therapeutic care in high care environments such as RACFs including redressing the special needs of people living with dementia.

- Ensuring that a trained, highly skilled, equitably distributed health care workforce is employed to meet population needs (including emphasising geriatric training across relevant professions such as GPs, emergency departments, nurses, physician trainees.

We stress that timely risk assessment, instilling more health literacy within the community on healthy ageing, emphasising early patient centred management of conditions in cross sector integrated approaches is key to our population's optimal functionality and quality of life. This approach also offers the potential for reducing avoidable hospital admissions.

We draw attention to the divisions of funding between state and federal governments that have led to experiences of both patients and healthcare providers alike of poor connectivity, a poorly defined continuum of care, an emphasis on volume of activity and limited capacity for team care as the norm. The integration of health services across hospital, community and primary healthcare settings is crucial to higher quality and safer care and better health outcomes, reducing gaps in care, reducing instances of conflicting advice or treatments, and reducing duplication and wastage of resources.

Eight per cent of all hospital admissions across Australia in 2012 were for permanent residents of residential aged care[3]. This is an area of significant government expenditure that could be better managed by strategic attention, including to rehabilitation services. For example, emphasis would be well-placed on care closer to home, including outreach services to residential care, rehabilitation and restorative care and bed substitution models.

We commend the new Aged Care Quality Standards (1 July 2019) and trust these will reinforce safer, higher quality practice.

The College has developed recommendations in the following areas:
- Assessment
- Accessibility and cost of aged care
- Support services in the community
- Aboriginal and Torres Strait Islander older persons
- Proactive patient management and innovative models of care (including pain management and medication management)
- Protection of older persons from abuse
- Dementia
- Disability
- Facilitating opportunities for home-based care
- Improving quality of care in residential aged care facilities (RACFs)
- Workforce and service planning

This submission links each of the above areas to one or more Terms of Reference.

[3] Australian Institute of Health and Welfare 2014 Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW

Recommendations

The RACP recommends:

Assessment

1) The Commonwealth Government should guarantee continued funding for subsidised access to Comprehensive Geriatric Assessments (CGA).
2) The Commonwealth Government should, in cooperation with the State and Territory governments, develop a policy for the assessment of older patients to proactively diagnose delirium and oversee the introduction of an appropriate management strategy for all hospitals and RACFs.
3) The Commonwealth Government should reduce delays associated with ACAT assessments.
4) The Commonwealth Government should develop an approach that uses an Aged Care Assessment Team, fully funded to which there is direct access, with expertise in the care, needs and coordination required for older people, who liaise with medical personnel (General Practitioners and Specialist), integrate with Local Health Districts' Aged care/ geriatric medicine services, provide appropriate experienced allied health assessments and assist with choosing and initiating care packages.
5) The Commonwealth Government should consider measures to allow carers or family to apply on behalf of an individual to My Aged Care, without the requirement of a form, to lessen the difficulties in accessing services. This should include streamlining the online application process so that General Practitioners, Allied Health Staff and others can make timely referrals on behalf of an older person.
6) The Commonwealth Government should consider provision of My Aged Care support personnel to assist with navigating the system, allocation of funding, and selection of service providers; similar to the model currently used for National Disability Insurance Scheme.
7) The Commonwealth Government should provide accessible multidisciplinary comprehensive assessments for older patients in hospital and community care settings. The assessment services should have strong links with Geriatric Evaluation and Management (GEM) Units; existing geriatric services; and have a clear point of contact.

Accessibility and cost of aged care

8) The Commonwealth Government should remove the distance restriction in the current MBS items for telehealth.
9) The Commonwealth Government should investigate measures to address the cost burdens of residential care for older people who have income or assets that place them just above the pension/concessional eligible threshold.
10) IHPA should review whether the current Activity Based Funding system is adequately accounting for all hospital episodes of care for older patients with cognitive impairment and Behavioural and Psychological Symptoms of Dementia (BPSD).

Support services in the community

11) The Commonwealth Government should increase the availability of Home Care Packages (HCPs) to eliminate delays in access which frequently lead to progressive impairment and loss of independence.
12) The Commonwealth Government should formulate measures to further reduce the cost to consumers of Level 1 and 2 Home Care Packages (HCPs).
13) The Commonwealth Government should critically review the proportion of "service fees" charged by service providers to administer care packages that impacts the quantum of services actually received by consumers.
14) The Commonwealth Government should, in cooperation with the States, institute more strategic planning of the domiciliary health workforce to address unmet needs for community support services for older people in rural communities.

Meeting the needs of Aboriginal and Torres Strait Islander older people

15) The Commonwealth Government should better fund early condition assessment and comprehensive condition management, and community-based care for older Aboriginal and Torres Strait Islander people.
16) The Commonwealth Government should establish models of medical service provision and sustainable funding which ensure equitable and appropriate access for Aboriginal and Torres Strait Islander older people to consultant physician services, across varying locations.

17) The Commonwealth Government should guarantee long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) commensurate with the burden of disease.
18) The Commonwealth Government should introduce trials of enhanced primary and specialist shared care delivery models for Aboriginal and Torres Strait Islander people.
19) The Commonwealth Government should look at ways of addressing the barriers Aboriginal and Torres Strait Islander older people experience in relation to health services including through investing in improving the cultural competency of healthcare professionals.
20) The Commonwealth Government should increase funding for palliative care services for Aboriginal and Torres Strait Islander older people, especially in non-urban areas.

Proactive patient management and innovative models of care

21) The Commonwealth Government should work with the State and Territory governments to formulate more healthcare pathways or care programs that are appropriate for managing older patients with multi-morbidity and/or frailty and which take account of competing risks and potential for harmful interactions between treatments for different conditions or groups of conditions.
22) The Commonwealth Government and State and Territory governments should work together to implement holistic patient centred Models of Care for older persons. These should include: 1) integrated and co-ordinated care between primary and secondary care healthcare systems; 2) models of multidisciplinary clinical care such as the use of health panels; and 3) mechanisms for information sharing and connectivity between practitioners. For example, this could include integrated care models such as that described in the RACP Model of Chronic Care Management. The RACP Model provides an example framework designed for pilots in a number of high prevalence chronic diseases but the framework could be extended to other disorders. These models of care should also involve integrated information systems between service delivery sectors, between organisations, and between multidisciplinary health care providers.
23) The Commonwealth Government should, in cooperation with State and Territory governments, mandate the regular documentation of pain of residents in all facilities caring for older people using self-reporting as the gold standard or using validated observational and behavioural scales as alternatives.
24) The Commonwealth Government should in cooperation with State and Territory governments mandate the routine assessment of cognitive impairment, sensory impairment, delirium, skin integrity, mood disorders, malnutrition, mobility and elimination (bowel/bladder) capacity in all facilities caring for older people by means of observation, self-report and risk assessment tools
25) The Commonwealth Government should in cooperation with State and Territory governments mandate the introduction of protocols for regular review of older patients' medications encompassing GPs and consultant physicians as well as pharmacists aimed at the early detection and management of potential side effects and interactions.
26) The Commonwealth Government should in cooperation with State and Territory governments put in place protocols to ensure that all older patients who are receiving medical care (irrespective of care setting), and their relatives and care givers, have the opportunity to discuss advance care planning to identify the values, preferences, and outcomes of most importance to patients. These should guide the formulation of agreed care plans.
27) The Commonwealth Government should in cooperation with State and Territory governments establish a satisfactory recording and reporting system of performance indicators that also includes patient/carer reported outcome and experience.

Protection of older persons from abuse

28) The Commonwealth Government should establish a register of Enduring Powers of Attorney (EPOA) and standardise EPOA provisions nationally so that there is recognition of older persons' EPOA stipulations across states and territories.
29) The Commonwealth Government should train lawyers and health professionals in capacity assessment prior to the completion of an EPOA.
30) The Commonwealth Government should further develop protocols to eliminate inappropriate administrations of pharmaceuticals as chemical restraints for older patients and put in place programs to promote the use of non-pharmacological management as first line treatments. Supportive guidelines need to be communicated setting out supported actions such as RACP Evolve guidelines on antipsychotics and benzodiazepines and quality use of medicines.

31) The Commonwealth Government should in cooperation with State and Territory governments establish regional reference groups comprising lawyers, health and aged care professionals and police, to provide expertise for the urgent assessment of cases of potential older persons' abuse.

Dementia

32) The Commonwealth Government should invest in additional research into dementia care.
33) The Commonwealth Government should jointly with State and Territory governments invest in providing and training community based multidisciplinary teams which can undertake assessment services of dementia where needed and appropriate. This could also include a policy for the assessment of older patients for delirium, that is accompanied by an appropriate management strategy for all hospitals and RACFs.
34) The Commonwealth Government should in cooperation with State and Territory governments contribute funding to increase the number of community based, fully resourced dementia assessment and management services available in metropolitan and rural areas. Care management should be based on a strategy/ healthcare pathway for people with dementia that includes a multidisciplinary approach and a cross-sector care continuum of integrated community-based services.
35) The Commonwealth Government should enhance funding to ensure adequate training in dementia care to all service providers.
36) The Commonwealth Government should establish and recurrently resource Primary Care Dementia Nurses positions in primary healthcare with the view towards also deploying these positions to purpose-built dementia units for those with significant Behavioural and Psychological Symptoms of Dementia (BPSD) who are/cannot be managed by non-pharmacological means and/or are aggressive and physically able.
37) The Commonwealth Government should enhance funding for programs to better support family and other non-professional carers.
38) The Commonwealth Government should introduce a specific quality assurance requirement in aged care services in relation to care of younger residents/users which specify attention to a younger person's biopsychosocial and physical needs.

Disability

39) The Commonwealth Government should develop aged care facility policies and protocols to formally respond to the fundamental differences between disability associated with ageing and chronic multi-morbidity, and disability associated with congenital or acquired conditions in younger people.
40) The Commonwealth Government should fund the introduction of accommodation options for young people with disabilities from a person-centred, evidence-based perspective, recognising that these young people require a similar level of personal care as that provided to older persons in RACFs.
41) The Commonwealth Government should consider ways to minimise the number of young people residing in RACFs by providing funding to support them to live in their own homes or other age appropriate accommodation in the community.
42) The Commonwealth Government should ensure that younger people with disabilities who reside in RACFs have timely access to the NDIS and receive the right level of support through NDIS services while in the RACFs.

Facilitating opportunities for home-based care

43) State and Territory governments should ensure adequate funding to facilitate the development of community situated services that promote healthy aging, such as community transport for older people.
44) State and Territory governments should ensure adequate funding to build up community services for geriatric evaluation and home-based rehabilitation, restorative care, and capacity building.
45) State and Territory governments should ensure adequate funding to improve support for patients and carers in home-based care from non-English speaking backgrounds, and which includes community-based facilities and services.

Improving quality of care in residential aged care facilities (RACFs)

46) The Commonwealth Government should review and improve the design of RACFs to more effectively customise their services to the population being served, for example, appropriate physical facilities where the majority of older persons have intellectual disabilities.
47) The Commonwealth Government should develop strategic plans to ensure that for the complex range of specialised services that must be provided by RACFs, there is secure resourcing which better matches the health and psychosocial needs of the residents and ensures that standards and

accreditation systems are able to validate appropriate allocation of these resources within facilities including workforce. This is so that the right professional services are provided to residents in line with accessible, high quality, safe, person centred and comprehensive care.

48) The Commonwealth Government should look at ways to enhance accreditation for best practice in RACF protocols.
49) The Commonwealth Government should in cooperation with State and Territory governments better link RACFs with hospitals that provide outreach services whereby trained paramedics and nurse practitioners can assess and assist RACF nursing staff to treat patients in the RACF who have acute but uncomplicated illnesses.

Health professionals for the future

50) The Commonwealth Government should develop a strategic plan to match health professional demand to the present under-resourced service delivery sites and future service need.
51) The Commonwealth Government should sufficiently resource and monitor the National Palliative Care Strategy 2018 (released 2019) so that the needed end of life and palliative care services are able to be received by patients reaching the end of their lives as appropriate.
52) The Commonwealth Government should introduce post graduate training programmes for General Practitioners (GPs) in dementia management.
53) The Commonwealth Government should develop a strategic plan for improving access to physicians in places where there are low points of face of face contact (such as due to geographic maldistribution). Solutions may include innovative models of service delivery such as telehealth.
54) The Commonwealth Government should ensure there is sufficient funding to increase the number of appropriately qualified physicians and advanced trainees in ambulatory and community settings.
55) The Commonwealth Government should review re-education needs for nursing and allied health education in regard to the identification and management of geriatric syndromes.
56) The Commonwealth Government should undertake a review of the standards of quality and safety of care for places in which older people become residents, including for consistency given there are different care-environments emerging which can range from the home to aged-care institutions

Aged care and the quality of aged care services in Australia must be improved to correspond to best practice. Out of this Commission must come an improved health care experience for older persons, their carers, health practitioners and ancillary services.

Context

Brief description of aged care services in Australia

The Australian Government is the primary funder and regulator of the aged care system. The Royal Commission has detailed descriptions of the aged care system in Australia. By way of introduction we include a synopsis only here. Aged care is available to Australians aged 65 and over (and Indigenous Australians aged 50 and over) who can no longer live without support in their own home. Sites for care delivery include residential aged care facilities (or nursing homes) through various providers, community facilities and private residential houses. The Australian Government controls the number of subsidised aged care places that are available (in the home or in a care facility). Aged care places are currently allocated to providers who are approved to provide care under the Act (approved providers), and eligible clients must find a provider with an available place in order to access care.

The mechanism to access aged care services (subsidised by the Australian Government) is a needs assessment. The main portal for this is My Aged Care, from where people may be directed to a face to face assessment. There are different assessments. For home support services, they are referred to a Regional Assessment Service; for more complex care, they are referred for comprehensive assessment by an Aged Care Assessment Team. Where appropriate, they may be referred to health or other support services.
The Commonwealth Home Support Programme (CHSP) provides entry-level home help for older people, as well as planned respite activities to relieve carers. CHSP services may be provided at home or in the community.

For older people requiring a greater level of help to remain at home, the Home Care Packages (HCP) Programme offers coordinated packages of care from an approved home care provider. HCPs assist older people to stay at home (rather than entering residential aged care) and provide ongoing personal and support services and clinical care.

Residential aged care is provided in aged care homes on a permanent or respite (short-term) basis. It is for people who need more care than can be provided in their own homes.

Flexible care caters for older people who may need a different care approach than that offered by mainstream home and residential care services.

In addition to mainstream residential and home care, there are alternative programs such as: Transition Care; Short-Term Restorative Care; Multi-Purpose Services; Innovative Care; and National Aboriginal and Torres Strait Islander Flexible Aged Care Program services. However, older people do not necessarily progress through the system in a linear fashion nor does program design always reflect how the system works in practice.

