Statement of John Brian Maddison

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Date: **8th October 2019**

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

2. Where direct speech is referred to in this statement, it is provided in words or words to the effect of those, which to the best of my recollection, were used at the time.

3. The views I express in this statement are my own based on my education, training and experience. I make this statement on behalf of the Australian and New Zealand Society for Geriatric Medicine and I am authorised to do so.

Professional background

4. I am currently the President of Australian and New Zealand Society for Geriatric Medicine (ANZSGM). I have held this position since May 2019.

5. I am a Consultant Geriatrician and Clinical Pharmacologist (MBBS FRACP) with over 20 years' experience as a doctor. I am currently the full time Division Director of Aged Care, Rehabilitation and Palliative Care (ACRPC) in the Northern Adelaide Local Health Network. In this capacity I am responsible for services in a variety of settings including acute, subacute, community, ambulatory, residential aged care and rural settings. I have held this position for seven years.

6. Prior to working at the Northern Adelaide Local Health Network, I worked for the Royal Adelaide Hospital and in private practice as a geriatrician.

Preamble

7. I make this statement in response to NTG-0484 dated 25 September 2019 in which a number of questions were posed. These questions have been reproduced in **bold** text below. Where reference is made to "private" this is taken to largely mean activity ultimately funded by the Medical Benefits Schedule (MBS) rather than private health insurance or self-funding by patients through other means.

8. From the outset it is important to recognise that ageing does not inevitably lead to a requirement to access care – whether that be in the home or in a facility. Predictors of admission to residential care are overwhelmingly health-related, rather than social (13). It is usually "geriatric syndromes" or multiple medical problems which contribute to loss of function and independence. Hence any aged care system must be designed to robustly meet the medical needs of older Australians.

9. Older people in residential care or receiving high levels of care in their homes are amongst the most medically complex patients which doctors manage. It is not surprising that the highest level of training and expertise is required to achieve the best outcomes for these patients. Geriatricians are well placed to work alongside the patients GP, allied health, nursing, facilities and providers to achieve contemporary interdisciplinary care, strong clinical governance and ongoing education and quality improvement.

10. Potential changes to the Medical Benefits Schedule and Aged Care Assessment Teams are a potential threat to the participation of geriatricians working in aged care. This may be offset provided continuing growth in training and workforce is supported. These matters are described further below.

What is geriatric medicine?

11. Geriatric medicine is the specialist medical care of older people and is provided by geriatricians. It is the specialist branch of medicine concerned with the diagnosis, treatment and prevention of disease in older people and the problems specific to ageing. It should be distinguished from gerontology which has a wider connotation and relates to old age in all its aspects (1).

12. Geriatric medicine is a physician sub-speciality akin to Cardiology or Oncology.

13. A geriatrician has expertise in the diagnosis and management of complex and multifactorial internal medicine disorders that impact upon the cognition and functional status of older individuals (2,3).

14. A geriatrician has specific training in managing the so called "giants of geriatric medicine" which include frailty, cognitive impairment and dementia, confusion and delirium, changed behaviours and behaviours of concern, multiple morbidity and polypharmacy (4).

15. The major diagnostic and therapeutic intervention which geriatricians provide is known as Comprehensive Geriatric Assessment (CGA) which is supported by extensive evidence (5-10). This has been shown to reduce morbidity, mortality and reduce the likelihood of placement in residential aged care. This is recognised by the Australian Government through specific item numbers in the Medical Benefits Schedule (MBS) (Item numbers 141, 143, 145, 147).

16. As with other specialist services a referral from another medical practitioner is required in order for the MBS to be utilised. The CGA item numbers specifically require referral from a GP, prompting and facilitating interdisciplinary care.

17. The CGA as an intervention can be effectively applied throughout the care continuum including a person's home or residential aged care facility, outpatients settings such as Memory Clinics, emergency departments, perioperative care, acute and subacute hospital care including Geriatric Evaluation and Management Units and Rehabilitation (11-14).

Training in Geriatric Medicine

18. The extent of training required to become a specialist geriatrician is not commonly understood by those outside of the Royal Australasian College of Physicians. This can lead to some confusion regarding the role of the geriatrician, the role of the general practitioner and the role of other health care professionals within the system.

19. Training as a geriatrician in Australia is only available through the Royal Australasian College of Physicians. Following the completion of Internship (the first year of practice after obtaining medical qualification), trainees must complete a minimum of three years of basic physician training. This is undifferentiated common training for all specialist physicians – for example cardiologists, gastroenterologists or geriatricians. To become a specialist in a chosen field a minimum of a further three years of advanced training is required – once again whether that be cardiology or geriatric medicine.

