



Australian  
General Practice  
Network

# Australian General Practice Network submission to the Productivity Commission's Draft Report on Caring for Older Australians

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**Delivering local health solutions through general practice**  
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AGPN represents a network of 111 general practice networks as well as eight state based entities. More than 90 percent of general practitioners (GPs) and an increasing number of Practice Nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an accessible, high quality health system by delivering local health solutions through general practice.

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## Executive Summary

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The Australian General Practice Network (AGPN) welcomes the Productivity Commission's (PC) comprehensive draft report on aged care and the emphasis it has placed on making the system fairer and more consumer friendly, and its insightful analysis of the complex and deep-seated problems that are inherent in the current system that hamper Australians from ageing well.

The PC's report comes at a time when Australia's health system is about to undergo major reform under recent agreements and policy directions set by the Council of Australian Governments (COAG). The most recent of these – the COAG *Heads of Agreement: National Health Reform* – reaffirms a leadership role for the Commonwealth in primary health care and, in particular, its policy leadership in the establishment of a system of primary health care organisations in Australia to better organise this domain of the health system to improve access, integration, quality and to promote a preventive-orientation to the way health and social care services are delivered. Primary health care is an important setting to consider when framing policy solutions to improving the aged care system.

In this context, it is AGPN's view that there are some key points that have been omitted from the draft report which must be added if the report is to fully reflect the structural reforms proposed in the New Health and Hospitals Network, some of which are already well under way. In particular, the important overall role of primary health care (PHC), as well as the specific role that Medicare Local primary health care organisations (MLs) will play in the aged care system needs to be discussed much more elaborately in the PC's final report, along with how linkages between PHC/MLs and other parts of the system can best occur to improve the delivery of aged care.

AGPN's submission focuses on opportunities for MLs to improve the aged care system in:

- Aged care workforce planning and training
  - Mental health in aged care
  - Prevention, rehabilitation and restoration
  - Medicare Locals relationship with the proposed Gateway Agency
  - The patient journey
  - eHealth
  - Achieving rural, remote and Indigenous access and equality
  - Aged care assessments
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In particular, AGPN's further key recommendations for inclusion in the final report also include that:

- The role of Medicare Locals in aged health care workforce planning and training should be acknowledged and discussed.
  - The role that Medicare Locals will, or could, play in brokering and coordinating mental health services in the aged care sector is identified and emphasised.
  - The role that Medicare Locals - and primary health care setting more generally - will play in restoration, rehabilitation and health promotion of elderly Australians is recognised.
  - The potential duplication of mandates between the proposed Gateway Agency and Medicare Locals is explored, with the aim of clarifying roles and responsibilities between the two.
  - The relationship that must be formed between the proposed Gateway Agency and Medicare Locals to mobilise and coordinate primary health care teams to perform aged care assessments is identified.
  - The role that Medicare Locals will play in creating a seamless patient journey through their planning and coordinating function needs to be articulated.
  - Emphasis is put on the importance of adequately funding and resourcing Medicare Locals who will take the lead in rolling out the adoption, implementation and use of eHealth infrastructure in both primary and aged care.
  - The responsibility Medicare Locals will have in specifically addressing Indigenous, rural, regional and remote elderly Australians' health through a suite of brokering and coordination mechanisms should be discussed.
  - The PC's proposed reforms take into account and are better linked with the Australian Government's National Health and Hospitals Network reforms.
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## Introduction

### AGPN and the Network: experience and expertise in aged and palliative care

The Australian General Practice Network (AGPN) welcomes the Productivity Commission's (the PC's) commitment to identifying and articulating the proposed aged care reforms that are necessary for delivering world class aged care services now and into the future, and to considering the "full spectrum of care needs of older Australians" with "a system-wide perspective...[that] looks at the needs of older people in a holistic way, including at the interfaces of related policy areas."