Issues

With increased life expectancy in Australia, along with the improved effectiveness of managing acute disease comes a corresponding need to plan and provide for a significant population of older persons. Older adults are currently significant consumers of health care and will continue to be, based on projected demography statistics for Australia[4]. This context of aged care presents significant challenges that stem from high demand, inequitable workforce distribution, poor service access and limitations within the organisation of the health system. Some factors to consider are:

- Hospitalisation rates for older persons are four times that for younger groups.
- The demand for care has shifted from acute treatment to management of chronic diseases. Australia has the highest prevalence of chronic disease among OECD countries (80%), followed closely by Hungary (70%) and New Zealand (65%)[5]. This will have significant impact on the projected care services as our demographic becomes older.

[4] Wyman, M.F., Shiovitz-Ezra, S. and Bengel, J., 2018. Ageism in the health care system: Providers, patients, and systems. In *Contemporary perspectives on ageism* (pp. 193-212). Springer, Cham.

[5] Business Council of Australia, *Overview of megatrends in health and their implications for Australia: Background paper*

- Within the OECD, it is expected that economies will face a ratio of two working-age people for every person aged over 65 years compared to the current four working-age people[6].
- There is a geographical maldistribution of services for older persons as well as a maldistribution of the required physician workforce. This impacts access to and affordability of services for those in outer metropolitan, rural and remote communities and has a particular impact on Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) patients and their carers.
- High need demographic sections of the population are more likely to live in outer suburban areas. In these locations there is a poor ratio of health providers to persons high in need compared to capital cities. Suburbs with high growth rates (for example, western suburbs in Sydney) are leading to increasing presentations at hospital emergency departments placing pressure on public resources[7].
- The experience of older Aboriginal and Torres Strait Islander Australians highlights many shortfalls in service provision that compound inequities in overall health outcomes.
- Future impacts of climate change on public/population health need to be planned for in health system redesign, for example anticipating a disproportionate impact on vulnerable sections of the populations of Australia and New Zealand. This impact may be higher rates of respiratory illness, diarrhoea, heat stress and morbidity requiring hospital admission[8].
- The extended working life of older persons beyond 60 or 65 years[9]. Older persons in the community cannot be assumed to have retired. Occupational medicine is likely to have an increasing role.

In this already pressured service provision environment we can expect compounded system impacts arising from a reduced number of carers, for reasons of family mobility (potential carers living elsewhere), financial pressures for potential carers to continue working, and carers' own reduced incapacity.

The organisation of, and strategic addressing of clinical care needs of aged persons must recognise these categories of patients:

- Aged persons with complex and multiple chronic illnesses, living independently.
- Aged persons with functional limitations or permanent disability requiring long-term assistance.
- Aged persons making transitions across the care continuum, such as moving from a hospital to a rehabilitative facility after surgery[10].

We support the Australian Charter of Healthcare Rights (2008)[11] which states patients have a right to expect timely high quality access to care, in the Australian health system. For older patients, in a less empowered and vulnerable position, this Royal Commission will be expected to redress inequitable and inconsistent access to care that is not of the standard we would expect for ourselves or our parents.

One key area we must reconsider is the arbitrary boundary between primary care and secondary care and understand that care for older persons is most often (as far as the health system is concerned), about efficiently caring for complex patients. If their health problems are poorly managed, older persons become potentially complex and costly patients, with greater and more permanent loss of functionality. Combined national and state responses must ensure that the physical care of older patients is properly addressed to prevent irrevocable and rapid deterioration. Health responses should be neither cost prohibitive, nor detrimentally delayed. The Australian Government has placed aged care among the key priorities for Primary Health Networks (PHNs) and it is here that we would expect to see a drive for more cross sector integration.

[6] Business Council of Australia, *Overview of megatrends in health and their implications for Australia: Background paper*

[7] See for example Aubusson, Kate, 2017 Emergency department wait times blow-out at four western Sydney hospitals, report shows, *The Sydney Morning Herald*, 12 September (http://www.smh.com.au/national/health/emergency-department-wait-times-blowout-at-four-western-sydney-hospitals-report-shows-20170911-gyf336.html) accessed 12 September 2017

[8] RACP Environmentally Sustainable Heathcare Position Statement Nov 2016; and RACP The Health Benefits of Mitigating Climate Change Position Statement Nov 2016

[9] Australian Institute of Health and Welfare 2015. Australia's welfare 2015. Australia's welfare series no. 12. Cat. no. AUS 189. Canberra: AIHW.

[10] Wan, T.T.H., 2017. A transdisciplinary approach to healthcare informatics practice and research: Implications for elder care with poly chronic conditions. *Journal of Health Informatics and Management*, *1*(1), pp.1-7

[11] Second edition to be released in August 2019

1. Assessment - Early and timely diagnosis of conditions for the older persons in the community

This section addresses Term of Reference (a)

The conditions experienced by older persons often require multidisciplinary assessments. Comprehensive geriatric assessment is an "interdisciplinary process used to quantify an older individual's medical, psychosocial and functional capabilities"[12] (for example, dementia which requires the input and expertise of carers, families and clinicians, such as general practitioners, general physicians, psychologists, psychiatrists, neurologists, psychogeriatricians, geriatricians, specialist nurses and allied health professionals). It is also the core of any specialist outreach service. This process encapsulates diagnosis, problem identification and goal setting. An outcome is a comprehensive management plan, in collaboration with other involved care providers.

With prolonged working lives this may also involve assessment for older persons' capacity for work, for example involving occupational physicians.

1.1 Complex and multiple chronic conditions

Nearly a quarter of all Australians (23%), and 3 in every 5 Australians (60%) aged over 65 years, have been identified as having two or more chronic conditions[13]. Complex co-morbidities are common amongst older persons and access to general physicians and other specialists to manage these in the hospital setting, and to assist general practitioners in the community, must be assured. Frail, older Australians with multi-morbidity are among the most complex patients the health system must manage as they experience medical syndromes that are multifactorial and involve multiple organ systems. Timely, early assessment, and formulation of a comprehensive care plan can be critical to maintaining optimal functionality.

This care group is ideally managed using multidisciplinary team care approaches coordinated by a geriatrician or geriatric nurse practitioner, general physician or rehabilitation medicine physicians. These older persons should be able to easily access essential specialist interdisciplinary care, but often this is not the case[14].

While our health care system remains poorly coordinated and the demand for chronic care increases, older patients continue to be at risk of sub-optimal outcomes. Older persons have a lower ability to recover from acute health events, and this means the risks to health resulting from poor quality, unsafe care for this population group are magnified[15]. Examples of concurrent conditions that are highly prevalent in this population and must be managed are:

- Geriatric syndromes comprising falls and unsteady gait, cognitive impairment, delirium, pressure injuries, malnutrition, depression and other mood disorders, urinary or faecal incontinence, and swallowing disorders.
- Age related peripheral neuropathy (a significant contributor to falls and is often unrecognised).
- Visual and hearing impairments.
- Arthritis causing pain and limiting mobility.
- Heart disease (acute exacerbations such as angina or decompensated heart failure).
- Aspiration pneumonia complicating dysphagia due to oesophageal disorders or neurological conditions resulting in impaired level of consciousness or bulbar dysfunction.
- Vascular disease, including stroke, cardiovascular disease/ heart failure and vascular dementia.
- Strokes resulting in paralysis, limited mobility, inability to communicate and continence issues.
- Frailty.
- Neurodegenerative disease, for example, Alzheimer's disease, Parkinson disease, Lewy Body dementia.
- Sensory impairment including deafness, not just visual impairment e.g. macular degeneration.
- Sarcopaenia (loss of muscle bulk)

[12] Australian Society for Geriatric Medicine 2011. Position Statement No. 8 Comprehensive Geriatric Assessment and Community Practice. http://www.anzsgm.org/documents/positionstatementno8geriatricassessmentandcommunitypractice.pdf
[13] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health no. 15. Cat. no. AUS 199. Canberra: AIHW.
[14] Dr Eddy Strivens, President, Australian and New Zealand Society for Geriatric Medicine (ANZSGM) submission to the Royal Commission into Aged Care Quality and Safety 2019 (cited with permission)
[15] Wan, T.T.H., 2017. A transdisciplinary approach to healthcare informatics practice and research: Implications for elder care with poly chronic conditions. *Journal of Health Informatics and Management*, *1*(1), pp.1-7

- Metabolic Non-insulin-dependent diabetes mellitus (NIDDM) and obesity.

Health related consequences
When an older person experiences one or more likely multiples of the aforementioned list of conditions, this can lead to:

- Progressive impairment of activities of daily living/ personal care
- Cognitive decline in some people leading to memory impairment, apraxia (neurological disorder characterized by loss of the ability to execute or carry out skilled movements and gestures, despite wanting to or having the physical ability to perform them[16]), dysexecutive function including diminished awareness and impaired judgement and planning.
- Gait impairment/ apraxia
- Falls
- Frailty
- Sensory deprivation
- Loss of independence, vulnerability, social withdrawal, loneliness, abandonment and boredom.

The current Comprehensive Geriatric Assessments (CGA) undertaken by geriatricians and other appropriately trained health professionals is a world best practice approach and should be recognised as essential to the provision of care for older persons in the community and residential aged care facilities. The CGA is intended for patients 65 years of age or more who suffer from complex and possibly interacting medical, physical and psychological problems. The CGA is a multidimensional, interdisciplinary process used to assess an older individual's medical, psychosocial and functional capabilities. It includes diagnosis, problem identification, goal setting and formulation of a comprehensive management plan for holistic treatment, rehabilitation, support and long-term follow-up. It is part of the core skills and knowledge base of specialists in geriatric medicine. Access to the CGA is currently subsidised through MBS patient rebates and it is essential that there continue to be some form of public funding or subsidy for provision of this services.

Access to the CGA can be enhanced if GPs, general physicians, rehabilitation physicians, nurse practitioners and allied health professionals were able to undertake these assessments with proper training and experience in using assessment tools, including modified or abbreviated forms of CGA (as is being currently rolled out in Queensland hospitals using the Geriatric Emergency Department Initiative (GEDI nurse-led model). Geriatricians should be integral to these training and accreditation programs.

1.2 Aged Care Assessment Team assessment

The Aged Care Assessment Team (ACAT) assessment process could be rendered more efficient. Assessments are delayed because of the time required involving complex, multi-page documents, much bureaucracy, rules and regulations. The waitlist has increased from one month to two - three months.

Person centred teams able to address the complex interaction of medical, psychosocial, physical and cognitive are essential to each individual patient's healthcare as he or she transits through what should be structured as a care continuum: from the initial interface with assessment teams such as the Regional Assessment Service (RAS) and Aged Care Assessment Team/Service (ACAT/ACAS), through community service provision, into and out of acute and subacute hospital and health services and through to residential care and eventually end of life care. The RACP is aware of the need to avoid doubling up on unnecessary assessments and low value treatment recommendations. For example, a multidisciplinary team could be part of the ACAT process, coordinated by a community nurse role.

The current all-inclusive system for accessing services My Aged Care has proven to be difficult for many older individuals to navigate. There is a difference between the description and design of the aged care system, and the experience of older people when they need and seek care[17].

The reasons for the difficulties that older persons experience (relevant to many aspects of aged health care) must be an integral part of the practical forethought of aged care health provision. This experience must be a

[16] https://www.ninds.nih.gov/disorders/all-disorders/apraxia-information-page
[17] Smith, C., 2019. Navigating the maze: an overview of Australia's current aged care system.

key part of the Royal Commission's responses to ensure safe, high quality care for older persons. Reasons include:

- Difficulties in accessing the internet or using online services;
- The requirement in the current process for individuals to advocate for themselves or appoint someone using a form to help them navigate the process (clearly difficult for older people suffering from dementia or cognitive impairment)
- The older person must tender their own services with funding provided in the absence of a support person being offered to help in the navigation.
- The application process is time-consuming which works against most health practitioners being able to apply or advocate on behalf of their patients.

Part of the solution could be to make available support officers for My Aged Care to assist with the allocation of funding, and selection of service providers; similar to the model currently used for National Disability Insurance (for those deemed eligible).

Recommendations

The College recommends:

- The Commonwealth Government should guarantee continued funding for subsidised access to Comprehensive Geriatric Assessments (CGA).
- The Commonwealth Government should, in cooperation with the State and Territory governments, develop a policy for the assessment of older patients to proactively diagnose delirium and oversee the introduction of an appropriate management strategy for all hospitals and RACFs.
- The Commonwealth Government should reduce delays associated with ACAT assessments.
- The Commonwealth Government should develop an approach that uses an Aged Care Assessment Team, fully funded to which there is direct access, with expertise in the care, needs and coordination required for older people, who liaise with medical personnel (General Practitioners and Specialist), integrate with Local Health Districts' Aged care/ geriatric medicine services, provide appropriate experienced allied health assessments and assist with choosing and initiating care packages.
- The Commonwealth Government should consider measures to allow carers or family to apply on behalf of an individual to My Aged Care, without the requirement of a form, to lessen the difficulties in accessing services. This should include streamlining the online application process so that General Practitioners, Allied Health Staff and others can make timely referrals on behalf of an older person.
- The Commonwealth Government should consider provision of My Aged Care support personnel to assist with navigating the system, allocation of funding, and selection of service providers; similar to the model currently used for National Disability Insurance Scheme.
- The Commonwealth Government should provide accessible multidisciplinary comprehensive assessments for older patients in hospital and community care settings. The assessment services should have strong links with Geriatric Evaluation and Management (GEM) Units; existing geriatric services; and have a clear point of contact

2. Accessibility and cost of aged care

This section addresses Terms of Reference (a) and (f)

2.1 Expanded access to specialist care through telehealth and retaining access for home visits

In addition to having access to GP and primary care services, it is essential for older people to have timely access to input of a medical professional with expertise in recognising and managing the problems of ageing, such as a geriatrician, a general physician or a neurologist. This is a simple risk measure to mitigate against physical and mental decline when an underlying medical condition needs expert management. In particular, older people should have access to this expertise within their place of residence, whether this be in the community, or in RACFs.

One means of enabling more access to specialist care especially for less mobile older persons is through telehealth. However, the ability of patients to claim rebates for telehealth consultations is currently restricted to patients who live within a 15 km distance from a specialist service. This disadvantages older patients who have difficulties associated with travel, such as needing carer support, or suffer discomfort in waiting for long periods for consultations. Wider use of telehealth in these cases could, aside from reducing these inconveniences, facilitate more timely appointments and allow the patient's GP to receive specialist opinions and advice earlier so care management can be continued in the community.

As discussed previously, access to CGAs is currently subsidised through MBS patient rebates. This includes access through home visits. We would therefore reiterate that it is essential that there continue to be some form of public funding or subsidy for provision of this services especially if needed access to these services through home visits is to continue.