20. The minimum number of years of study following completion of a medical qualification to become a geriatrician is seven years.

21. The duration of training required clearly has implications regarding workforce planning and initiatives intended to increase workforce.

Geriatric Medicine in Residential Aged Care

22. In the context of the Royal Commission into Aged Care Quality and Safety it is helpful to reflect on the origins of modern geriatric medicine.

23. Geriatric medicine as a specialty owes much to Dr Marjory Warren who is known as the "mother of geriatrics". Dr Warren was given responsibility for 714 chronically ill patients in the "Poor Law Infirmary" at the West Middlesex Hospital in 1935, many of them elderly. By systematically examining every new patient and instituting a geriatric medical approach (the modern equivalent being a CGA) she was able to improve the function of her patients sufficiently such that institutionalisation was no longer necessary and the number of chronic beds required by this service was reduced to 240 (15).

24. This triumph of better outcomes for individual patients with more efficient use of resources is the clinical outcome which all geriatricians aspire to. The origins of geriatric medicine in providing better care for complex institutionalised older patients and the subject matter of this Royal Commission are clear.

25. The value of geriatricians in relation to federally funded aged care services within Australia was recognised in August 1986 when Government announced funding to develop Geriatric Assessment Teams (GATs) in order to avoid unnecessary nursing home admission. Assessments were required to evaluate physical, medical, psychological and social needs of the frail older person. Such an assessment was

necessary before obtaining approval for admission to a nursing home. These assessments were completed by multidisciplinary teams jointly funded by the Commonwealth and the states and included geriatricians. The name was changed to Aged Care Assessment Team (ACAT) in 1992 (16).

26. Contributing to the care of older people in residential care remains an important part of both the practice of geriatric medicine (2) and teaching of geriatric medicine (17). Within the Australian context, geriatrician involvement in delivering care in patients' homes or residential aged care is clinically effective (18) and cost effective (19), as reflected in recent studies.

27. ACATs are currently embedded in with public hospital departments of Geriatric Medicine in many jurisdictions in Australia. This has provided an important point in an older person's health care journey where there is ready access to a geriatrician.

28. Unfortunately, the three decades of close association between ACATs and geriatricians will soon change following the "Legislated Review of Aged Care 2017" (20). Recommendation 27 of this report proposes combining the Regional Assessment Service (RAS) and ACAT workforces and as a result we do not anticipate there will be any meaningful direct involvement of geriatricians in this process once these changes are implemented. This remains an unintended and unrecognised consequence of this recommendation for which no mitigation has been articulated.

29. Older people access Commonwealth subsidised care due to medical problems – not as an inevitable consequence of ageing or lifestyle choice. These medical conditions are often chronic, multiple and dynamic. Hence, adequate medical care for older people in receipt of care must be a critical consideration in any model. The foundation of this care must be a properly provisioned General Practitioner (GP) workforce.

30. Geriatricians should perform CGA to inform and guide the medical management in complex cases which is both clinical and cost effective. In the absence of an adequate GP workforce or access to geriatricians it will not be possible to achieve the best outcomes for the most vulnerable and some of the most medically complex patients within our society. Accessibility to other key specialist groups such as old age psychiatrists (psychogeriatricians) and palliative care medicine specialists must also be considered.

What is the role of the ANZ Society for Geriatric Medicine?

31. The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) represents specialist geriatricians and medical professionals who strive to provide the best possible health care and support for older people, working to improve their quality of life and well-being.

32. The Australian Geriatrics Society formed in 1972 and became the Australian Society for Geriatric Medicine (ASGM) in 1993. In 2006, the ASGM and the New Zealand Geriatric Medicine Society amalgamated to form the ANZSGM.

33. The ANZSGM has over 1200 members in Australia and New Zealand who work across all healthcare settings, including residential and community aged care, and are experts in managing the complex medical and health related problems faced by older people. ANZSGM strongly believes access to high quality medical care is a critical component of the overall wellbeing of our aged care residents.

34. ANZSGM supports scientific research and strives to provide the best possible education and training for our professional workforce. ANZSGM also strongly advocates for improvements to policy and social attitudes to recognise older people as valued members of our society, seeing ageing in a positive light and recognising the importance of health for every individual irrespective of age and the support required to age well.

What is the current makeup of the geriatric profession, broken up on a state by state and private/government employed basis?

35. Obtaining accurate, comprehensive and detailed workforce data for specialist medical practitioners can be a challenge. As such it is necessary to review a range of sources to understand the profile of geriatric medicine nationally. The Medical Board of Australia Registrant data for 1 April 2019 to 30 June 2019 reports the following number of registered geriatric medicine specialists in Australia at 874 (table 1).