AGPN and its members (the Network) have been committed to a holistic approach to aged health care delivery for a number of years and have a sound track record in this area. We were the principal architects and managers of the Aged Care Panels Initiative, which successfully improved quality systems and activities in aged health care delivery by building and facilitating partnerships and linkages between primary health care providers and residential aged care facilities (RACFs). Through the Panels Initiative, Divisions of General Practice were given the opportunity, support and encouragement to create innovative, localised solutions to some of the barriers impeding health service access and to ensuring the necessary continuum of care for elderly Australians. (For a specific example, see Box 1 below)

Box 1: Application of the Aged Care Panels initiative in Caboolture Division. One example of innovation from the Aged Care Panels program is the "yellow envelope" transition tool initiative that was created and utilised by the Redcliffe, Bribie, Caboolture Division of GP. This initiative was instrumental in improving clinical handover practices between health professionals and RACF staff when aged care facility residents were being transferred between different care settings. This saved on time and unnecessary duplication for health professionals, and more importantly decreased the health risks to elderly patients through better medication management and better informed RACF staff regarding the residents' condition. This simple and innovative solution was considered a great success and it led to a number of other Divisions adopting it in one form or another.

Following the cessation of the Panels Initiative in June 2008, the Australian Government introduced in its place the incumbent Aged Care Access Initiative (ACAI), under the broader Practice Incentives Program (PIP), which is targeted at increasing direct primary care services in aged care facilities, including an allied health access component. Through a national aged and palliative care Principal Network Adviser, AGPN has worked collaboratively with the

Network and its aged care support officers to ensure the delivery of increased primary health care services in RACFs by directly assisting GPs through advocacy, information and general support. The outcomes of this program to date have been a great success, with both the Department of Health and Ageing and the Australian National Audit Office indicating that the ACAI initiative has been effective in increasing GP and allied health service delivery in RACFs, resulting in better chronic disease management and decreasing unnecessary hospital admissions.

AGPN and the Network have also been successfully involved in delivering palliative care programs within RACFs for more than seven years, with the Australian Department of Health and Ageing (DoHA) most recently engaging AGPN to manage the Rural Palliative Care (RPC) Project 2008-2011. The RPC Project is one of a number of initiatives designed to achieve the goals of the National Palliative Care Strategy. Further information about AGPN's role in this program is also provided in Box 2 below.

Box 2: AGPN's Rural Palliative Care program: The 2008-2011 Rural Palliative Care Project aims to further build upon the successes of the pilot project implemented by the Murrumbidgee Division of General Practice, from which the Griffith Area Palliative Care Services model was established. Subsequently, a further pilot project, managed by AGPN, was funded to assess the transferability of the model into a range of rural settings. The 2003 - 2006 pilot Rural Palliative Care Program supported eight rural general practice networks to further develop and implement collaborative models that, over the three year period, significantly improved the rural community's access to quality, coordinated palliative care. The announcement of the 2008-2011 Rural Palliative Care Project aims to build upon the successes of both projects and to deliver enhanced access to palliative care services across a broader expanse of rural Australia. AGPN has also managed the development of the "Resources for a Rural Palliative Care Program". The project developed a web-based Rural Palliative Care Resource Kit which consolidated the resources developed in the RPC pilot program 2003-2006 and will assist Network Members in implementing any new RPC program.

Given the successful aged and palliative care programs that the Network has already developed and managed, AGPN believes there is significant scope for the Network to both continue and enhance these successes in order to advance any new policy and programs developed in response to the final recommendations from the PC regarding aged care reforms. In particular, AGPN would note that aged care primary health and a more responsive system to aged care issues can be particularly enabled through the establishment of Medicare Local

primary health care organisations into which many Divisions are likely to evolve, as part of the Government's broader National Health and Hospitals Reforms. Further discussion about this future context is provided in the next section.

### **Aged Care and the health reform context: Medicare Locals and the National Health and Hospitals Network**

The Australian Government has clearly recognised the issues of inequity, inequality and consumer confusion that currently afflicts the aged care system. Under the auspice of the National Health and Hospitals Network reforms and the imprimatur of COAG, it has therefore identified this area as a health system priority to be addressed in its second term.

The clear message to come out of the Australian Government's health reform proposals is that primary health care **must** be strengthened and supported to attain the capacity it requires to become the principal point of care for all Australians, including and especially elderly Australians. This will, in turn, steadily relieve some of the weight and burden from the acute/hospital sector through promoting healthy communities and minimising unnecessary hospital admissions.

To achieve this, primary health care organisations – announced as Medicare Locals - are being established with mandates that encompass a more holistic and comprehensive view of primary health care. Building on Divisions of General Practice, Medicare Locals will be charged with a range of strategic objectives including:

- improving the patient journey
- supporting clinicians and service providers to improve the quality of service delivery
- identifying the health needs of local areas and developing locally focused and responsive services
- implementing primary health care initiatives and programs.