2.2 Cost burden of residential care for people above pension/concessional eligible threshold

The RACP draws the Royal Commission's attention to those people who are not entitled to concessions for the cost of entry to residential care which can impose prohibitive financial burden on the patient and/or family. This is problematic for those just above the pension/concessional eligible threshold and include self-funded retirees who are not very well off and have to use up most of their savings/assets to enter into residential care.

2.3 Accounting for costs of older patients with special needs in hospitals

This review should also consider cases where appropriate provision has not been made for higher costs for patients with special needs in hospitals.

This is particularly pertinent to the significant and growing cohort of patients with cognitive impairment and non-cognitive behavioural and psychological symptoms of dementia (BPSD). Care of such patients require significant resources (such as 24 hour special nursing and security services) and longer stays in order to stabilise these disruptive behaviours and render them suitable for discharge to community carers or residential care. The cost of this care is not adequately captured within existing DRG classifications, despite the ability to code for some degree of medical complexity.

Recommendations

The College recommends:

- The Commonwealth Government should remove the distance restriction in the current MBS items for telehealth.
- The Commonwealth Government should investigate measures to address the cost burdens of residential care for older people who have income or assets that place them just above the pension/concessional eligible threshold.
- IHPA should review whether the current Activity Based Funding system is adequately accounting for all hospital episodes of care for older patients with cognitive impairment and Behavioural and Psychological Symptoms of Dementia (BPSD).

3. Support services in the community

This section primarily addresses Term of Reference (a)

3.1 Timeliness and gaps in coverage of support services

If more timely support care was available, then more patients might be able to remain at home, utilising support packages, rather than be moved into a Residential Aged Care Facility (RACF). However, although additional packages have recently been released (10,000 packages nationally) current waiting times are unacceptable and create system pressures in that:

- Patients often need immediate care and support.
- Families struggle to cope with patients' care during the wait times.
- Delays lead to more costly default care settings such as hospitals.

Patients also prefer to remain close to family and community support as the burden of one or more conditions increases over time. There are significant gaps in services not only in rural and remote areas, but also outer metropolitan zones characterised by high population growth.

A key contributing factor to gaps in services is the skewed distribution of the health workforce, including physicians, and ageing of the health workforce (the latter in rural areas in particular). This severely limits continuing access to expert care for older persons living outside major cities (also refer to section 11).

An area of community support relevant to older persons more recently is supporting people to remain in the workforce. Working reduces social isolation, reduces morbidity and mortality, and indeed many OECD countries are encouraging policies to support longer working activities[18].

3.2 Community Care

Current Home Care Packages (HCPs) are problematic for these reasons:

- The current cost for Level 1 and 2 packages is such that eligible people often delay accepting a package. By the time they reach a higher level of need (Levels 3 and 4), older patients may no longer be at a point where they have the decision-making capacity to accept this support.
- There are prolonged wait times for community care packages, which can be confusing and frustrating for older people and their families, and this also results in people being unnecessarily placed in residential care. For example, there is currently a long waitlist – up to 12 to 18 months - for HCP level 3 or 4 packages, which results in some patients having to enter residential care unnecessarily because care needs have exceeded what is available at home.
- The level of "service fees" charged by service providers to administer care packages absorb a significant amount of funding. Even a HCP 4 package only provides a maximum of 8-10 hours (more usually 8) a week at the most. Carer support is even less if the package must also cover the cost of equipment, allied health, and nursing needs.

These delays and limitations in service all result in avoidable admissions to residential care or applications for higher levels of care which are more costly. The waitlists and time delays for home care packages is such that older persons are forced to wait long periods during which time their conditions and circumstances may deteriorate. The response needed is to both reduce the wait time and better meet the demand, which may mean increasing the number of packages which our members advise is below the current need level.

As noted, an additional 10,000 home care packages were released in February 2019 by the Australian Government. This is still not sufficient to meet demand, the immediacy of demand and the need to reduce strain while packages are being finalised. When individuals are not able to access services they often end up in hospital or requiring residential aged care as needs are not met at home. Providing an increase in packages in the long run will maintain function, independence and ultimately reduce the burden of cost for older individuals on the government.

Consumer-directed care packages (as home care packages have been since 2015) give consumers a personalised budget for them to purchase their desired mix of services. However, this budget can only be used for services that are geographically available, which is not the case in some parts of Australia,

[18] Organisation for Economic Cooperation and Development (2006) *Live Longer Work Longer,* OECD

particularly in rural areas, resulting in unmet need, especially for those requiring higher level care packages. It needs to be recognised too that there are older people who have difficulty with this, and support and guidance from a social worker or nurse can add value.

Consumer-directed care packages are confusing to many people who are limited in their capacity to choose and negotiate suitable care the ability (for example due to dementia, hearing/ visual impairment). This is also stressful to carers, who have described to our members charges for services under this provision to be higher than when not under a care package. Our members have given examples of high allied health charges for treatments that are unlikely to be of benefit (one example, is older aphasic patient (frontotemporal disorder or FTD) charged almost $9000 for a plan of treatment by a Speech Pathologist from her allocation through Aged care).

Recognising social isolation as a health issue
Separate to support 'packages' is the need to address social isolation, as important to mental and physical health and well-being, which is an increasing problem for older persons. This is equally relevant to people in the community and also in RACFs, where either families are not able to or choose not to interact frequently. Sensory deprivation and feelings of being abandoned are detrimental.

Recommendations

The College recommends:

- The Commonwealth Government should increase the availability of Home Care Packages (HCPs) to eliminate delays in access which frequently lead to progressive impairment and loss of independence.
- The Commonwealth Government should formulate measures to further reduce the cost to consumers of Level 1 and 2 Home Care Packages (HCPs).
- The Commonwealth Government should critically review the proportion of "service fees" charged by service providers to administer care packages that impacts the quantum of services actually received by consumers.
- The Commonwealth Government should, in cooperation with the States, institute more strategic planning of the domiciliary health workforce to address unmet needs for community support services for older people in rural communities.

4. Meeting the needs of Aboriginal and Torres Strait Islander older people

This section primarily addresses Term of Reference (a)
We note here that many of the recommendations could equally apply to most older persons in rural and remote communities.

Foremost is the appreciation of the importance of health care services achieving a high degree of trusted cultural safety. It is this that is essential to person-centred care for older Aboriginal and Torres Strait Islander peoples.

4.1 Lower aged care threshold

The differential threshold for aged care services for Aboriginal and Torres Strait Islander Australians needs to be recognised and considered in both service planning and service delivery. While life expectancy has increased overall for most Australians, Aboriginal and Torres Strait Islander people do not have the same experience. For the population born in 2010–2012, life expectancy was estimated to be 10.6 years lower than that of the non-Aboriginal and Torres Strait Islander population for males (69.1 years compared with 79.7) and 9.5 years for females (73.7 compared with 83). Ageing syndromes are more apparent in younger Aboriginal people but mostly those syndromes still occur in the 60s years, 70s and 80s.

The **aged care target population** is defined for services funded under the national aged care system. This is defined as all people aged 65 years or over and Aboriginal and Torres Strait Islander Australians aged 50–64 years – which aligns with the funding arrangements as specified under the National Health Reform Agreement. However, the Australian Government's **aged care 'planning population'** is defined as people aged 70 years or over which is used, along with the population of Aboriginal and Torres Strait Islander Australians aged 50–69 years in some cases, to allocate places under the *Aged Care Act 1997*.[19]

Generally speaking, Aboriginal and Torres Strait Islander Australians are more likely to present at a much younger age for all aged care services and their health conditions need to be appropriately assessed and risk managed. Consequently, all service provision eligibility criteria must be population relevant.

4.2 Aboriginal and Torres Strait Islander older peoples access to aged care and specialist care

There are inequities in access to health services, especially among Aboriginal Australians and people living in rural or remote Australia. Although attention should be given to the needs of rural and remote Aboriginal people we must also bear in mind that 60 per cent of Aboriginal and Torres Strait Islander people live in major cities or inner regional areas.

Barriers to necessary care can come from:

- Assessment processes – the aged care assessment process requires a person to talk about their intimate and personal health and their domestic situation with a complete stranger. That stranger may be of the opposite sex and may not have had any cultural awareness training.
- Avoidance of the aged care system and ACAT discussions by Aboriginal and Torres Strait Islander people.
- Challenges that Aboriginal and Torres Strait Islander people face in navigating My Aged Care.
- Limited literacy and access to postal services required for My Aged Care, as well as limited e-literacy and e-connection in some parts of Australia.
- The need for Aboriginal or Torres Strait Islander interpreters which, if not readily available as a public service, may require persons to pay for this out of their home care package.
- Lack of infrastructure in small communities or the capacity to provide a complete range of community support services, for example, alcohol or disability related services, as there is insufficient economy of scale to sustain such services in particular communities.

Dedicated mental health and social and emotional wellbeing heath teams for Aboriginal and Torres Strait Islander people should also be a part of integrated service delivery in health care settings.

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Aboriginal and Torres Strait Islander people, including older Aboriginal and Torres Strait Islander people experience poor access to both primary and specialist services. This includes access to appropriate palliative care services due to their general shortage across remote Australia.

A recent Western Australian study highlights the disparity of receipt of specialist (physician) expertise. In relation to ischaemic heart disease, Aboriginal people (vs. non-Aboriginal) people were younger (mean 50.2 vs 60.5 years), had more comorbidities, were more likely to have had GP long/prolonged consults and non-vocationally registered GP consults, but were less likely to received specialist consults[20]. This study found that despite being over-represented in urgent/semi-urgent ED presentations and admissions for ischaemic heart disease (IHD), health care services for Aboriginal people were under-resourced compared with the rest of the population, particularly in terms of specialist care prior to first IHD hospitalisation[21].

The RACP has urged the Australian Government to commit to secure, long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) that is commensurate with the burden of disease[22].

Recognising the role of ACCHOs

Aboriginal community-controlled organisations (ACCHOs) are trusted providers of services to Aboriginal and Torres Strait Islander people who know how critical culturally safe service delivery environments are to communities. This has been integral to their success as Aboriginal and Torres Strait Islander service providers. In the context of this Royal Commission, the College supports that ACCHOs be considered preferred providers of primary health care services for aged care, and that they be funded appropriately to continue their critical role as culturally safe service providers, and able to focus on the older persons in their community.

4.3 Ensuring services are culturally safe and optimised towards culturally appropriate care

To Aboriginal and Torres Strait Islander people culture, identity and connection to family, country, language and traditions are central to their definition and understanding of health. It is essential not to overlook the cultural context if health care deliver is to have an impact on the health of older Aboriginal and Torres Strait Islander people. For example, older Aboriginal and Torres Strait Islander people may have carer and family obligations in that:

- 22% (22,255) provided unpaid care for children[23], and
- 18% (17,744) assisted a person with daily activities due to disability, long-term health conditions or problems related to old age (ABS 2017)[24].

Other culture related factors to consider in relation to health services are as follows:

- The diversity of Aboriginal and Torres Strait Islander cultures and language is often not recognised or incorporated into service commissioning. There are over 500 indigenous nations and over 250 different language groups across Australia. An approach that works for one particular cultural group may not be appropriate in another setting. At the forefront of these challenges, whether care is delivered in the city, rural or remote Australia, it needs to be culturally safe and culturally appropriate.
- A simple example given to the Royal Commission is when a health provider tries to request a translator and, despite following the correct procedure, discovers there is no inclusion on the form to state *which* Aboriginal language is needed.

[20] Teng TH, Katzenellenbogen JM, Geelhoed E, Gunnell AS, Knuiman M, Sanfilippo FM, Hung J, Mai Q, Vickery A, Thompson SC. Patterns of Medicare-funded primary health and specialist consultations in Aboriginal and non-Aboriginal Australians in the two years before hospitalisation for ischaemic heart disease. International journal for equity in health. 2018 Dec;17(1):111.
[21] Teng TH, Katzenellenbogen JM, Geelhoed E, Gunnell AS, Knuiman M, Sanfilippo FM, Hung J, Mai Q, Vickery A, Thompson SC. Patterns of Medicare-funded primary health and specialist consultations in Aboriginal and non-Aboriginal Australians in the two years before hospitalisation for ischaemic heart disease. International journal for equity in health. 2018 Dec;17(1):111.
[22] RACP 2019 Pre-budget submission
[23] *Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over 2019—In brief In the 2 weeks prior to Census night 2016, among Indigenous Australians aged 50 and over*
[24] *Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over 2019—In brief In the 2 weeks prior to Census night 2016, among Indigenous Australians aged 50 and over*

- There are challenges for older people when they must go off country to access health and aged care services, for example, when it comes to residential care. There is a strong connection to family and community that must be accommodated to reduce stress and accompanying impact on health.
- The unique role of the elder in traditional Aboriginal and Torres Strait Islander communities must be appreciated and incorporated into the design and operation of local health services in ensuring that care is delivered in a culturally sensitive manner that gains the trust of residents and their community.
- The provision of culturally appropriate food in a residential care facility should be considered.
- Culturally safe palliative care is also needed (as stated in previous section).
- The delivery of care may require attention to significant male and female roles and kinship relationships.

Orthodox Western treatment approaches have underlying concepts of sickness which may not resonate with Aboriginal beliefs. The symptomatology of conditions may not always have relevance to older Aboriginal people. Care decision making is undertaken using a science and medicine-based framework that may be at odds with an Aboriginal and Torres Strait Islander conceptualisation of the situation.

Aboriginal and Torres Strait Islander languages can be poorly recognised, let alone understood or able to be translated readily. An RACP Fellow described a situation in which an older woman was thought to have dementia and was incarcerated incorrectly in a locked ward for 12 months before it was recognised that she was the last speaker of her language. Similar cases of misinterpreted behaviour pertain to some elderly people born in remote areas.

For some older people born in remote areas, their behaviours in hospitals may be interpreted as signs of dementia when they are not.

At a practical level it may also be difficult to fully comply with the rules and regulations to return a person home in remote Australia as this may require addressing construction requirements and falls risk mitigation renovations which require costly expenditures by the patient's family.

In remote Australia there may be no nursing home within jurisdictional boundaries so older Aboriginal and Torres Strait Islander people may have go somewhere that is a long way from their family and country. Thus, families are often disempowered by well-meaning allied health professionals who state that the family home is not an appropriate or safe environment.

Conversely, some remote families are pushed to cope with older persons for whom they cannot provide care in such environments and are not offered aged care beds when required.

We note that there are some good examples of non-Western built environments where aged care is provided with an excellent high level of cultural competency. One is Kalano Aged Care in Katherine; another is in Victoria where the Aboriginal Community Elders Services (ACES) is the only Aboriginal & Torres Strait Islander community-controlled organisation in an urban setting which provides all three aged care programs: Residential Care Services, Community Aged Care (also known as Koori Community Aged Care Program or KCACP); Home and Community Care (HACC) Planned Activity Groups.