State	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Geriatricians	**13**	**279**	**3**	**121**	**71**	**13**	**272**	**93**	**9**	**874**

Table 1. Geriatricians by State as per the Medical Board of Australia at 30 June 2019

36. The Medical Education and Training (3rd) report tables (at https://hwd.health.gov.au/met.html) show in 2018 there were 701 RACP fellows in geriatric medicine and 66 new fellows added to the workforce.

37. Historical data from Health Workforce Data (HWD) available at https://hwd.health.gov.au demonstrates the changes in time by major jurisdiction. Specific counting of geriatricians did not occur in this dataset prior to 2012. This is shown below (table 2).

Geriatricians	2012	2013	2014	2015	2016	2017
NSW	164	164	174	189	207	215
Vic	138	144	161	166	180	198
Qld	54	63	63	75	81	96
WA	43	45	57	62	67	71
SA	37	38	36	41	43	50
Total*	**453**	**470**	**507**	**550**	**599**	**654**

Table 2. Geriatricians by State as per the HWD 2012 – 2017 (*Includes all jurisdictions such as ACT, Tasmania and NT)

38. To put this in context using the same dataset from 2013 to 2017 the number of geriatricians increased by 39% compared to a 20% increase in the number of cardiologists and a 6.5% increase in the number of general physicians. In 2013, 55% of the geriatricians were male compared to 51% in 2017.

39. These most recent workforce figures reflect the significant ongoing growth in the geriatric medicine workforce which has been occurring for some years and is appropriate given the health needs of an ageing population.

40. Modelling workforce demand is similarly difficult – methodology which relies on acute hospital data (reliant on Diagnosis Related Groups) is likely to under-estimate demand (39). Similarly it is not always possible to specifically identify geriatrician activity with the Medical Benefits Schedule. Evolving models of care in both acute and community medicine are increasing the demand for geriatricians. Finally geriatric medicine is affected by general workforce issues such as increasing participation of female trainees and likely reduction in working hours of future specialists (male and female).

41. "Specialist-to-patient ratios" are one proposed methodology for determining workforce demand. There are wide ranging figures for this internationally which are many years old and may be difficult to contextualise given different health systems and scopes of practise in other countries. A recent Australian estimate of 0.4 FTE per 10 000 population has been proposed (40), which would equate to approximately 1000 full time geriatricians working in geriatric medicine (many geriatricians are qualified in other specialities). It is likely this is a conservative estimate of population demand.

Private practice

42. In 2011, an internal ANZSGM survey suggested approximately 15% of geriatrician hours were spent in the private sector. According to Australian Government in 2016 there were 619 geriatricians in Australia – of whom 19.6 % worked in the private sector (3).

43. Analysis of HWD for 2013 showed 43% of geriatricians undertook some private clinical work which increased to 45% in 2017. The number of geriatricians who undertook substantial (more than 20 hours a week) private clinical work remained similar between 2013 and 2017 at 18% (noting the total number of geriatricians over this time increased from 470 to 654).

44. A recent survey in Victoria of newly qualified geriatricians examined their work profile six months after graduation. The majority of work remains in the public sector. Acute care is the main area of work, with 30% of time spent in the community/residential care sector.

ANZSGM Membership

45. In order to better understand the geriatrician workforce prior to 2012 it is useful to review ANZSGM membership numbers.

46. The vast majority of practising geriatricians in Australia are members of the ANZSGM which currently has 789 full members which approximates the 874 specialists registered in geriatric medicine. The growth of the membership over the last two decades suggests that the growth in geriatrician numbers has been continuing for some time. In 2002 there were 455 total members of the ASGM reflecting approximately 300 practising geriatricians in Australia at that time.

47. The number of geriatricians has grown significantly over the last decade as reflected in ANZSGM membership figures, and this growth will continue given the increasing number of advanced trainees who are within a few years of becoming specialists (table 3).

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Full Member* (Australia)	490	507	578	563	598	595	650	697	696	789
Advanced Trainee	83	116	120	150	185	216	232	235	231	225
Other	37	49	48	46	43	48	49	47	48	53
Total (Australia)	**610**	**672**	**746**	**759**	**826**	**859**	**931**	**979**	**975**	**1067**

Table 3. Australian ANZSGM Membership by category 2010 – 2019 (*largely consultant geriatricians).

48. In summary it is estimated the number of geriatricians in Australia has increased from approximately 300 in 2002 to 874 in 2019.

To what extent does undergraduate education for medicine prepare graduates to deliver good quality health services to elderly people?