For further information, see the Invitation to Apply at

[http://www.health.gov.au/internet/main/publishing.nsf/Content/grantITA2491011/\\$FILE/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/grantITA2491011/$FILE/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.pdf)

Inherent in these goals is the expectation that Medicare Locals will establish and maintain broad and effective relationships with aged care stakeholders, and build on these relationships to broker and coordinate aged care health services to increase access to quality, multi-

disciplinary primary care, and to create and maintain a seamless patient journey for elderly Australians.

Based on this premise, AGPN envisions a model of care for elderly Australians that is reflective of the Australian Government's vision. This model is one in which GPs are principal case managers in aged care service delivery, but where non-GP health professionals, including nurses and allied health workers, also play a key role through expanded scopes of practice.

Should the Government take a policy decision to implement the PC's proposed Gateway Agency, Medicare Locals would be ideally placed to work closely with the Agency in determining service needs and the most appropriate service models, as informed by local context, service infrastructure, population and workforce profiles. It is expected that Medicare Locals will be directly supported by a national organisation, who should also have responsibility for working collaboratively with the proposed Gateway Agency, but will in addition provide leadership, advocacy and play a coordinating and policy development role at the national level, ensuring consistency across the board and acting as a communication hub for the dissemination of evidence-based practice models among Medicare Locals and other relevant stakeholders.

With this vision being articulated by the Australian Government, and the transition process already well underway, AGPN believes that its expression should be much better reflected in the PC's final report.

## **Primary health care: achieving accessible, patient-centred, coordinated care for elderly Australians**

AGPN welcomes the PC's steps to ensure that it performs a wide and robust consultation process in informing its final report. We would strongly recommend that any comprehensive approach to the quality, viability and future of Australia's aged care system consider the interface between the aged care system and the primary health care (PHC) system and the quality of care for older Australians that this supports. The interfaces between the aged care system, the primary health care (PHC) system and the hospital care system impact on the quality of care that older Australians receive as well as on the performance and efficiency of each of these service sectors. Ensuring older Australians can access quality care in accordance with their needs through either community care or residential aged care requires integration of, and coordination across, the aged care, primary health care and acute care sectors. This is a role that Medicare Locals will be well placed and mandated to play.

AGPN believes that all Australians have a right to access timely, patient-centred, well coordinated and comprehensive PHC. The provision of timely multidisciplinary PHC to older Australians is critical to ensuring optimal health, wellbeing and functioning as well as limiting acute episodes of chronic illness and reducing unnecessary hospitalisations and presentations to emergency departments.

AGPN's submission to the PC focuses on the role that PHC will, and must, play in the future of aged care service delivery, with particular emphasis on the role that Medicare Locals - in partnership with other relevant stakeholders and service providers - will have in being the local primary health care organisations responsible for coordinating seamless, integrated and efficient aged care services. In particular we focus on opportunities for Medicare Locals in:

- Aged care workforce planning and training
- Mental health in aged care
- Prevention, rehabilitation and restoration
- Medicare Locals relationship with the proposed Gateway Agency
- The patient journey
- eHealth
- Achieving rural, remote and Indigenous access and equality
- Aged care assessments

AGPN is an active member of the National Aged Care Alliance (NACA) and supports for the NACA vision for care for older Australians.

## **Aged Care for the Future: Opportunities and Delivery through Primary Health Care**

### **Aged care workforce and access**

The PC has identified in its draft report that workforce issues in the aged care sector are deep-seated and complex, and that they underlie many of the service problems that afflict the current system – and will continue to afflict the future system unless they are structurally and systemically addressed. We commend the PC for articulating the breadth and depth of the problems, but the absence of any meaningful recommendations for remedying them is unlikely to result in any real and necessary change. AGPN sees Medicare Locals (MLs) as playing a key role in working collaboratively with Health Workforce Australia, the PC's proposed Gateway Agency, professional groups and aged care providers in identifying and addressing workforce shortages and access barriers in the aged care sector to build on the existing work of Divisions

to further develop solutions around quality service delivery in Aged Care. Examples regarding access, workforce shortages and workforce training are provided below.