Notwithstanding such examples, we are concerned that the voices of Aboriginal people are not being heard in the decision-making processes in many of these complex situations.

Recommendations

The College recommends:

- The Commonwealth Government should better fund early condition assessment and comprehensive condition management, and community-based care for older Aboriginal and Torres Strait Islander people.
- The Commonwealth Government should establish models of medical service provision and sustainable funding which ensure equitable and appropriate access for Aboriginal and Torres Strait Islander older people to consultant physician services, across varying locations.
- The Commonwealth Government should guarantee long-term funding for the Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) commensurate with the burden of disease.

- The Commonwealth Government should introduce trials of enhanced primary and specialist shared care delivery models for Aboriginal and Torres Strait Islander people.
- The Commonwealth Government should look at ways of addressing the barriers Aboriginal and Torres Strait Islander older people experience in relation to health services including through investing in improving the cultural competency of healthcare professionals.
- The Commonwealth Government should increase funding for palliative care services for Aboriginal and Torres Strait Islander older people, especially in non-urban areas.

5. Proactive patient management and innovative models of care

This section addresses Terms of Reference (a), (d) and (f)

5.1 Pain management

Pain is a common symptom in older people, but we refer here to the increased burden of disease experienced by older people, not in relation to ageing itself. All health professionals have a responsibility to identify individuals with unrelieved pain and even if the underlying cause cannot be cured, to relieve suffering. This is especially important when individuals can no longer advocate for themselves or communicate their pain.

5.2 Medication management and monitoring

Because older people often use multiple medicines, appropriate review and rationalisation of medications is critical for older persons as both underuse and overuse of medications can cause harm.

Geriatricians, general physicians and clinical pharmacologists are trained to weigh the benefits and risks of each medicine and assess the potential for dangerous interactions between medicines for older patients. It is possible there is a need for more medication training to be extended to GPs.

The experience of our members is that older persons need considerable assistance with medication management for reasons such as vision impairment, difficulty opening packs, memory lapses and others. Dosage simplification is one area for improvement. Also, promoting knowledge of programs for returning unused medications would help to prevent medications being accumulated which can also cause confusion.

5.3 Wound management

Wounds in older persons require preventative care and careful management because the consequences can life threatening and severe. Generally, anyone over the age of 65 with poor nutrition and poor circulation can be at risk of developing pressure ulcers[25].Wounds are not just part of an ageing process but are treatable and need to be factored into care facility regimes and aged care service provision[26]. Examples are pressure ulcers. These lead to chronic wounds, and with significant pain, discomfort and decreased mobility. There are high death rates among older people with these types of wounds[27]. Diabetes is a major concern for chronic wounds.

Wound care services are another example of how Australia health care is characterised by a complex mix of treatment options, health care sectors and funding mechanisms. It has been stated that along with the implementation of evidence-based wound care there are also marked health improvements and cost savings, but most Australians with chronic wounds do not receive evidence-based treatment[28]. Chronic wounds benefit from the support of a management team that could include physicians, specialist wound care nurses, dieticians, physiotherapists, community/home-care nurses or other carers.

Between 17-35% of persons admitted to aged care facilities have pressure ulcers. The approximate number of cases in hospital and residential care settings in Australia each year is 400,000, with pressure injuries being the most common wound type, comprising 84% of these wounds, followed by venous leg ulcers (VLUs) (12%), diabetic foot ulcers (DFUs) (3%) and arterial insufficiency ulcers (1%)[29]. It has been reported that stage 4 pressure ulcers can cost a patient in excess of $60 000 to manage, and further that pressure ulcers cost approximately $286m per annum in hospital beds[30].

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[25] Pacella R, Tulleners R, Cheng Q, Burkett E, Edwards H, Yelland S, Brain D, Bingley J, Lazzarini P, Warnock J, Barnsbee L. Solutions to the chronic wounds problem in Australia: a call to action.
[26] Pacella R, Tulleners R, Cheng Q, Burkett E, Edwards H, Yelland S, Brain D, Bingley J, Lazzarini P, Warnock J, Barnsbee L. Solutions to the chronic wounds problem in Australia: a call to action.
[27] Pacella R, Tulleners R, Cheng Q, Burkett E, Edwards H, Yelland S, Brain D, Bingley J, Lazzarini P, Warnock J, Barnsbee L. Solutions to the chronic wounds problem in Australia: a call to action.
[28] Norman RE, Gibb M, Dyer A, Prentice J, Yelland S, Cheng Q, Lazzarini PA, Carville K, Innes-Walker K, Finlayson K, Edwards H. Improved wound management at lower cost: a sensible goal for Australia. International wound journal. 2016 Jun;13(3):303-16.
[29] Graves N, Zheng H. Modelling the direct health care costs of chronic wounds in Australia. Wound Practice & Research: Journal of the Australian Wound Management Association 2014;22(1):20-4, 6-33.
[30] Pacella R, Tulleners R, Cheng Q, Burkett E, Edwards H, Yelland S, Brain D, Bingley J, Lazzarini P, Warnock J, Barnsbee L. Solutions to the chronic wounds problem in Australia: a call to action.

Vulnerable patients at a high risk of developing pressure ulcers are those older people with neurological impairments and those who are immobile for extended periods of time. Other risk factors include arthritis, chronic liver disease, diabetes inflammatory disease, cognitive dysfunction, renal failure, vascular disease and weakened immune system.

5.4 Multidisciplinary teams

There is clearly a need to better integrate secondary and primary care services, including residential care facilities[31]. Multidisciplinary care planning, with a designated care leader (most often the GP) with follow-up play a vital role for the patient and the carer in providing care in a timely way.

- Planning and coordinated cross sector services are important in situations where there is a diminished capacity to navigate complex systems.
- Effective discharge planning may help to ensure appropriate support continues when people return to their usual care environment.

Multidisciplinary approaches should emphasise restorative care.

We advocate for the development and support of community-based models that connect specialist care with multidisciplinary teams such that care planning and management can include general practitioners, psychologists, nurses, psychogeriatricians, geriaticians and general physicians within a model of usual care. We stress the need for clear coordination (a single point of contact) to minimise risk of duplication and also confusion to patients and their carers.

Medical syndromes most commonly experienced by frail older people are multifactorial and complex, and best managed with multidimensional approaches delivered by a multidisciplinary team coordinated by a geriatrician, general physician or geriatric nurse practitioner.

The College is not stating that multidisciplinary assessments and full multidisciplinary teams are required in all cases. We are saying that health reform is needed to allow more integrated care when it is appropriate. At present this is a limitation that impacts and restricts comprehensive, safe, high quality care.

Geriatricians and general physicians take a multidisciplinary team approach to healthcare for older persons, always endeavouring to work with GPs and other health professionals such as nurses, physiotherapists, occupational therapists, speech pathologists, dieticians, psychologists, social workers and pharmacists. Older people may need to see a range of physicians such as cardiologists, neurologists and palliative care physicians. In this way, these specialists promote and prolong older persons' capacity to safely remain at home. Their role and appreciation of the impact and complexity of multi-morbid conditions on older persons should be considered central to supporting carer and patient decision-making.

Older people require access to the full range of specialist care because current evidence suggests that many older people have the potential to benefit from specialised medical treatments, perhaps even more so than younger people. On the other hand, overuse of invasive or ineffective interventions must be assiduously avoided in those older people who are frail and have diminished physical and mental reserve.

This can be a particular problem in rural and remote areas where there are shortages of health practitioner, for example, geriatricians. Accordingly, there may need to be different models explored to ensure care is accessible in a timely way.

The impact of chronic conditions and other social issues must be recognised and taken into account in planning health care. A particularly significant factor is the need to recognise and respond to mental health needs. Around 10 per cent of older Australians have symptoms of depression or anxiety[32]. Earlier data show that over 50 per cent of those living in residential aged care facilities had either or both conditions and just under half had come to residential care with a pre-existing depressive condition[33].

It is vital to plan and deliver whole of patient health care responses because their absence can result in more health system costs of care and significant social and community costs. Untreated mood disorders can

[31] https://agedcare.health.gov.au/sites/default/files/documents/09_2015/national-framework-for-action-on-dementia-2015-2019.pdf
[32] National Ageing Research Institute. (2009). Depression in older age: a scoping study. Final Report. Melbourne. Beyondblue
[33] Australian Institute of Health and Welfare 2013. Depression in residential aged care 2008–2012.
Aged care statistics series No. 39. Cat. no. AGE 73. Canberra: AIHW

significantly impact on quality of life and contribute to increased suicide rates seen in older Australians, with men aged over 85 years the most likely of any age group to take their own lives[34].

Similarly, management of risk factors for falls such as delirium and polypharmacy have much wider benefits than just preventing falls. The most effective approach within residential care will be one that involves all staff within a multifactorial and multidisciplinary falls prevention program. Best practice in falls management also includes the principles of minimising injuries from falls, including optimising bone health and fracture prevention.

Many falls and resultant injuries can be prevented by risk assessment and subsequent implementation of targeted and individualised multidisciplinary interventions that are monitored, reviewed regularly and adequately resourced. These interventions can include management of medical comorbidities, medication review, proactive management of continence, screening for visual impairment, appropriate footwear and interventions that identify and eliminate environmental hazards (such as carpets which can trip, and lack of grab rails in bathrooms).

5.5 Use of information technology

Health information exchanges (HIE) and electronic health records (EHRs) can be used to coordinate care to high-risk seniors requiring acute, subacute, and community-based long-term care[35].

One example is Patient Priorities Care[36] which asks patients and caregivers to articulate their health priorities, supported by a trained member of the healthcare team. These are then communicated to team members such that, together, patients, caregivers, and clinicians select the health care best aligned with these health priorities. This is important for scenarios for which there is minimal evidence-based recommendations to guide care for older adults with multi-morbidity and functional limitations, in which case informed priorities can guide clinical decision-making and current care planning.

Communication of health care management from Primary Care to Hospitals (in fact across the whole healthcare system) is often very poor, with a diversity of communication technologies from faxes to electronic systems. Much of this communication is untimely, has many inaccuracies, is often illegible (for paper-based systems) and, most of all, is poorly accessible and in formats that do not facilitate decision making.

A robust information system that is more clinically useful, is needed, that is one in which clinicians (e.g. physicians) have been included in leading the design and implementation of future health care systems.

The system should aim for high quality and cost-effective care at all levels. This requires up to date, timely and accurate data and information generated from direct patient care in formats which are interoperable and shared across the whole health care system, with specific reference here to Aged Care.

Recommendations

The College recommends:

- The Commonwealth Government should work with the State and Territory governments to formulate more healthcare pathways or care programs that are appropriate for managing older patients with multi-morbidity and/or frailty and which take account of competing risks and potential for harmful interactions between treatments for different conditions or groups of conditions.
- The Commonwealth Government and State and Territory governments should work together to implement holistic patient centred Models of Care for older persons. These should include: 1) integrated and co-ordinated care between primary and secondary care healthcare systems; 2) models of multidisciplinary clinical care such as the use of health panels; and 3) mechanisms for information sharing and connectivity between practitioners. For example, this could include integrated care models such as that described in the RACP Model of Chronic Care Management. The RACP Model

[34] Australian Bureau of Statistics, Suicide in Australia 2015

[35] Wan, T.T.H., 2017. A transdisciplinary approach to healthcare informatics practice and research: Implications for elder care with poly chronic conditions. *Journal of Health Informatics and Management*, *1*(1), pp.1-7.

[36] Blaum, C.S., Rosen, J., Naik, A.D., Smith, C.D., Dindo, L., Vo, L., Hernandez-Bigos, K., Esterson, J., Geda, M., Ferris, R. and Costello, D., 2018. Feasibility of implementing patient priorities care for older adults with multiple chronic conditions. Journal of the American Geriatrics Society, 66(10), pp.2009-2016.

provides an example framework designed for pilots in a number of high prevalence chronic diseases but the framework could be extended to other disorders. These models of care should also involve integrated information systems between service delivery sectors, between organisations, and between multidisciplinary health care providers.

- The Commonwealth Government should, in cooperation with State and Territory governments, mandate the regular documentation of pain of residents in all facilities caring for older people using self-reporting as the gold standard or using validated observational and behavioural scales as alternatives.
- The Commonwealth Government should in cooperation with State and Territory governments mandate the routine assessment of cognitive impairment, sensory impairment, delirium, skin integrity, mood disorders, malnutrition, mobility and elimination (bowel/bladder) capacity in all facilities caring for older people by means of observation, self-report and risk assessment tools
- The Commonwealth Government should in cooperation with State and Territory governments mandate the introduction of protocols for regular review of older patients' medications encompassing GPs and consultant physicians as well as pharmacists aimed at the early detection and management of potential side effects and interactions.
- The Commonwealth Government should in cooperation with State and Territory governments put in place protocols to ensure that all older patients who are receiving medical care (irrespective of care setting), and their relatives and care givers, have the opportunity to discuss advance care planning to identify the values, preferences, and outcomes of most importance to patients. These should guide the formulation of agreed care plans.
- The Commonwealth Government should in cooperation with State and Territory governments establish a satisfactory recording and reporting system of performance indicators that also includes patient/carer reported outcome and experience.

6. Protection of older persons from abuse

This section primarily addresses Term of Reference (a)

6.1 Last resort uses of chemical restraints

Certain conditions, particularly dementia but also others, mean that the person and potentially staff of facilities may be at risk of physical harm. While behavioural management and the right staffing may address some aspects of this problem, sometimes careful medication can be an appropriate management approach.

Medical or pharmaceutical interventions should not be routinely used as chemical restraints or as a substitute for proper assessment of remedial causes of patient behaviour or to offset inadequate staffing levels or education. Such interventions should only be applied as a last resort for time limited, specific indications when non-drug treatments have failed. Agitated depression is very common in many neurodegenerative diseases, while distressing hallucinations are not uncommon, both of which need to be managed by the careful use of psychoactive medications such as low dose quetiapine that some may consider 'chemical restraint'.

Studies in Australia have shown that up to 80 per cent of nursing home residents are receiving at least one psychotropics agent, such as an antipsychotic or antidepressant[37].

We acknowledge the following initiatives in responding to disturbing findings on the frequent use of chemical restraints for older persons in Australia:

- The establishment of the position of Chief Clinical Adviser at the new Aged Care Quality and Safety Commission, established on 1 January 2019.
- New Aged Care Quality Standards, that stipulate best-practice clinical care to minimise the use of chemical and physical restraint (from 1 July 2019), including an assessment by the medical practitioner or nurse practitioner who prescribed the medication before the use of chemical restraint.
- Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019
- The provision by the Department of Health to all aged care homes with the Guiding principles for medication management in residential aged care facilities to assist managers and staff to practice quality use and safe management of medicines.

6.2 Strict use of physical restraints

Restrictions on medications to 'manage' older patients or residents of aged care facilities can lead to the inappropriate use of physical restraints which is unacceptable.