In what respects is undergraduate education for medicine adequate or inadequate when it comes geriatric medicine?

49. The ANZSGM maintains that all medical schools should ensure that students have specific training in the assessment and management of older patients and recommends essential areas of study regarding knowledge, skills and attitude.

50. The requirement for medical education to adapt to meet community needs, including the transfer of clinical teaching to community and nursing home settings and the development of interdisciplinary teaching has long been recognised by Australian geriatricians (21). The ANZSGM has had a published position statement regarding the training of medical students since 1996 (22).

51. The medical care of older people with multiple co-morbidities located in nursing homes and community care settings is one of the most difficult challenges for doctors. It is not realistic to think that this can be mastered solely at the undergraduate or junior doctor level. However, every doctor that deals with older adult patients does need some familiarity of the problems of these patients. A good understanding of the care of older people in non-hospital settings is needed for effective management of the transfer of older people between these settings (for example formulating discharge plans from hospital to home or residential care). There are models for teaching of medical students in residential aged care environments (23) but these are not widespread.

52. Learning to care for older people with frailty, multiple medical problems, cognitive impairment and functional limitations in a hospital setting is one step to learning to care for older people in other settings. Early exposure as a medical student to the care of older people in non-hospital settings is crucial and subsequent exposure in the early postgraduate years is also important. These training experiences need to be properly supervised by clinicians, such as geriatricians and general practitioners, working in those environments.

53. Students need to meet older patients in the various settings in which they seek medical care (e.g. hospital, community, home, residential care) (22). The British Geriatrics Society Education and Training Committee recommends that medical students should have the opportunity to be attached to a Geriatric medicine unit for a least four weeks to optimize learning opportunities (24).

54. A recent survey of Australian Medical Schools suggests that adaptation of robust teaching in geriatric medicine is deficient. Of the 18 medical schools responding, rotations in geriatric medicine were not mandatory in seven. The duration of attachments in geriatric medicine ranged from one to eight weeks (25), with one third of these attachments not exclusive to geriatric medicine, suggesting possible inadequacies of both duration and intensity.

55. Anecdotally the number of funded clinical academic and research positions within Universities for Geriatricians in Australia is fewer than would be expected given the health needs of the community, especially when compared to other areas of medical specialty. As these roles are important in shaping individual medical school curricula and teaching this may be a factor. It is unclear how the specific curricula between medical schools compare regarding geriatric medicine content and this is a current gap in knowledge.

56. In summary the changing profile of health and ageing within Australia presents challenges and opportunities for both undergraduate and postgraduate medical, nursing and allied health training. A paradigm shift is required, where we develop curricula to equip the health professionals of the future with the skills and attitudes they need for their core patient groups of tomorrow and not yesterday.

What, if anything, needs to change in the medical curriculum?

57. The Australian Medical Council Limited (AMC) is the independent national standards body for medical education and training and is responsible for the accreditation of medical programs of study. This includes medical schools and the specialist medical colleges. The AMC assesses a medical school curriculum's compliance with the standards required of a primary medical program, but universities develop their own curriculum/educational models and medical knowledge content.

58. There is no national curriculum for the teaching of medical students. Medical school curricula should be evaluated against the recommendations of the ANZSGM (22).

59. Given that the majority of doctors spend a significant portion of their careers managing older patients, there should be an agreed minimum duration of exposure to clinical geriatric medicine.

60. Internationally there is consensus with regard to required curriculum content key areas such as delirium (26). This should be guiding the teaching of Australian medical students.

61. Competency based training approaches should also be considered – an example being the NSW Health Dementia Care Competencies (https://dementiacare.health.nsw.gov.au/).

62. Ensuring there are sufficient funded clinical academic and research positions in Geriatric Medicine within the Universities will be an important enabler in improving the teaching of medical students. Currently these positions are under-represented within the University sector.

What is the process for amending the undergraduate medical curriculum to accommodate more content to better prepare graduates to work with elderly people?

63. This is determined by individual Universities which are accredited by the AMC. The ANZSGM recommends that the ANZSGM position statement (22) is considered when reviewing undergraduate curriculum.

What are the current postgraduate or other education options available to medical practitioners who either wish to either specialise in geriatrics or improve their ability to provide good quality health services to elderly people? Is there scope for geriatrics training and education to be improved? If so, how?

64. The RACP Advanced Training Program in Geriatric Medicine is the only program available to become a geriatrician. This training is accredited by the RACP and delivered primarily by public hospital departments of geriatric medicine. The training relationship between the RACP and ANZSGM is a close one and is subject to a formal agreement (27).