### **Access**

AGPN and the Network have been working over a number of years through the Aged Care Panels Initiative, and its successor, the Aged Care Access Initiative (ACAI), to increase access to primary health care services for RACF residents. In addition to creating varied and innovative solutions to access barriers as already outlined, AGPN, through ACAI, has also advocated for the changes to the MBS item schedule to provide remuneration incentives for primary health care professionals to visit RACFs. This initiative has been recognised by the Department of Health and Ageing and ANAO of being successful in driving a marked increase in RACF visits from health clinicians. Building on this work, Medicare Locals will also be supporting primary health care professionals in attending RACFs by advocating for Medicare Benefits Schedule (MBS) item utilisation through the ACAI.

Another structural barrier identified in the draft report as impeding an adequate number of health professional visits to RACFs is the lack of a dedicated clinical space for health professionals to carry out consults and store clinical equipment. Not only does this deter health professionals from wanting to attend RACFs, but it also impedes the level of care that a clinician can offer, as well as diminish the dignity of the patient if they need to have consultations performed in open or impersonal spaces. AGPN believes that the easiest and most appropriate solution to this problem is for the Australian Government to fund an RACF clinical infrastructure fit out/upgrade. This could be organised in a similar way as the current primary infrastructure grants which provide funding in various categories up to \$0.5 million on a competitive basis to support new and upgraded clinical facilities, training rooms and facilities for group work with clients in the general practice setting. AGPN recommends that the PC canvass an infrastructure grant proposal in its final report.

### **Workforce shortages**

In addressing workforce shortages, Medicare Locals will have a mandate that encompasses population health planning at the local level. This will include attaining local health workforce data in partnership with the necessary workforce, research and/or other bodies, and using it to identify needs and planning in collaboration with health workforce stakeholders to fill the identified gaps. This type of systematic approach to data collection and identification of needs will take time to implement, but once in place, it has real potential to target and then address a substantial proportion of the aged health care workforce shortage.

One strategy aimed at relieving workforce pressures already in development is the After Hours initiative. The initiative comprises a national health advice phone line staffed by nurses and GPs, facilitation of face to face after hours services by Medicare Locals and a telehealth component. The phone advice line, which is due for national implementation from July 2011, will allow RACF staff to access advice about their aged care residents over the phone. This initiative will take some of the burden off medical professionals by minimising the need for face to face consultations. It will also greatly assist RACF staff who can be confident that they can access medical advice about their patients. This will allow them to better manage cases that do not require face to face consultation and result in less disruption to patients from avoidable hospital visits. Recognition of these points in the PC's final report is highly recommended.

### **Workforce training**

Medicare Locals are also expected to work with aged care providers and education and training bodies to identify and fill skills gaps in the aged health care sector. The PC's draft report clearly acknowledges the severity of skills shortages in the sector today, and explicitly articulates the adverse implications that this has for care delivery, especially clinical care delivery. AGPN commends the PC for recommending that the Australian Government promote skills development through an expansion of courses to provide aged care workers with the skills they need, with particular emphasis on nurse practitioner and management training. The draft report leaves out however any suggestion of how the skills gaps within different provider settings are going to be identified and analysed, and who will play the role of coordinating the delivery of training courses necessary for addressing these gaps.

Medicare Locals will be geared to work with aged care providers and training and education bodies to identify health workforce skills shortages and assist with the coordination of the delivery of the necessary training. AGPN would therefore see value in acknowledging this in the final report, as it adds clarity to how this will be addressed.

### **Mental health in aged care**

There has been serious concern expressed among aged care stakeholders that the Report fails to deal adequately with mental health in aged care (psycho-geriatric services). AGPN sees Medicare Locals (MLs) playing the principal role, in collaboration with other relevant stakeholders, in identifying service gaps and coordinating and brokering appropriate mental health services in the aged care sector. Under the current system, elderly Australians with mental health issues too often fall between the cracks that have formed between the mental

health and aged care silos. The problem is that there is confusion from both consumers and providers around whose responsibility it is to service these needs, which has left many elderly Australians without necessary treatment.