We support the strict adherence to the new Aged Care Quality Standards (from 1 July 2019), in which providers delivering clinical care are required to have a clinical governance framework in place that minimises the use of all forms of restraint.

We support the new regulations wherein residential aged care providers must satisfy several conditions, including the requirement for an assessment by an approved health practitioner before physical restraints are used and an assessment by the medical practitioner or nurse practitioner who prescribed the medication before the use of chemical restraint.

We recognise provisions that stipulate any restraint must be the least restrictive restraint in the circumstances.

6.3 Protection against exploitation and abuse, and workplace discrimination

The abuse of older persons is common, poorly detected and under reported as this Royal Commission has discovered. This can pertain to neglect of needs and/or financial disadvantage to older persons for personal gain. Aside from the fundamental humanitarian issues, the potential for the exploitation and abuse of older persons has obvious adverse implications for access to care.

[37] Hosia-Randell & Pitkälä, 2005; NPS Health News and Evidence, 2013

Poor quality capacity assessments, particularly with regard to the granting or changing of Enduring Powers of Attorney (EPOA) contributes to the exposure of older people to financial exploitation. The RACP holds that wherever possible, individuals should be involved in decisions about their care. When appointing supporters and co-decision makers there needs to be awareness of the likelihood of any diminution in decision making capacity over time (e.g. dementia).

To properly protect and empower older persons the legal provisions for substitute decision-makers must be standardised and recognised nationally so that if circumstances change, the older person does not have to repeat the process of appointing a substitute decision-maker (when they may have deteriorated since that time). Currently the forms are different in different states and territories which complicates matters if the appointed persons have moved interstate or an older person moves.

A public awareness program describing the need for older persons to protect their own financial interests before illness becomes incapacitating, and how they can do this, is important.

As people live longer and must make economic provisions for extended living, it is important social and health polices in workplaces are not negatively age discriminatory and that appropriate workplace support is provided.

Recommendations

The College recommends:

- The Commonwealth Government should establish a register of Enduring Powers of Attorney (EPOA) and standardise EPOA provisions nationally so that there is recognition of older persons' EPOA stipulations across states and territories.
- The Commonwealth Government should train lawyers and health professionals in capacity assessment prior to the completion of an EPOA.
- The Commonwealth Government should further develop protocols to eliminate inappropriate administrations of pharmaceuticals as chemical restraints for older patients and put in place programs to promote the use of non-pharmacological management as first line treatments. Supportive guidelines need to be communicated setting out supported actions such as RACP Evolve guidelines on antipsychotics and benzodiazepines and quality use of medicines.
- The Commonwealth Government should in cooperation with State and Territory governments establish regional reference groups comprising lawyers, health and aged care professionals and police, to provide expertise for the urgent assessment of cases of potential older persons' abuse.

7. Dementia (Cognitive Impairment)

This section primarily addresses Term of Reference (b)

There is a pressing need for the government to implement a funded comprehensive national strategy on dementia over the next decade[38] given that:

- Overall more than 400,000 Australians are living with dementia, with these numbers expected to increase to 589,000 by 2028 and over a million by 2058[39].Dementia is now the second leading cause of death of Australians, according to death certificates[40].
- It has been estimated that 30 per cent of the total dementia burden in Australia is due to the joint effect of certain vascular risk factors.[41]
- By 2036, the total cost of dementia is predicted to increase by 81% to $25.8 billion in today's dollars, and by 2056, to $36.8 billion which represents a 2.6-fold increase in costs from 2016.

A more preventative measure would be to campaign for early and ongoing community education to maintain 'brain health', for example, continued education covering street drug use and possible long-term harms of alcohol use, smoking and other vascular risk factors, and the protective role of exercise.

The projected trends related to dementia have significant implications for the healthcare system because:

- Hospitalisation and care costs are the largest components of direct costs of dementia, representing 52.6% and 37% of total direct costs respectively.
- Costs of hospitalisation and the cost of care are projected to rise to $8.8 billion and $6.2 billion by 2036 and to $12.6 billion and $8.9 billion respectively by 2056. Direct costs such as the cost of hospitalisation, visits to GPs and medical specialists, care, pharmaceuticals, transport and other direct costs, contribute to 62% of the total costs of dementia, and indirect costs through the lost productivity of both persons with dementia and carers to 38% of total costs[42].

There are major challenges for clinicians in balancing the risk of restraints for these patients against the challenges of containing difficult behaviours which threaten other patients, staff and the treatment plans of the patients own acute illness.

7.1 Assessment of dementia

Early assessment of dementia is critical – to the patient, the carer, the team of practitioners, and not least the subsequent efficient use of health care resources.

Services for assessing and managing dementia in the community are often insufficient, even though this is often the most appropriate location in terms of ensuring access to such services.

Dementia and its various forms (for example, fronto-temporal dementia and Lewy body disease) can be difficult to diagnose. This requires clinicians with expertise in dementia, such as neurologists (particularly at the early stages, but certainly throughout, to identify the reason for changes - for example, apraxia may be interpreted as weakness), geriatricians, and psychogeriatricians, to support general practitioners. Delays in accessing services further burden the health system as a result of increased stress and anxiety. Behavioural and Psychological Symptoms of Dementia (BPSD), which affects up to 50% of people with dementia, are the cause of most stress when the diagnosis is delayed and there is no responsive case management.

The assessment of dementia is much more than a medical diagnosis, and includes functional, psychosocial and behavioural assessments for which GPs may not have the time or skills.

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[38] Brown, L., Hansnata, E. and La, H.A., 2017. Economic cost of dementia in Australia. *Alzheimer's Australia, Canberra*.
[39] (Dementia Australia (2018). Dementia Prevalence Data 2018-2058, commissioned research undertaken by NATSEM, University of Canberra)
[40] Brown, L., Hansnata, E. and La, H.A., 2017. Economic cost of dementia in Australia. *Alzheimer's Australia, Canberra*.
[41] Australian Institute of Health and Welfare 2016. Contribution of vascular diseases and risk factors to the burden of dementia in Australia: Australian Burden of Disease Study 2011. Australian Burden of Disease Study series no. 9. Cat. no. BOD 10. Canberra: AIHW
[42] Australian Institute of Health and Welfare 2016. Contribution of vascular diseases and risk factors to the burden of dementia in Australia: Australian Burden of Disease Study 2011. Australian Burden of Disease Study series no. 9. Cat. no. BOD 10. Canberra: AIHW

Diagnosis without the right level of expertise can be problematic and general practitioners need adequate support from other healthcare professionals for the following reasons:

- GPs are often reluctant to make what can be a very upsetting diagnosis for patient and family, even if it is straightforward Alzheimer disease.
- Dementias such as fronto-temporal and Lewy body dementias are difficult to diagnose for GPs
- Dementia is a major attack on a person's self-esteem and it is important that we do not add to this by a poor approach to assessment. This means that a team approach at least involving both a doctor and nurse is required so that the patient and family can be questioned and counselled separately. For example, certain delicate issues should not be asked of the family when the patient is present (such as delusions, hallucinations, personality change, difficult behaviours or capacity questions).

There needs to be a clear leadership responsibility for the assessment and management of dementia in the community. In this regard, at present neither level of government has assigned responsibility and therefore accountability. As a result, carers carry an unnecessary burden, BPSD and other co-morbidities are poorly managed, people with dementia living alone are neglected; and people are admitted to residential care prematurely.

The delay to initiating an assessment even when the My Aged Care program can be accessed and understood, is lengthy.

7.2 Community based multidisciplinary assessment

Well trained community based assessment and subsequent care of patients with possible dementia by multidisciplinary teams is needed. For the patient and carer this means better quality of life and independence in the community. To be effective, these teams require up to date evidence-based education and training[43]. For the broader health system, and state government hospital care, this means potentially fewer admissions, while admissions to aged and facilities are delayed or avoided[44]. This does not mean every patient must be assessed by a full team of health professionals, but that given the comorbidity and complexity of many older people, multidisciplinary assessment and team care should be accessible and streamlined for the patient and their carers.

Multidisciplinary teams must be appropriately constituted and supervised and have an available single point of contact. A major challenge is the lack of acceptance of interventions by people with dementia because they often lack insight. The burden on carers of BPSD can be alleviated by day programs that allow respite for the carer and which also include appropriate multidisciplinary interventions (such as an exercise program after a physiotherapy assessment).

A pragmatic solution to promoting more community-based assessment and management is to engage specialised nurse positions. Primary Care Dementia Nurses could work alongside GPs to augment assessment and case management, when necessary. An operating example is the 'Newcastle Model' in NSW in which Community Dementia Nurses work with geriatricians in geographically based teams[45].
Another example is the ability of a service like Dementia Support Australia to deploy consultant specialist nurses directly into patient care environments to advise and support appropriate care interventions, especially where local population numbers or remoteness might not otherwise allow such specialist nurses to be an ongoing component of the local community aged / disabled care services.

Primary Care Dementia Nurses positions could be located in the community. These roles would better support GPs to feel more confident about treating these patients in primary care. Such a role would enhance:

- Patient education
- Patient access to multidisciplinary teams
- Appropriate information transfer within teams
- Baseline assessment
- Case conferencing
- Monitoring of clinical parameters and notification of physicians of issues

[43] Brown, L., Hansnata, E. and La, H.A., 2017. Economic cost of dementia in Australia. *Alzheimer's Australia, Canberra*.
[44] Brown, L., Hansnata, E. and La, H.A., 2017. Economic cost of dementia in Australia. *Alzheimer's Australia, Canberra*.
[45] Gibson, C. and Yates, M., 2018. The Memory Health Support Service (MHSS). Improving dementia care in primary practice: a nurse-enhanced service. Final report.

- Management by ensuring timely testing occurs for both monitoring and for initial assessment[46].

Geriatricians, Neuropsychologists, Neuropsychiatrists, Psychogeriatricians and other support specialists should be available as required. The Behavioural Assessment and Management Service should be locally integrated, not run from some distant centre (often interstate) as currently exists.

7.3 The patient and carer experience - process of assessment (My Aged Care registration vs direct referral to Aged Care Assessment Team)

A significant problem that must be underlined here is the immense confusion that people with dementia have, along with the carers, in regard to service provision, whereby many do not remember who they have seen, what has been offered, or what they need.

Access to diagnostic services and care pathways must be simplified to overcome:

- The distress for carers of trying to get to multiple appointments (including for younger carers with other family and work responsibilities)
- Lack of individually tailored approaches to care that matches the stage of the disease and specific co-morbidities.

In this subsection we highlight some aspects of the patient and carer experience which need improvement. ACAT is an important source of support when an older person is no longer able to be at home without assistance.

The current system causes significant carer stress as carers attempt to navigate the system and wait for an ACAT assessment that may not take into account medical advice.
The person or the carer is then expected to work out how to use funds and access providers appropriately. For example, some people are told that only the affected person should apply - even when that person is very severely affected. In cases of low awareness, the person may not realise what care is needed or that their carer is in need of assistance.

Case example: an RACP member related a patients' experience. A woman rang [My Aged Care] about assistance for herself (the carer) and some respite for her husband, the person with dementia and many behavioural changes. The carer was told the patient would need to make the request. Contrastingly, a direct ACAT visit would have resulted in an immediate link to appropriate assistance and then follow up and review.

To reduce the number of occasions where the patient, having no insight into their condition, refuses much needed help, we propose that *My Aged Care* staff always include both the person with dementia and their next of kin in their interactions.

The information booklets for patients and those needing care are of low utility.
Generally, these booklets are written for the older person seeking care. They are not appropriate nor effective in practice because:

- Those seeking help may not recognise their own need
- They may have an impaired ability to read, understand and remember
- They may have a limited capacity to plan ahead.

Booklet examples: *Your Guide to Commonwealth Home Support Programme services* (small print and 22 pages long), *Your Guide to home care package services* (small print and 38 pages long) and *Five steps to entry into an aged care home* (small print and 32 pages long).

Some older patients may live alone without family assistance to navigate the process of assessment. ACAT and the treating GP and Specialist offer a more personalised approach compared to the more bureaucratic My Aged Care Program which can add significant distress. Not everyone needing care has a carer or family member to assist, or the carer (usually a spouse) may have dementia as well or be baffled by the process. This imposes significant risk when a person lives alone and has cognitive impairment and dementia.

[46] See RACP 2019 Complex care, consultant physicians and better patient outcomes

A system that presumes self awareness, physical and mental capacity, and/or internet access is limited

While it is desirable to respect patient autonomy and decisions, lack of awareness of the cognitive or neurodegenerative changes taking place and the need for care and acceptance of care, are barriers to care. Currently, dementia and neurodegenerative diseases affect mainly a generation of people who may not be computer literate and so a web-based approach is not appropriate.

Coordination and consistency of care providers

Dementia is a very confusing state that takes immense toll on carers over the long term. It is essential that interactions are personalised and that the person and their carer, if there is a carer, have a stable 'go to' person for explanation and responsive, timely assistance and care provision. In addition, care workers need to be constant over time, as great confusion exists when many different people come to visit or at different times. For example, some patient and carers complain that showers are never given at the same time each visit or by the same care worker. This adds to carer stress or increases the person's confusion and results in the person forgetting that showers, for example, are needed.

7.4 Timely community support

Dementia impacts the demand for support services when one considers dementia is now the second most prevalent cause of disability in the community[47]. The current model for dealing with this demand is already stretched to capacity.

There are some significant community service deficiencies, including the important need to supervise medication, which are highlighted in this section.

Funding to existing (and excellent) dementia support services is already limited relative to demand and should at the very least be maintained.

Currently service provision is currently very limited, and improvements are needed in the following areas:

- Level 4 care HCP packages are very limited. Some high need demented people receive only two hours a fortnight.
- Service providers extract a significant service management fee (sometimes reported by carers as being as much as 30% of allocated funds). When package levels change, the services may only marginally increase but management fees increase more.
- A system of regular GP visits in Aged care facilities is essential to maintain health and determine appropriate interventions, with the preferable model being a GP who is contracted or employed part-time or full-time by the facility.
- Advance care plans and end of life decisions need to be reviewed regularly, particularly as the consumer may have a different view of their quality of life to that of care providers.

Reviewing how some important services are delivered for maximum reach to those most in need and effectiveness is important, for example, using the EVOLVE principles[48]. This sort of review can lead to funds being directed to where there may be more benefit or need.

For example, while there is provision for medication reviews by GPs and pharmacists in residential aged care, a medication hotline for Specialist and GP queries/concerns re medication effects would be preferable (this might relate to a situation where the pharmacist goes out and sees a complex patient, such as one with Parkinson's disease and then writes a report of recommendations without discussing the individual patient with the specialist). . Pharmacy review has a limited place unless the Specialist prescribers are included in the review. If reviews are done, then the physician or GP needs to be consulted.