65. There have previously been postgraduate diploma courses available for medical practitioners other than geriatricians (28) although there is none currently. There is discussion with regard to developing these courses in various jurisdictions in Australia but the progress of these discussions is unknown. There are international examples (29).

66. The Royal College of Physicians (UK), the British Geriatrics Society and the American Medical Directors Association have previously recommended that some form of diploma or additional certification be required for medical practitioners delivering care in long term settings (13).

67. The RACP offers a Clinical Diploma in Palliative Medicine which is available to General Practitioners and other specialists (30). No such diploma exists in geriatric medicine.

68. Currently there is no financial incentive for medical practitioners to undertake this further training. This contrasts to the General Practice Mental Health Treatment Items – GPs who have completed the required training (https://gpmhsc.org.au/) are offered approximately 25% higher remuneration for the preparation of a GP mental health treatment plan (MBS Item Numbers 2700, 2701, 2715 and 2717). A similar model could be replicated for GPs delivering care in the residential aged sector. Without appropriate incentives participation rates in targeted education are likely to remain low (31).

69. The Commonwealth Department of Health specifically funds the "Specialist Training Program (STP)" which aims to extend vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals, including regional, rural and remote and private facilities. According to the 2017 review (32), 35 of 900 positions across medical specialties (excluding general practice) were allocated to geriatric medicine. Providing ongoing funding (e.g. 5 years) for targeted STP positions in geriatric medicine to undertake training in the community and residential aged care factor is likely to be an effective method of improving health care of older patients in the medium term.

70. Opportunities for medical practitioners to access further education are available through traditional professional development activities such as conferences, webinars and e-learning. Participation in these is self-directed.

What specialised services do geriatricians provide? What differentiates geriatricians from general practitioners and other specialists?

71. Geriatric medicine is the specialist medical care of older people and is provided by geriatricians. A geriatrician has expertise in the diagnosis and management of complex and multifactorial internal medicine disorders that impact upon the cognition and functional status of older individuals. This will often focus on geriatric syndromes such as frailty, cognitive impairment, confusion and delirium, dementia including behavioural and psychological symptoms of dementia, multiple morbidity and polypharmacy.

72. Usually a geriatrician will only provide an opinion on referral from another health practitioner which must be another medical practitioner if access to the MBS is required. A referral from a general practitioner is required to access the specific CGA MBS item numbers.

73. General practitioners are responsible for the day-to-day medical care of patients and will identify when referral to a specialist is required. For example, a patient may present to a GP with episodes of chest pain which may result in a referral to a cardiologist and a subsequent angiogram – a GP is not expected to perform an angiogram. In the setting of older people, referral to geriatric medicine for CGA may be triggered following the initial assessment of a geriatric syndrome. The CGA will offer a tailored intervention that will help many older people maintain their independence and remain at home.

74. It is not necessary to perform Comprehensive Geriatric Assessment (CGA) on a regular basis in older people. CGA is not a screening process but rather a resource intensive assessment and intervention which should be targeted to appropriate patients. It is important to consider CGA when there is a change in cognition or function, or at key decision points – such as during assessment for eligibility of high level Commonwealth aged care programs. Entry into residential aged care may also be a key time. Similarly, if there is marked change in the function or behaviour of an older person in residential aged care, a CGA should be considered if no cause is identified.

75. Geriatricians thus work effectively alongside GPs and other health professionals and are trained to identify and assess decline in an older person and put in place strategies to minimise or reverse the impact on function. This is often undertaken by multidisciplinary teams that include nurses, physiotherapists, occupational therapists, speech pathologists, dietitians, psychologists, social workers and pharmacists.

76. As previously stated, an adequate GP workforce for the residential aged care sector is critical to optimise the medical outcomes of older people.

To what extents does either the RACP or the ANZ Society for Geriatric Medicine seek to encourage medical practitioners to take up a specialisation in geriatrics? What programs have been shown to work in attracting geriatric specialization?

77. In order to train in geriatric medicine it is necessary that a training position is funded by the relevant state government (STP training positions are an exception). Given that state governments directly fund hospitals, as opposed to the Commonwealth which directly funds most medical activity outside of hospital (via the MBS), it is perhaps unsurprising that the majority of geriatric medicine training positions deliver activity in the hospitals rather than in the community or nursing homes.

78. Shortages of candidates wishing to undertake training in geriatric medicine has been recognised in Australia and overseas. The Victorian Geriatric Medicine Training Program (VGMTP) was established in 2005 to redress the shortage of geriatricians and trainees in Victoria. It is an initiative of ANZSGM (Victorian Division) and fully funded by Victorian Government. The curriculum is developed by a board of studies, using the RACP curriculum as the minimum standard. The success of the program has resulted in ongoing funding. The current grant is approximately $770 000 per annum. The Victorian Government subsequently adopted this model for palliative care, rehabilitation medicine and old-age psychiatry.