Under the Government's new health reform agenda, MLs will be resourced, equipped and given responsibility for identifying and brokering mental health services in their communities, including in the aged care sector although there will be limits to the extent and range of service delivery possible due to 'capped' budgets. This will go a long way to addressing the ambiguity, inefficiency and inequity plaguing the current system. For this to be effective however, it is important that the aged care community is well informed of where they can attain service information and what they can expect from their Medicare Local in relation to these services. Although Medicare Locals will clearly have a role in promoting their services, AGPN recommends that, in addition to identifying and elaborating on the mental health in aged care issue, discussion around MLs' role, or potential role, in this domain would add clarity to the final report.

### **Prevention, rehabilitation and restoration – keeping elderly Australians active and engaged in their communities for longer**

The substance of the Government's new health reforms is indicative of a paradigmatic shift towards prevention, well-being and health promotion generally and the premise of the PC's Report is no exception. Preventative and health promotion activities have demonstrably proven their worth in reducing the incidence and severity of chronic conditions, reducing unnecessary hospital admissions and assisting elderly Australians in living actively in their homes and communities for longer. It is well articulated in the draft report that this approach to health care delivery in the aged care sector is both cost efficient and preferable to the consumer, and that adequate attention must therefore be paid to the mechanisms required for delivering on this approach.

Although all parts of the health system can play a role in prevention, health promotion and prevention fall well within the scope of primary health care. The growing emphasis on this sectors' role in this area has become evident with the planned establishment and proposed functionality of Medicare Locals. MLs are being charged with the responsibility for brokering and coordinating multi-disciplinary health care teams both in the community and aged care sectors. They will be responsible for working collaboratively with the Australian National Preventative Health Agency and other existing bodies in identifying, designing, targeting and delivering prevention and health promotion activities. It is thus surprising that the mention of

MLs' role in this area has been omitted from the draft report. AGPN recommends emphasising the role that MLs will play in delivering preventive approaches in the PC's final report.

### **Medicare Locals and the proposed Gateway Agency**

There is significant potential for role duplication in some areas between the PC's proposed Gateway Agency (Agency) and Medicare Locals. AGPN supports the PC's proposal that the Agency will be responsible for maintaining the national aged care information base, and for delivering assessment and care coordination services. We also support the suggestion that accredited RACF providers should take responsibility for being care coordinators for their residents (where not provided by the Agency). However, AGPN considers that collaboration and strong working relationships between the Agency, providers and MLs will also be essential in order to adequately and efficiently identify, coordinate and manage the delivery of clinical aged care services within the community. especially as government has clearly articulated a role for MLs in the facilitation and coordination of aged care.

AGPN recognises that the proposed national Agency has been given oversight of a broad range of responsibilities including aged care assessments, being an information 'clearing house', coordinating basic support services like home modifications, meal preparation and cleaning, and carer support such as respite services, counselling, education and advocacy. AGPN's own experience and strong recommendation is that while there is a clear role for national input/and oversight in coordinating and managing the large and complex task of clinical service delivery, this is principally done most successfully at the local level by specific health care organisations that have, at their core, the necessary knowledge, data, relationships, service provider and clinical engagement, clinical leadership and service development experience in identifying and delivering health care services across the community, including in aged care. Medicare Locals and Divisions are examples of agencies with such knowledge and AGPN recommends that local providers work closely with their ML in managing clinical care for their aged care residents.

AGPN also strongly recommends that if the Government establishes the Agency, and promotes a level of responsibility within providers – as AGPN agrees it should - then it must work with the relevant providers, including MLs, to carefully and clearly determine and articulate the specific roles and responsibilities of all bodies involved, and establish formal communication/engagement channels between them. This point should be emphasised in the PC's final report.

## The patient 'journey'

The need for responsibility to be taken for the coordination of care between the multiple layers of the health and aged care systems is absolutely critical. This coordination entails the journey through community care, primary health care, acute/hospital care, transitional, respite, palliative and end-of-life care. Under the current system, these different areas are 'siloed' and fragmented, causing confusion, inefficiencies and jeopardising patient health and safety. The PC has suggested in its draft report that the proposed Agency and individual providers should be responsible for this, and to a degree AGPN agrees.

However, as already outlined, AGPN believes that this will be achieved most effectively through close working relationships between the Agency, providers, Medicare Locals and Local Hospital Networks. Medicare Locals' performance framework is likely to include criteria regarding effective partnerships with multiple levels of stakeholders, including those within aged care. As the most common case managers of elderly patients, GPs will be best positioned to monitor and advise on the patient 'journey', and Medicare Locals will be best geared to support and coordinate this supervision and management by possessing the resources, skills sets and relationships necessary to ensure a continuum of care.