Again, being strategic with limited resources, we point out that not all patients require all allied health assessments. Allied health assessments should be directed to need. For some patients allied health assessments are unwarranted, others are very necessary although the RACP advocates all patients receive allied health support in maximising physical activity, falls prevention, social engagement, and nutritional intake.

[47] Ward, J. 2019 Submission to Royal Commission into Aged Care Quality and Safety (cited with permission)

[48] Reviewing clinical practices that, in particular circumstances, may be overused, provide little or no benefit or cause unnecessary harm

If we take the management of a worst-case scenario such as an older person, living alone without much if any support from family or friends and with dementia. This person will not be able to get to appointments without assistance, and, importantly, may not need to see every member of the allied health team.
Physician experience suggests that when a multidisciplinary team input has input into the case of a person with Huntington's Disease (type of dementia), although recommendations may be valid, the person will not take up the advice due to cognitive impairment and apathy if they are at home. Therefore, the review of needs, including by Allied health personnel, should be on an as needs basis and encourage physical activity and falls prevention as well as cognitive and age appropriate activities.

Match level of support as functionality progressively declines
Care planning must be individualised, avoiding a one size fits all approach. Many Commonwealth Home Support packages are not suitable for consumers with dementia where being left at home overnight and alone poses considerable risks. Many care services are refused by patients with dementia, such as meals on wheels, and home care support is often variable (for example, persons not being allowed to lift patients).

An individual's needs vary according to the progression of his/her condition and also the capacity (that changes) of carers. The impacts of functional deterioration (such as inability to drive, and the patient's response to this) need to be addressed if the person is to remain in the community.
At day programs or at inpatient care facilities, there needs to be a much greater emphasis on activity programs and individual preferences and engagement to help to reduce boredom and influence behaviours. For example, recognising that not everyone wants to play Bingo or listen to fixed programs such as cartoons being shown on television sets in RACFs.

There should be provision for customised transportation needs
Transport is a crucial need at a relatively early stage to ease the transition from driving to dependency. The Netherlands, for example, has a system of buses for older people, on regular routes.

Safety vs personal choice
It is rarely possible for people affected by dementia and/or severe physical disablement to manage at home indefinitely, either alone or with one carer, particularly an older carer. There are risks associated with staying at home even though this may be the aim promoted by many aged care packages that try to allow people to 'Age in place'. Whilst this may be desirable, very few people would have professional carers overnight, and interaction with others may be very limited. It is therefore important that residential decisions and level of home support is commensurate with assessed need and provided at the time of need with no unnecessary delay.

Under current government funding arrangements there is no provision for constant or night time supervision of a patient, including those living alone. Sometimes living alone at home may in fact be counter- productive, in that a higher level of cognitive stimulation may delay progression of dementia, even though the upheaval of moving from a familiar environment also has impact.

Support for young onset dementias within the NDIS
In this complex area of care, for adults with diseases causing progressive cognitive impairment and acquired, progressive physical and functional disability, we would like to see more liaison and collaboration with medical professionals about healthcare requirements. This suggestion is made to maximise health outcomes and tailor care to the person's needs. We would also support assessments and reviews being undertaken only by accredited allied health professionals.

***There is a service deficit for those with significant BPSD who are/cannot be managed by non-pharmacological needs and/or are aggressive and physically able*.**
These patients often end up in hospital as a last resort which can then lead to further delirium and hospital acquired complications. Nursing homes may not currently have adequate funding nor staff capacity to deal with such patients. Training in dementia care, establishing goals of care (including options that do not involve moving to hospital), facilitating communication between primary and secondary facilities, and an integrated approach between hospital specialists/senior residential care nurses, and GPs on admission or discharge are all beneficial strategies.

Addressing the potential for negative carer roles

We need to protect vulnerable older persons from incompetent or nefarious professional carers and care providers(refer to previous section 6.3). Controls are also needed to mitigate against elder abuse and neglect by families, and the inappropriate use of the older person's assets.
In saying this, we acknowledge the many dedicated carers, both professionals and family members, who go to extraordinary lengths to support the affected person.

Driving assessment
Transport in the community is important and people with dementia must be assessed for driving capability. Addressing fitness to drive has been reported by health professionals to be one of the most difficult and emotional tasks they face in providing care for people with dementia.

There is a need to develop and fund driving more assessment services for people with dementia. There are limited public services are available, that incur a cost, and this is not a sustainable situation, given the cost of living in Australia. Private services are expensive. The average Australian may not be able to afford such assessments or would consider it a luxury rather than a necessity. The assessment services should include an occupational therapist and driving instructors[49].

There is no internationally accepted standard for an on-road assessment of driving for people with dementia. The costs of these assessments are largely borne by the driver; some medical centres and some insurance programs provide a level of subsidy, but the full cost is generally borne by the driver. They are not part of Medicare, hospital or community health programs or other government funding sources.

Occupational therapists trained in on-road assessments for drivers with dementia conduct the tests which can be costly and difficult to access. For carers of people with dementia the biggest barrier to assessment is the cost of the service followed by the timely availability of the assessment service in rural and regional areas[50].

7.5 Aboriginal and Torres Strait Islander people – culturally safe services

The RACP has stated earlier the importance of culturally safe treatment and condition management approaches to older Aboriginal and Torres Strait Islander patients.

Here we acknowledge and support the importance of Dementia Australia's call for culturally appropriate, person-centred care, where the services provided are sensitive to, respectful of, and responsive to, the preferences, needs and values of people from diverse backgrounds including those who care for them[51].

This is essential for Aboriginal and Torres Strait Islander people living with dementia for whom involvement of local Aboriginal communities in care and amelioration of infrastructure gaps, such as transport needs, are most important.

7.6 Accommodation services for patients with dementia

Many facilities claiming to have dementia specific care are understaffed and under-qualified for the type of specialised care that is required for this population. Higher standards of care need to be enforced along with more in depth and mandated education for carers in the community and nursing staff.

People admitted to hospital with dementia can be inpatients for twice as many days as people without dementia[52].

Within RACFs, just over half of all residents suffer from dementia with many having high care needs[53].
The RACP brings to the Royal Commission's attention the urgent need to review accommodation for older persons with mental health issues and challenging behaviours who are at risk of requiring chemical restraint.

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[49] In October 2016, AustRoads and the National Transport Commission released a revised version of the Assessing Fitness to Drive Guidelines. Under the revised guidelines, all people with a diagnosis of dementia who wish to continue to drive may be eligible for a conditional licence, but not eligible to hold an unconditional licence. A condition of this licence type is that the driver is reassessed, at least annually, either by an RMS driving assessor, by a medical practitioner or by a qualified occupational therapist. This licence type is also subject to medical opinion and a practical assessment as required.
[50] 2016 Driving and Dementia Discussion paper No. 18 Alzheimers Australia
[51] https://www.dementia.org.au/media-releases/2019/culturally-appropriate-person-centred-care-essential
[52] Draper, B., Karmel, R., Gibson, D., Peut, A. and Anderson, P., 2011. The Hospital Dementia Services Project: age differences in hospital stays for older people with and without dementia. *International psychogeriatrics*, *23*(10), pp.1649-1658.
[53] Brown, L., Hansnata, E. and La, H.A., 2017. Economic cost of dementia in Australia. *Alzheimer's Australia, Canberra*.

Some dementia patients act violently towards others and an appropriate response is needed for these patients. Currently these patients are not charged by police and RACFs do not allow them to return after being transferred to hospitals wherein they reside, often for long periods of time, which is completely inappropriate. These patients need to be housed in an environment which better meets their needs and those around them.

7.7 Rehabilitation services for people with dementia have been overlooked

There is increasing evidence of the importance of rehabilitation for people living with dementia[54] . It is important that multidisciplinary rehabilitation be embedded in programs of dementia care.

Non-pharmacological interventions can delay functional decline and improve quality of life in people with dementia. A structured, multidisciplinary rehabilitation program allows specific symptoms to be addressed and identifies goals that are meaningful to the person.

7.8 End of life care for people with dementia

Until recently, hospital based Palliative Care Services have paid little attention to end of life care in dementia. Most people with dementia will die in RACFs or hospitals, and relatively few people with dementia will die in hospices.

The major unmet needs in end-of-life care in dementia include:

- Addressing the difficulties families experience accepting dementia as a terminal illness and their reluctance to consider advance care planning. It is important that there is enhanced support for the GP to address any family conflict or varied levels of understanding of end of life care, especially prior to any transfer to an aged care facility.
- The need for upskilling of GPs and RNs in identifying persons who have reached the final stage of their lives and require transition to palliative or comfort care.
- The need for skilled nurses in the community services or in RACFs to provide high quality end-of-life care
- The high number of people who are inappropriately transferred to hospital during the final days of their illness and are dying in an environment that is lonely and frightening.

When it comes to end of life directives, not all family members may agree on the options for care provision. For this, and other reasons it is important GPs are involved in nursing homes.

Potential solutions to these unmet needs are:

- All RACFs should include rooms that are designed for people who are dying and allow family members to stay with them.
- All residents (or formal guardians) of RACFs should complete an advance care plan within two months of entry and this should be reviewed regularly or at least annually.
- All large RACFs should have a specialised nurse position (nurse practitioner, specialist nurse, clinical nurse consultant) whose role would include the identification of patients who are dying and the coordination of high quality end-of-life care.
- End-of-life care packages should be available in the community within one month of application.
- End-of-life care should be a program provided by all Community Acute and Post-Acute Care Services.

Recommendations

The College recommends:

- The Commonwealth Government should invest in additional research into dementia care.
- The Commonwealth Government should jointly with State and Territory governments invest in providing and training community based multidisciplinary teams which can undertake assessment services of dementia where needed and appropriate. This could also include a policy for the assessment of older patients for delirium, that is accompanied by an appropriate management strategy for all hospitals and RACFs.

[54] Cations, M., Laver, K.E., Crotty, M. and Cameron, I.D., 2017. Rehabilitation in dementia care. *Age and ageing*, *47*(2), pp.171-174.

- The Commonwealth Government should in cooperation with State and Territory governments contribute funding to increase the number of community based, fully resourced dementia assessment and management services available in metropolitan and rural areas. Care management should be based on a strategy/ healthcare pathway for people with dementia that includes a multidisciplinary approach and a cross-sector care continuum of integrated community-based services.
- The Commonwealth Government should enhance funding to ensure adequate training in dementia care to all service providers.
- The Commonwealth Government should establish and recurrently resource Primary Care Dementia Nurses positions in primary healthcare with the view towards also deploying these positions to purpose-built dementia units for those with significant Behavioural and Psychological Symptoms of Dementia (BPSD) who are/cannot be managed by non-pharmacological means and/or are aggressive and physically able.
- The Commonwealth Government should enhance funding for programs to better support family and other non-professional carers.
- The Commonwealth Government should introduce a specific quality assurance requirement in aged care services in relation to care of younger residents/users which specify attention to a younger person's biopsychosocial and physical needs.

8. Disability

This section primarily addresses Term of Reference (b)

8.1 Interface between NDIS and Aged care

At present we see patients being referred to National Disability Insurance Scheme (NDIS) in the absence of available appropriate services.

Currently there is a great divide between services provided by MyAgedCare and those provided by NDIS, with very little communication between the two funding bodies, as well as little flexibility in awarding services for individual cases. For example, residents needing NDIS funding when going into residential care, or even returning home but requiring assistance, are generally required to be assessed in a home setting. However, such patients in most cases cannot be discharged from hospital to enable home assessments because their needs for care are so great, resulting in a difficult stalemate like situation leading to a prolonged hospital stay.

Health services must be person-centred and suitable for a condition or combination of conditions. At present we see patients being assessed as requiring certain services which are simply not available.

Care pathways need to be developed at the regional level as a collaboration between primary health networks (PHNs) and local health districts (LHDs) to address care needs of conditions associated with ageing and congenital or acquired disability in younger people. Rather than a division of services (disability, aged care and acute health care) for younger adults with disability, there could be purposeful sharing or pooling of resources at local level that enables appropriate care and accommodation for these patients.

For people with disabilities residing in aged care facilities there is an increased risk of complications such as pressure injury, falls and respiratory and urinary tract infections. This applies to younger people; and people with significant physical and / or cognitive disability, for example, stroke, head injury, spinal cord injury, traumatic brain injury, amputation etc. The needs for these patients include:

- Additional training and education of staff in RACFs in order to provide the necessary care.
- More specialised equipment and technology (specialised wheelchairs, mattresses, toilet and shower aids and communication devices) to maintain function but which are often not available in RACFs and which may not be supplied by other state-based equipment supply schemes, particularly to people over the age of 65. This requires the person or family to pay for the required equipment or go without. Lack of appropriate equipment reduces functional ability and increased risk of complications.
- People with disability who do live in RACFs require better access to specialist rehabilitation medicine services, including “bursts” of rehabilitation to maintain function and manage / reduce the risk of complications and in some case longer formal rehabilitation programs. This could be achieved by increased the number of community rehabilitation services which provide rehabilitation in the home (or nursing home).

For those people with disability who are living in aged care facilities, the person, the carer(s) and their families need to be involved in decisions and their care preferences sought. For example, a person with intellectual disability may prefer to reside with their older parent who is now needing aged care themselves, in which case it may be more appropriate for that person to be in an aged care facility close to the parent, rather than remain in supported community accommodation. Sometimes a person with disability is renting a disability specific unit situated on an aged care residential site; or it may be that in a rural area with one aged care facility, there is no local disability specific accommodation that can serve as an alternative. This flexibility in choice needs to be seen against the background of available local supports for younger people with disability.

A higher level of collaboration between NDIS and MyAgedCare is also needed to address gaps arising from the way in which health care is organised for people with disabilities and patients who, for one reason or another, are not eligible for NDIS support, all of which can lead to gross inequities in health care and support delivery.

This collaboration should pertain to both funding and non-funding areas:

- NDIS and aged care funding must be equally and concurrently available for residents of aged care facilities aged less than 65 years. At present the funding sources for care needs are

discrete, when due to lack of services, people under 65 years must make use of aged care facilities.

- The aged care sector can assist the disability sector, for example, in education on how to manage younger patients with BPSD
- Similarly, the disability sector can assist aged care facilities which are caring for younger people with disability.

Improvements are needed in the processes by which people with disability can access both NDIS support and residential aged care, or transition from aged care to NDIS. For young people with a disability and their carers, the system is not patient centred, nor easy to navigate, with regard to:

- the paperwork required for entry into aged care facilities
- the means for finding out information
- the means for understanding complexities
- the means for communicating with government aged care departments, especially at times of emotional distress when seeking urgent admission.
- the focus of the NDIS primarily on younger disabled people with relatively fixed deficits rather than those with progressive conditions of long duration, often neurological, which result, in some cases, in severe disability and dementia. Such persons are not able to make their own application, which becomes a major problem when there is no carer or substitute decision-maker, and further complicates allocation of funding and access to service providers.
- the fact that a person on NDIS may live beyond the age limits of NDIS, but for whom there is no clear path to My Aged Care and aged care services. People with early onset dementias e.g. Huntington disease, frontotemporal dementia, some cases of Parkinson's disease and related disorders, as well as young onset Alzheimer disease, would be better assessed and advised by ACAT teams as the problems encountered in these patients are similar to those encountered and managed in aged care and who may be better managed in a more seamless way by applying for aged care from the beginning of their illness, even though they are less than 65 years of age.