79. This program saw an increase in the number of trainees in Victoria from 26 in 2007 to 89 in 2017. The number of specialist geriatricians in Victoria, with a population of 6 million people, increased from 99 to 209 over this time (33).

80. A similar state government funded model has been successful in Queensland for geriatric medicine.

81. Geriatric medicine trainee numbers continue to grow and contribute to growth in the geriatrician workforce over the coming decade. Recent numbers are shown below (table 4).

Year	2014	2015	2016	2017	2018 (as at 6 November)
Trainee numbers	**241**	**274**	**302**	**306**	**319**

Table 4. Australian Geriatric Medicine Advanced Trainees (source: RACP)

82. In summary, national and international models of training, including targeted support and the use of levers to encourage training within sub-specialties, have been proven to be effective and provide a framework for building a job ready workforce equipped to provide excellence in healthcare for older, frail Australians across the care continuum.

How has the geriatrician workforce in Australia changed in size, employment and roles in the past 10 to 20 years?

83. This has largely been addressed above. The number of geriatricians has increased significantly over the last 20 years.

84. In the initial stages of this growth, much of the new workforce was directed towards unmet need for inpatient care in public hospitals. Coupled with this, the role of the geriatrician continues to expand as the importance of CGA is recognised and new roles have emerged for the geriatrician within public hospitals as an expert in fields such as orthogeriatrics, perioperative medicine, oncogeriatrics and in-reach models into the emergency department.

85. The public hospital system has also increased investment in outpatient, ambulatory and community programs including programs focussed on hospital avoidance and hospital substitution. Geriatricians are often involved in these programs and much of the nascent workforce has been employed by these programs.

86. It is difficult to estimate the exact quantum of geriatrician private practice. Health workforce data may provide a high level overview but this depends on the accuracy of data entered by individual doctors at the time of registration – it is unclear that this is validated. Similarly, MBS data can be difficult to interpret, as although there are the geriatric specific item numbers (MBS Item Numbers 141, 143, 145, 147) much private geriatric medicine that is practiced will utilise standard physician item numbers (such as MBS Item Numbers 110, 116, 132).

87. As discussed earlier, in both 2013 and 2017 one in five geriatricians reported substantial private clinical work (more than 20 hours a week). The number of geriatricians increased over this time from 470 to 654 – suggesting a significant increase in the contribution of private geriatric practice to the community. This proportion is relatively consistent with internal ANZSGM data from 2011.

88. Geriatrician numbers have increased again since 2017 – according to the latest 2019 figure from AHPRA there are now 874 medical practitioners registered as geriatricians. It is not clear how this figure compares to the figure of 654 given different data sources, however it is likely that real and substantial growth continues in the geriatrician workforce.

89. The public hospital system is unlikely to create new positions for geriatricians at the same rate as it has over the last decade. Much of the new geriatrician workforce will be available to undertake significant activity in the private sector.

i) What are the factors driving these changes?

ii) What are the implications for aged care recipients and the aged care industry?

90. In terms of political, public and professional interest, geriatrics is something of a Cinderella amongst the consulting physician and procedural specialties. It is not fashionable, or glamorous. Dealing with the needs of frail aged patients in physical and cognitive decline is not "sexy". The reality of old age, and our own mortality, is something few of us want to confront. That reluctance arguably affects clinicians, allied health professionals and policy-makers as well as the general community (35).

91. The introduction of dedicated geriatric medicine item numbers was an important validation of both the role and value of the comprehensive geriatric assessment. The introduction of these has been a key driver to attract trainees to the speciality of geriatric medicine.

92. The geriatric medicine item numbers articulated a viable model to private practice – enabling geriatricians to use CGA in an MBS funded model rather than defaulting to generic physician item numbers (e.g. MBS Item Number 110) where time constraints would make it difficult to operate to the full scope (36).

93. The proposed abolition of ACAT within public hospital geriatric medicine departments is a potential threat to some publicly funded geriatrician time and access. ACAT is clinically a very suitable time to consider the need for a CGA.

94. Targeted programs such as the VGMTP have been important in building training capacity. The benefits of the Victorian program have been realised as the Victorian government has concurrently invested in positions in public hospitals for geriatricians. It is expected over coming years that private geriatrics is likely to grow faster than public geriatrics.

95. Job satisfaction amongst geriatricians is usually higher than most other medical disciplines – understanding this is helpful in marketing the speciality to prospective recruits (4).