AGPN applauds the Commission's recognition of the need for a strong coordinating body, but would recommend that it better reflect the working relationships required with a broader set of stakeholders, especially Medicare Locals, in its final report.

## eHealth

Achieving an effective continuum of care will also be heavily reliant on the sufficient rollout and use of the Government's eHealth infrastructure, and AGPN commends the PC for the level of support and advocacy that it provides for this in its draft report. It does however fall short of identifying the specific role that eHealth will play as the enabling link between the aged care and primary health care sectors, as well as Medicare Locals' role in coordinating and managing the rollout, uptake and use of eHealth in both sectors.

Medicare Locals have been flagged as the organisations best suited for driving the change and adoption of new information management and information technologies across primary health care settings. This will include Government initiatives already in early development stages such as the Personally Controlled Electronic Health Record, Health Identifiers, secure messaging, electronic referral and discharge, electronic prescribing and telehealth. As the principal case

managers of elderly patients, it will be absolutely vital to the rollout of the PC's proposed reforms that GPs, and their primary health care teams more broadly, have the capacity and skills required to best utilise this technology.

AGPN would also see value in the PC emphasising, along with reiterating the case for eHealth generally, the need for Medicare Locals to be adequately resourced and supported to ensure the rollout of the Government's eHealth agenda, as this will be critical to the successes of many of the PC's proposed reforms.

### **Advanced care planning**

AGPN supports the views expressed in the PC report that advanced care directives are an essential part of advanced care planning and end of life care but that current variation in jurisdictional systems can hamper effective implementation of this process. AGPN is therefore highly supportive of the Commission's recommendation that interstate inconsistencies be removed in regulations regarding advance care planning as the current lack of regulatory consistency confuses and concerns Australians. An easy to use, national system will encourage people to make better use of this useful mechanism to express choices about care. AGPN strongly recommends that national legislation (or at least consistent legislation across States and Territories), national guidelines, forms and associated information be developed with regard to advance care planning within reasonable and realistic time frames and is included as part of the patient electronic record.

### **Rural, remote and Indigenous elderly Australians**

Our rural, remote and Indigenous Australians are by far the most disadvantaged when it comes to access to health care services generally. This is no exception when it comes to aged care. The Government has flagged this issue as a top priority on its health reform agenda, and has already taken steps to address it, such as through supporting Rural Health Workforce Australia, providing incentives for health workers to practice in rural areas, and by broadening the age gap required for Indigenous Australians to access aged care benefits. Despite these efforts, the health inequities and inequalities in these areas are still a major concern.

The PC has been light in its draft report on proposing solutions to this, or of recognising the important role that Medicare Locals will play in improving this situation. Being local primary health care organisations, MLs will be responsible for assisting to coordinated care in the aged care sector (as discussed above), with a particular mandate for addressing service gaps, workforce issues, skills shortages and coordinating Indigenous specific cultural education

services for relevant health care workers. This work will be done as part of a larger collaboration with the Gateway Agency, local aged care providers, the Rural Health Workforce Australia agency and Aboriginal Controlled Community Health Clinics.

In addition to advocating for a more in-depth discussion on these issues in the PC's final report, AGPN also sees value in identifying the relationships discussed here that will be necessary for achieving improvement on these disparities.

### **Aged care assessments**

The PC acknowledged in its draft report that the current aged care assessment mechanism (ACATs) was slow and inefficient in providing assessment services, leaving elderly Australians for too long without the care they need, contributing significantly to unnecessary hospitalisations. The PC acknowledged the potential role that primary health care provider teams – namely GPs and nurses - can play in assessing the needs of elderly Australians, which would substantially speed up the assessment process and improve its efficacy. This initiative was one of the recommendations AGPN made to the PC in its submission prior to the draft report, and therefore commends its consideration in the draft.

It is proposed in the draft report that the Gateway Agency will be responsible for coordinating and managing the assessment process, and AGPN agrees with this notion as long as it is done in collaboration with Medicare Locals who will be responsible for coordinating and mobilising the individual health professionals being contracted to carry out the assessments. AGPN recommends including this point in the final report as part of a more comprehensive discussion around health care workforce and delivery issues.