8.2 Older persons and disability

The introduction of the NDIS has led to significant inequity in provision of rehabilitation and disability services to people over the age of 65. This is perhaps most apparent for people who have incurred a significant new and permanent disability as a result of, for example, a stroke, spinal cord injury, or brain cancer. Although both individuals have the same access to inpatient rehabilitation services, a person who is 64 years of age and has access to the NDIS has significant advantages over a person who is 66 years of age and cannot access the NDIS, despite the fact that both may have been fit, healthy and independent prior to the event and have the same level of disability and same prognosis following the event. As the population continues to age, the number of people over 65 who will have no access to NDIS services, including those with permanent disabilities such as amputees, will increase, in which case the aged care system must be better resourced to deal with this unmet need.

We stress that older people with disability need to have the same access to periodic review and treatment as other community members. There should be no discrimination or disadvantage related to age.

A 2018 evaluation report of the NDIS [55] explored perceptions of the fairness and equity of the NDIS. It found the NDIS was not experienced as consistent for all people with disability. For example, although the NDIS was reportedly worked well for participants and families who were able to capably advocate for themselves there were poorer outcomes reported for NDIS participants with intellectual disability, psychosocial disability and complex needs or with older carers facing their own health issues. In addition, NDIS participants from CALD backgrounds and living outside urban areas were similarly considered to be disadvantaged under the NDIS.

This study identified that funding levels under the NDIS were found to be higher than within the aged care and state disability systems. Along with higher satisfaction in the NDIS with support quality and access, opportunities for social participation, and levels of choice and control this raises concerns about equity and fairness for older people with disability outside the NDIS.

[55] Mavromaras, K., Moskos, M., Mahuteau, S., Isherwood, L., Goode, A., Walton, H., Smith, L., Wei, Z. and Flavel, J., 2018. Evaluation of the NDIS. *Final report. Adelaide: National Institute of Labour Studies, Flinders University*.

8.3 Younger people and disability

At present between 6,000 and 7,000 people with disabilities who are aged less than 65 years live in aged care facilities in Australia. With the implementation of the NDIS we might expect the number of new entrants of young people with disability into aged care facilities will diminish. Prior to NDIS, young people with disability living in aged care facilities would receive all their funding from aged care services and none from disability services.

However, the introduction of the NDIS has not been matched by appropriate social housing stock and other specialist disability accommodation options. Consequently, young people can experience delayed discharge from inpatient rehabilitation units and/or have no option except to enter RACFs.

Some progressive disabling diseases begin in younger people. Prior to the My Aged care program and NDIS, most ACATs would be willing to assess a younger person's needs.

Facilities are limited for young onset dementia patients. We note that a young person with late stage dementia requires the same skilled nursing care as for an older person with similar stage dementia. Young people with progressive diseases can rarely remain at home. Younger people must be able to access facilities equivalent to those available to older people. It is not equitable to exclude a 55-year-old with dementia from the care that can be given to older people in RACFs. Younger people cannot always be managed at home. Currently, there is an unacceptable divide between high level care available to older people and the younger people with dementia, for example who cannot be cared for at home as disease progresses e.g. Huntington disease or FTD.

It is increasingly difficult to access much needed late stage care that requires inpatient care and expert nursing assistance if the person is younger, for example Huntington Disease usually with onset between 45 to 55 years of age but sometimes earlier e.g. in the teens or late age, and a relatively rare disease of long duration (up to 15 -17 years on average). Therefore, accommodation equivalent to RACFs needs to be accessible to younger people as well as older people. Younger people with disabling progressive diseases need the right level of support and care that is not always able to be provided in a home environment. The 50 to 65-year age group are excluded from high level care on the grounds of age. Barriers to care on the grounds of age should be removed when younger people are in advanced stages of a disease process that requires high level skilled chronic care.

Any decisions about aged care and care of younger people with disability must take the following into account so that services are appropriate:

- Illnesses of ageing are very often associated with dementia.
- Cognitive impairment and dementia can occur at younger ages.

We acknowledge the Australian Government's plan (March 2019) to reduce the need for younger people to live in aged care.

Most aged care services are provided to persons 65 years or older. There are fundamental differences between disability associated with ageing and the accumulation of chronic health problems and loss of functions over a long lifetime, and disability associated with congenital or acquired conditions which manifests at a younger age. These differences should be recognised in aged care facility policies and protocols:

- Aged care facilities should not be seen as the natural default option for accommodation for young people with disability, except for a few cases. Patients with a newly acquired disability should not be discharged to aged care facilities. This is an area of care that lacks options.
- Similarly, the disability sector should not automatically refer its patients aged less than 65 years who are receiving support for community accommodation to aged care facilities if they develop dementia.
- No younger person with disability should routinely be considered for aged care residential living, although the level of care required must be considered as described above. For some young people with disability, living in aged care facilities such as nursing homes is a significant barrier to maintaining a lifestyle commensurate with a young person's wellbeing (making and maintain friends, entertainment, seeking employment, self image etc).

Appropriate responses to the recommendations mentioned above will mean collaboration between aged care and the NDIS. For a significant number of current younger people with disability living in

nursing homes who wish to move into the community, this may require NDIS funding for specialist housing.

8.4 Aged care facilities and service provision for younger people

The RACP recommends there be a specific quality assurance requirement placed on aged care services in relation to care of younger residents/users which specifies attention to a younger person's biopsychosocial and physical needs. In situations where living in the aged care facility location is preferred by all stakeholders, mainstream services for the younger person related to social, psychological physical and healthy living activities, should be available as a matter of course, and in line with the principles expressed in the NDIS.

Aged care facilities could offer a purpose oriented part of the facility more suited to the lifestyle and needs of younger people with disability for whom the choice has been made to continue living in such a facility. This option should also mean that younger people who prefer to live in aged care facility can still access NDIS for a range of needed disability supports.

The RACP has previously recommended to the Australian Government in relation to the NDIS that it invest in the development of integrated, interagency models of care that will ensure that people and their families don't need to retell their stories over again; effectively coordinate intervention, especially for those people with complex needs or vulnerabilities[56].

Access to healthcare (primary, secondary and tertiary) must be prioritised for younger people with disability currently living in aged care facilities. The differences in approach due to age must be understood:

- There is a current deficit in quality of acute and chronic hospital care for current younger people with disability residing in aged care facilities, often related to the lack of appropriate physical and social amenity within hospital environments.
- Health professionals and aged care workers may wrongly assume that younger people with disability, by nature of their living in nursing homes, share the same physiology of an older person living in a facility, and should therefore have the same palliative or conservative approach to their healthcare.
  For current younger residents in aged care facilities, the aged care providers must be responsive to their commitment to provide the necessary disability supports while the resident is in hospital.
  We note that there are substantial health inequities remain for people with Intellectual Disability (ID). There is an increased risk of dementia among people with some intellectual disabilities such as Down's Syndrome[57]. In terms of health care, there are considerable inequities in health outcomes for these people. In a large population-based cohort study in NSW that included 42,204 people with ID, median age of death of people with ID was 54 years, compared to 81 years in the general population, with 38 per cent due to potentially treatable conditions. Respiratory and neurological causes of death were particularly common, with an overall mortality figure of 1.3[58].
  Therefore, we must also consider the needs of those people who do not reach official 'aged care age' and not only discuss the present and projected demographic.

8.5 Aboriginal and Torres Strait Islander communities and disability

Previously, under TOR (a) we have stressed the importance of culturally appropriate service delivery practices for Aboriginal and Torres Strait Islander people. Here we note that NDIS and the home care packages, are funded for individuals.

This can be a problem if there are no services in a community of a particular type, as specified in the care package. This may be especially relevant for Aboriginal and Torres Strait Islander people in small or remote communities where there is not the infrastructure or the workforce to provide a complete range of community

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[56] RACP 2017 Health and the National Disability Insurance Statement Position Statement

[57] Strydom, A., Chan, T., King, M., Hassiotis, A. and Livingston, G., 2013. Incidence of dementia in older adults with intellectual disabilities. *Research in developmental disabilities*, *34*(6), pp.1881-1885.

[58] Trollor J, Srasuebkul P, Xu H, et al Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data BMJ Open 2017;7:e013489. doi: 10.1136/bmjopen-2016- 013489

support services. We refer the Commission to the First People's Disability Network's ten priorities to address health inequity, which includes barriers for Aboriginal and Torres Strait Islander people accessing NDIS.[59]

Recommendations

The College recommends:

- The Commonwealth Government should develop aged care facility policies and protocols to formally respond to the fundamental differences between disability associated with ageing and chronic multi-morbidity, and disability associated with congenital or acquired conditions in younger people.
- The Commonwealth Government should fund the introduction of accommodation options for young people with disabilities from a person-centred, evidence-based perspective, recognising that these young people require a similar level of personal care as that provided to older persons in RACFs.
- The Commonwealth Government should consider ways to minimise the number of young people residing in RACFs by providing funding to support them to live in their own homes or other age appropriate accommodation in the community.
- The Commonwealth Government should ensure that younger people with disabilities who reside in RACFs have timely access to the NDIS and receive the right level of support through NDIS services while in the RACFs.

[59] First People's Disability Network 2019 Ten priorities to address disability inequity

9. Facilitating opportunities for home-based care

This section primarily addresses Term of Reference (b)

9.1 Low maintenance, low cost accommodation

Low cost, low maintenance accommodation can enable older people to live within communities for longer. Local governments could be required to develop plans for age and dementia friendly communities, taking into account such issues as transport, access to buildings and facilities, footpaths to accommodate walking aids, cycle paths, walking areas, exercise options (such as hydrotherapy and tai chi), meeting rooms in shopping centres, libraries and other learning opportunities, signage, street crossings, a community safety watch for older people (for example, to assist older people living alone during extreme heat events), and community drop-in centres for older people (using existing institutions such as schools) to connect people.

Accommodation should have economical provision of heating and cooling, recognising that in extreme climates older people often adopt cost saving practices on power bills that create risks of dehydration and hyper- or hypo-thermia.

9.2 Minimising the risk of isolation and loneliness

There are increasing numbers of older people living alone in our communities. Social stimulation is important for reducing cognitive impairment and maintaining wellbeing and physical function. Communities, at the local level, need to explore accommodation options for single older persons or couples with few family members close by, and that have varying levels of capability. These options should be based on promoting high community connectivity with, and integration of, older people, especially those from non-English speaking backgrounds.

Recommendations

The College recommends:

- State and Territory governments should ensure adequate funding to facilitate the development of community situated services that promote healthy aging, such as community transport for older people.
- State and Territory governments should ensure adequate funding to build up community services for geriatric evaluation and home-based rehabilitation, restorative care, and capacity building.
- State and Territory governments should ensure adequate funding to improve support for patients and carers in home-based care from non-English speaking backgrounds, and which includes community-based facilities and services.

10. Improving quality of care in residential aged care facilities (RACFs)

This section primarily addresses Term of Reference (d)

In the current aged care context RACFs have their services precariously stretched in an operating environment that has seen state government funding reductions to other providers of related services. There is constant pressure to discharge patients from acute care facilities back to residential care, and the funding of residential care tends to underfund higher care patients.

The span of responsibility of residential aged care is too broad given its current level of resources. RACFs must currently provide the full breadth of highly specialised services to younger and older patients which include:

- Becoming a specialist dementia service managing a full range of difficult to manage behaviours.
- Providing high quality medical and nursing care to older people with highly complex care needs.
- Administering hospice care for the dying, bearing in mind the average life expectancy in RACFs is just over two years, meaning that 30% of residents die each year. Most would like to die among family and friends, but RACFs often lack the physical environments or the trained staff to facilitate a good death.
- Delivering medical, nursing and behavioural management for younger people with brain injury and other neurodegenerative diseases.
- Being a mental health service for older people with chronic cognitive and psychogeriatric problems, given that at least 60% of residents have dementia, many of whom have challenging behaviours which cannot be managed in physically unsuitable environments by staff with very limited training.
- Providing a rehabilitation unit for people prematurely discharged from hospital with delirium or deconditioning resulting from acute illness.

In facilities that have such significant responsibilities as those described above it is critical that the safest staffing ratios are considered for RACFs and that some minimum standards be introduced. For older people, staffing levels are critical to high quality and safe care.

Patient care needs good clinical governance within RACFs and a GP who will be accountable for high quality medical care and coordination of multidisciplinary care plans.

10.1 Nursing and general practitioner roles

We note that RACFs are increasingly less able to provide primary care services because fewer GPs go to RACFs, partly because of the time required and lack of adequate remuneration.

The RACP is of the view that people in RACFs should have the same level of care as people in the community. To this extent RACFs may need to be incentivised to link to GP practices.

This underlines the need for all RACFs to have an experienced nurse (CNC or equivalent) to supervise the program of care and train other staff. A Nurse Practitioner in RACFs would provide basic medical care and engage GPs only for more difficult issues. Larger RACFs should have a Nurse Practitioner to manage all the standard medical issues such as UTIs, respiratory infections, cellulitis, leg ulcers, diabetes, hypertension, etc. This would allow the GPs to concentrate on more complicated medical concerns.

A nursing role has been shown to be effective in rural communities. For example, a pilot of Nurse Practitioner (NP) who coordinated care, targeted people living in a rural area nearing the end of their lives, and principally with non-malignant disease[60]. Specialist input was provided from the palliative care endorsed NP rather than a palliative medicine specialist. Central to this process was interprofessional integration facilitated by case conferences between the patient's service providers, and the generation of a negotiated care plan.

We also draw attention to the need to regulate and increase minimum nursing staff to patient ratios in RACF's.

[60] Mitchell, G.K., Senior, H.E., Bibo, M.P., Makoni, B., Young, S.N., Rosenberg, J.P. and Yates, P., 2016. Evaluation of a pilot of nurse practitioner led, GP supported rural palliative care provision. *BMC palliative care*, *15*(1), p.93.

In RACFs the skill set required for nurses also requires upgrading. Investment in the aged care workforce and capital infrastructure should focus on these two vital elements as the current RACF business model has allowed abuse and systemic failures to become rife throughout the sector.

10.2 Support for carers

The demands of caring can have a significant impact on the carers who need sufficient support, access to respite care, and, in some instances, physical protection from violent behaviour.