What factors influence the extent to which older Australians, that are either in or contemplating a move to residential aged care, can access a geriatrician?

96. Access to a geriatrician is primarily through an encounter with the public hospital system, referral by a General Practitioner or ACAT review.

97. As with other areas of medical specialty, there remains a maldistribution of workforce and access to specialist care outside of metropolitan centres can be more difficult.

98. There are significant opportunities to utilise telehealth to improve access to geriatricians (34).

99. The cessation of the MBS Telehealth Incentive Payments on 30 June 2014 reduced incentives for geriatricians to explore this as a model of providing service.

i) To what extent are services provided by geriatricians employed by State and Territory Health authorities?

ii) To what extent are services usually provided by private geriatricians?

100. This has largely been addressed above. Precise workforce data is unavailable and the limitations have been described. Proposed changes to ACAT will reduce access to geriatricians in the public sector. Proposed abolition of MBS geriatric specific item numbers will likely reduce access to CGA in the private sector.

iii) To what extent does Medicare enable such persons to obtain adequate medical treatment?

101. Lack of allowance for travel time for specialists, time speaking to relatives or gathering informant history or reviewing often copious volumes of notes and communications is a deficiency within the MBS structure. Remuneration of General Practitioners remains problematic.

102. In respect of CGA item schedule fees, the Committee's report shows that standard consultation items comprise 98 per cent of MBS income in geriatric medicine, and geriatric medicine has one of the lowest average out-of-pocket rates of any specialist or consultant physician specialty (37).

iv) What MBS items are available to for geriatric review in residential aged care? Can you describe the way in which items 141, 143, 145, 147 and any other items that you consider to be relevant, are used in practice? How adequate are those items? To what extent can these items be performed by practitioners who are not geriatrician?

103. The MBS CGA items 141, 143, 145 and 147 were introduced on the basis of being clinical effective and cost-effective. The evidence base has been described earlier. Similar items exist with the MBS for paediatric complex care plans (MBS items 135 and 137) which have similar domains to the CGA – namely assessment of functional, psychosocial, cognitive and physical needs in a complex patient group.

104. These items are restricted to geriatricians. Training in performing CGA is the core business of the Geriatric Medicine Advanced Training curriculum. The evidence base for CGA is derived from the practice of geriatric medicine.

105. An essential element to these item numbers is the definition of both the quality and quantity of the work involved. An overview is presented below (box 1).

Geriatrician Referred Patient Assessment and Management Plan (Item 141 – 147)

Items 141-147 apply only to Geriatricians.

Referral for Items 141-147 should be through the general practitioner for the comprehensive assessment and management of frail older patients, older than 65, with complex, often interacting medical, physical and psychosocial problems who are at significant risk of poor health outcomes. In the event that a specialist of another discipline wishes to refer a patient for this item, the referral should take place through the GP.

A comprehensive assessment of an older person should as a minimum cover:

- Current active medical problems;
- past medical history;
- medication review;
- immunisation status;
- advance care planning arrangements;
- current and previous physical function including personal, domestic and community activities of daily living;
- psychological function including cognition and mood; and
- social function including living arrangements, financial arrangements, community services, social support and carer issues.

Note: Guidance on all aspects of conducting a comprehensive assessment on an older person is available on the Australian and New Zealand Society for Geriatric Medicine website at www.anzgm.org.

Some of the information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the geriatrician. The remaining components of the assessment and development of the management plan must include a personal attendance by the geriatrician.

A prioritised list of diagnoses/problems should be developed based on information provided by the history and examination, and any additional information provided by other means, including an interview of a person other than the patient.

The management plan should be explained and if necessary provided in written form to the patient or where appropriate, their family or carer(s).

A written report of the assessment including the management plan should be provided to the general practitioner within a maximum of 2 weeks of the assessment. More prompt verbal communication may be appropriate.

Box 1. Adapted from MBS Book July 2019 (38)

106. The MBS fees are sufficient incentive for geriatricians to provide comprehensive services, and therefore offer sufficient incentive for physicians to specialise in geriatrics with a sustainable business model reflecting what they actually do (35).

107. A CGA approach includes diagnosis, identification of problems, goal setting and forming a comprehensive management plan for holistic treatment, rehabilitation, support and long-term follow-up. Studies show that CGA can and do:

107.1. reduce mortality and improve function and cognition in older people (5);

107.2. reduce mobility impairment in older people (6);

107.3. provide a service considered highly valuable by general practitioners (7);

107.4. reduce polypharmacy in older people (8), which can reduce national expenditures on potentially harmful medications taken by older people; and

107.5. provide benefit to community-dwelling older people as well as hospitalised older people (9, 10).

v) To what extent is the geriatric workforce able to deliver adequate medical treatment under the PBS in RACF.