There is a risk of harm in the physical interactions between carer and patient, and when injuries occur these may be mistakenly interpreted as physical abuse, although the latter may also be occurring. If a patient is confused or in a delirious state, which is common in aged care, both the patient and the carer are at risk of harm and the guidelines for management are usually unclear or if defined, are not readily available.

10.3 Ensure best practice can be accessed and is incorporated into service delivery protocols

There are areas of health service delivery that pose risks to older persons' safety due to limited access to evidence and guidelines.

An example of high-risk practice in aged care is in the administration of insulin therapy to older Type 2 Diabetic patients. Timely access to current knowledge and guidelines on the optimal dose and administration of insulin and its adverse effects is a major problem.

There is now evidence that certain insulin regimes with rapid-acting insulins have adverse outcomes when blood sugar control has become 'too rigid', manifesting as presentations to hospital with fits, faints, falls and, for some, the onset of or worsening of cognitive functioning[61]. The injuries sustained by these older persons as a result of these events are often severe and can be readily construed as abuse or neglect.

Where possible, RACFs should be linked with hospitals that provide outreach services (such as CARE-PACT and RADAR within Metro South and Metro North Hospital and Health Services respectively in south-east Queensland) whereby trained paramedics and nurse practitioners can assess and assist RACF nursing staff to treat patients in the RACF who have acute but uncomplicated illnesses that do not necessarily require transfer to hospital e.g. cellulitis, gastroenteritis, urinary tract infections. Such services prevent unnecessary and disturbing dislocation of older patients, especially those with dementia, into foreign hospital environments[62].

10.4 Ensure proper and dignified addressing of incontinence

Some older people must deal with the humiliation of incontinence. Best practice and minimum standards for the care and management of incontinence needs to be considered fundamental to RACFs.

There are two dimensions to incontinence from a care provision perspective: the impact on clinical functionality and the impact on social isolation and mental health, both of which are negative and can prove less costly (materially and socially) if managed explicitly and sensitively. The experience of incontinence can be detrimental to health and wellbeing, curtailing an individual's activities. For example, in residential aged care homes, urinary incontinence is associated with reduced quality of life, even in frail, functionally and cognitively impaired nursing home residents[63]. Incontinence contributes to social isolation and depression and for some is humiliating[64], [65].

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[61] Yun, J.S. and Ko, S.H., 2016. Risk factors and adverse outcomes of severe hypoglycemia in type 2 diabetes mellitus. *Diabetes & metabolism journal*, *40*(6), pp.423-432.

[62] Burkett E, Scott IA. CARE-PACT: A new paradigm of care for acutely unwell residents in aged care facilities. Aust Fam Phys 2015; 44: 204-209.

[63] DuBeau, C.E., Kuchel, G.A., Johnson II, T., Palmer, M.H. and Wagg, A., 2010. Incontinence in the frail elderly: report from the 4th International Consultation on Incontinence. *Neurourology and Urodynamics: Official Journal of the International Continence Society*, *29*(1), pp.165-178.

[64] Bartoli, S., Aguzzi, G. and Tarricone, R., 2010. Impact on quality of life of urinary incontinence and overactive bladder: a systematic literature review. *Urology*, *75*(3), pp.491-500.

[65] Stach-Lempinen, B., Hakala, A.L., Laippala, P., Lehtinen, K., Metsänoja, R. and Kujansuu, E., 2003. Severe depression determines quality of life in urinary incontinent women. *Neurourology and urodynamics*, *22*(6), pp.563-568.

From a health impact minimisation perspective urinary incontinence should be properly managed because it has been associated with poor ulcer healing, continence-associated dermatitis and iatrogenic injury from poorly applied or maintained continence products, and has been consistently associated with increased falls. A toileting program should be part of care management (and may include aids such as a urinal, bedside commode etc).

10.5 Other residential models

Given the range of responsibilities of RACFs and the pressure they are under, it makes sense to consider positive research outcomes on other models of residential care. For example, clustered domestic models of residential care. These have been associated with better quality of life and fewer hospitalisations for residents, without increasing whole of system costs[66]. Large residential aged care facilities are still typical in Australia.

Recommendations

The College recommends:

- The Commonwealth Government should review and improve the design of RACFs to more effectively customise their services to the population being served, for example, appropriate physical facilities where the majority of older persons have intellectual disabilities.
- The Commonwealth Government should develop strategic plans to ensure that for the complex range of specialised services that must be provided by RACFs, there is secure resourcing which better matches the health and psychosocial needs of the residents, and ensures that standards and accreditation systems are able to validate appropriate allocation of these resources within facilities including workforce. This is so that the right professional services are provided to residents in line with accessible, high quality, safe, person centred and comprehensive care.
- The Commonwealth Government should look at ways to enhance accreditation for best practice in RACF protocols.
- The Commonwealth Government should in cooperation with State and Territory governments better link RACFs with hospitals that provide outreach services whereby trained paramedics and nurse practitioners can assess and assist RACF nursing staff to treat patients in the RACF who have acute but uncomplicated illnesses.

[66] Dyer, S.M., Liu, E., Gnanamanickam, E.S., Milte, R., Easton, T., Harrison, S.L., Bradley, C.E., Ratcliffe, J. and Crotty, M., 2018. Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life. *Medical Journal of Australia*, *208*(10), pp.433-438.

11. Health professionals for the future

This section primarily addresses term of reference (f)

11.1 Undergraduate and Postgraduate training

Inadequate training and skills in aged care is a huge barrier to providing quality aged care to Australians, but one that can be easily addressed via training of all health professionals:

- Postgraduate training programmes for General Practitioners (GPs) in dementia management should be introduced.
- The RACP recommends that medical schools provide sufficient emphasis on geriatric medicine in the undergraduate curriculum to prepare for the future workload given Australia's aging population.
- Education needs should also be reviewed for nursing and allied health education around geriatric syndromes.

Within RACFs, our member experience suggests this Commission could consider recommending that GPs providing services to RACFs have additional qualifications, having regard for quality and safety of service provision.

11.2 Physician workforce planning

Determining the right number of geriatric medicine physicians, taking in to account both inpatient and outpatient settings is not straightforward nor subject to simple reliable formulae. There are no current projections we are aware of for geriatric medicine in Australia although current rates of specialists per head of population are available. There has never been a yardstick 'specialist-to-patient ratios' (SPRs) which 'defines' a satisfactory level of geriatrician or general physician manpower in any particular Australian hospital catchment[67]. This is an area for the Royal Commission to further consider.

Department of Health 2016 workforce data shows that almost 90% of the geriatric medicine workforce are located in capital cities,[68] with an average of 2.4 clinicians per 100,000 population across Australia in 2016.

We would like to see encouragement given to PHNs and LHDs to collaborate on ensuring there is forward planning for geriatrician positions (including advanced training positions in geriatric medicine). This will reduce future unplanned strain on aged care services.

11.3 End of life and palliative care services

Future provision of suitable levels of end of life care and palliative care services in residential aged care facilities needs to be more strategically planned. This is important given the known demographic projections, and that for many, this will be their last place of residence.
The elements that are essential for the provision of good patient-centred end- of life care are:

- Diagnosing dying or the imminent risk of dying
- Respecting patient autonomy and supported decision making and providing personalised care
- Ensuring that medical treatment decisions respect the patient's best interests
- Managing symptoms
- Supporting carers and family.

Patients who are in the last year of their lives may receive input from a great number of medical and non-medical health professionals in a range of care settings (acute, community, public, private), and may present repeatedly. Ensuring that patients who are reaching the end of their lives have access to the right care at the right time by the right provider can be challenging but is fundamental to providing optimal care and maintaining patient dignity.

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[67] Commerford, T., 2018. How many geriatricians should, at minimum, be staffing health regions in Australia?. *Australasian journal on ageing*, *37*(1), pp.17-22

[68] https://hwd.health.gov.au/webapi/customer/documents/factsheets/2016/Geriatric%20medicine.pdf

Fragmentation of care and lack of communication may mean that health professionals are unclear as to whose role it is to discuss end-of-life care with the patient. There may also be a perception amongst some health professionals that palliative care and end-of-life discussions are less relevant or more difficult to broach for patients with non-malignant diseases, such as dementia, frailty, neurodegenerative disorders, and progressive cardiac or respiratory failure.

Patients with dementia may be unwell for many years and may progressively lose the ability to meaningfully engage in end-of-life discussions, so it is especially important that these conversations are initiated early while the person still has capacity.

We support patients being able to access specialist palliative care support as needed, at any time of day or night.

Greater access is needed to specialist palliative care for people living in residential aged care and other community-based settings. Specialist palliative medicine physicians are needed to address these gaps: Current gaps in access to community-based specialist palliative care services limit people's opportunity to die in their own home or in other community-based settings such as residential aged care.

The palliative care needs of the growing number of people living with Alzheimer's Disease and other forms of dementia in residential aged care and other community settings, to avoid emergency and unplanned transfers to acute hospitals need to be better supported[69].
Nurse-led models of specialist palliative care, often involving nurse practitioners can assist here but does not yet measurably impact on the continued need for expansion of the specialist palliative medicine workforce[70].

11.4 Rural and remote services

The gaps in services for older people, including Aboriginal and Torres Strait Islander older persons in rural and remote areas has been made known to the Commission. The RACP also underlines this, along with the compounding issue for older persons of transport and ability to travel long distances in comfort.

For older persons, especially those with more than one chronic condition, it is imperative that access is facilitated at minimal or low cost, to multidisciplinary team care that includes more than one specialist. The safety issues here include the need for comprehensive care planning and medication reviews.

11.5 Reviewing design of RACFs

It is timely to review the degree to which RACFs are fit for twenty first century purposes and expectations. The structure and design of current RACFs has evolved out of a complex model of healthcare and its funding. There is a mix of public and private investments. Many operate as for-profit models which are often partially supported by government funding. Others offer a limited number of beds for 'those who cannot pay'.

This Commission needs to review the consistency and standards of quality and safety of care if people become residents in resource-limited (total) care environments which can range from home environments to aged-care institutions.

Given this is also a future scoping work, and considering available advances in technological capacity, specifically robotics, it is important future service planning considers how present gaps can be overcome using new technologies. For example, robots can be used to assist in lifting and moving patients and doing a range of other support tasks.

11.6 Discrimination and detrimental treatment of older persons

We want to raise the issue of ageist discrimination and poor communication with older patients[71]. Health care providers may develop inappropriate attitudes toward older patients based on their medical diagnoses, functional deficits, or symptoms. This increasing 'medicalization' of old age was associated with increasingly

[69] Australia, P.C., 2018. Palliative care service development guidelines. *ACT: Australia PC*.

[70] Australia, P.C., 2018. Palliative care service development guidelines. *ACT: Australia PC*.

[71] Wyman, M.F., Shiovitz-Ezra, S. and Bengel, J., 2018. Ageism in the health care system: Providers, patients, and systems. In *Contemporary perspectives on ageism* (pp. 193-212). Springer, Cham.

negative age stereotypes, leading the authors to conclude that this increasing negativity toward older adults is systemic and pervasive throughout medical culture.

11.7 Rehabilitation services

As more people demand to stay at home for as long as possible before entering RACFs there will need to be an increased number of community services providing rehabilitation / restorative care / re-ablement services. These services would provide ambulatory rehabilitation (in the home or centre-based) and assist in maintaining function and well-being and allow people to remain independent in their own home for as long as possible.

Rehabilitation should be available in people's homes or as close to their home as possible where it is safe to do so.

There is also a need for allied health services to be much more extensive within residential aged care as many people have multimorbidity. Current services are too limited and funding models appear to discourage access to multidisciplinary care.

This will require an increase in the number of rehabilitation medicine physicians and advanced trainees in ambulatory and community settings with multidisciplinary teams.

11.8 Workplace health of older workers

We have stated that the changing social context of health is one that features a longer lifespan, and also more years in the workforce. In the aged care system it can be anticipated there will older persons employed in services, including caring for older patients. From a service and policy outlook, this means ensuring supporting services and infrastructure is consistent with the needs of older persons. Key to this will be occupational health.

When people age, their physical, physiological and psychosocial capabilities change, and responsive practices can assist in keeping older workers healthy and productive[72]. Along with this trend we note that the concept of an older worker tends to be poorly defined[73].

Recommendations

The College recommends:

- The Commonwealth Government should develop a strategic plan to match health professional demand to the present under-resourced service delivery sites and future service need.
- The Commonwealth Government should sufficiently resource and monitor the National Palliative Care Strategy 2018 (released 2019) so that the needed end of life and palliative care services are able to be received by patients reaching the end of their lives as appropriate.
- The Commonwealth Government should introduce post graduate training programmes for General Practitioners (GPs) in dementia management.
- The Commonwealth Government should develop a strategic plan for improving access to physicians in places where there are low points of face of face contact (such as due to geographic maldistribution). Solutions may include innovative models of service delivery such as telehealth.
- The Commonwealth Government should ensure there is sufficient funding to increase the number of appropriately qualified physicians and advanced trainees in ambulatory and community settings.
- The Commonwealth Government should review re-education needs for nursing and allied health education in regard to the identification and management of geriatric syndromes.
- The Commonwealth Government should undertake a review of the standards of quality and safety of care for places in which older people become residents, including for consistency given there are different care-environments emerging which can range from the home to aged-care institutions

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[72] Poscia, A., Moscato, U., La Milia, D.I., Milovanovic, S., Stojanovic, J., Borghini, A., Collamati, A., Ricciardi, W. and Magnavita, N., 2016. Workplace health promotion for older workers: a systematic literature review. *BMC health services research*, *16*(5), p.329.

[73] Poscia, A., Moscato, U., La Milia, D.I., Milovanovic, S., Stojanovic, J., Borghini, A., Collamati, A., Ricciardi, W. and Magnavita, N., 2016. Workplace health promotion for older workers: a systematic literature review. *BMC health services research*, *16*(5), p.329.

Closing comments

The RACP looks forward to the release of the Commission's findings and recommendations for the future of aged care in Australia.

We acknowledge recent positive developments:

- The potential of the National Missions under the Medical Research Future Fund that brings together researchers, health professionals, stakeholders, industry partners, patients and governments to address *Dementia, Ageing and Aged Care Research*.
- The announcement of a $448.5m chronic disease funding model aimed at people over 70 with chronic conditions, using voluntary enrolment (Australian Government).
- The first independent commissioner for older persons and the disabled in NSW, with the role to have broad-ranging powers to conduct investigations into allegations of abuse and neglect[74].

Our goals are to:

- Positively address patient/carer capacity to manage conditions
- Facilitate patient capacity to move to the right points of care at optimal moment for intervention.

As a peak body representing over thirty different medical specialty areas, the RACP will work with all levels of Government to improve services for older persons, and specifically medical care, so that that older people, who constitute an increasing proportion of the population, can continue to live valued and fulfilling lives.

[74] https://www.theage.com.au/politics/nsw/nsw-to-appoint-ageing-and-disability-commissioner-premier-says-20190508-p51l59.html