108. The Pharmaceutical Benefits Scheme has not been identified by ANZSGM as a major barrier to medical treatment in RACF. Limitations on the frequency of medication administration due to lack of medication authorised nursing staff is a barrier with regard to using best practice for treating conditions such as pain in these settings.

vi) Describe the purpose, process and benefit of a Comprehensive Geriatric Assessment (CGA). Are these assessments conducted as routinely on aged care recipients as they should be? If not, why?

109. It is the ANZSGM's position that no older Australian should enter into residential care or receive the complex end of community supports for want of timely and accurate diagnosis and management of these reversible medical causes of disability. Access, therefore, to geriatricians and multidisciplinary care, involving the patient's GP as well, is a key component to this.

110. With regard to Commonwealth packages, there are key time points when these complex assessments can occur. The first opportunity is prior to entry into one of these packages or into residential aged care for patients identified by GP's, hospitals or other health professionals. Other triggers for assessment should include ACAT assessment, entry into RACF or high level home support package, or if there is a significant deterioration or change in clinical state.

111. As previously stated, CGA should be targeted to the most complex patients – it is resource intensive and is not a screening or monitoring tool. Practical methods of targeting CGA are described above.

What are the implications for the quality and safety of aged care of the take up of Medicare items 141, 143, 145 and 147? See for example the following table which shows utilization of these items in 2018-19:

	State							Total	
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	Services	Services	Services	Services	Services	Services	Services	Services	Services
141	18,462	7,838	4,529	2,172	1,103	641	1,656	48	36,449
143	9,824	4,164	2,155	885	536	295	896	7	18,762
145	8,711	7,121	1,300	923	505	249	497	9	19,315
147	4,030	3,602	713	186	111	109	287	2	9,040
Total	41,027	22,725	8,697	4,166	2,255	1,294	3,336	66	83,566

112. This table likely represents in excess of 55 000 CGA's performed by geriatricians under the MBS. A significant number of CGA are performed within the public hospital system which will not be captured by this figure.

113. This represents a significant volume of frail, complex older patients who have received this beneficial clinical assessment. To place this into context there are approximately 120 000 older patients approved for care packages but not yet receiving them – a group where the evidence reveals that CGA is likely to assist.

114. This suggests that while there is currently a large volume of CGA being completed, there is also significant unmet clinical need particularly in residential care settings. Given the projected growth in the private geriatric medicine workforce it is reasonable to anticipate this clinical need will be better met in the future.

115. Proposed changes to the MBS are a significant threat to this kind of assessment.

To what extent are geriatricians involved in developing clinical oversight and management programs in residential aged care? To what extent should geriatricians be involved in developing clinical oversight programs in residential aged care?

What would be the benefits of requiring independent geriatric oversight of the delivery of care in residential aged care? Are you aware of any examples of facilities who engage with geriatricians to provide such oversight? What are the benefits of doing so?

116. Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented to support safe, quality clinical care and good clinical outcomes for each consumer.

117. Modern aged care providers are aware of their responsibilities and clinical governance is embedded at a board and senior executive level. There are many examples of geriatricians sitting as board members in aged care organisations. It is unknown how this impacts these organisations performance.

118. Training in both clinical governance and quality improvement are a core part of a geriatrician's training. These principles are well enshrined in the public hospital setting.

119. For clinical governance to be successful it must be practised at all levels throughout an organisation. Where improvements need to be made, rapid cycle continuous improvement is a common methodology (e.g. PDSA – Plan Do Study Act cycles). These best occur close to the "coal-face" and it is here that geriatricians can make a difference at a local level. Clinical governance needs to move beyond the board room and into every resident's room.

120. Geriatricians can make a significant contribution at a facility level to clinical governance and quality improvement, including contributing to local medical governance. This should be operationalised within each residential aged care facility, not purely at a board level. A geriatrician visiting for one session every 2-4 weeks would be able to review any complex new or changing patient in a facility as well as participate meaningfully in local design and implementation of quality improvement activities and delivery of education. Hence the workforce requirements are not excessive.

121. Geriatricians must play a meaningful role in clinical governance of aged care facilities in order to improve health outcomes. Access to key data that reflects the overall performance of a Residential Aged Care Facility measured by clinical care, safety and quality must be provided to allow them to assess and report on a facility's overall performance (41).

122. Screening structures and referral pathways implemented according to the established principles of geriatric medicine should also be in place. Timely, appropriate, re-assessment of patients must be conducted whenever there is a change in functional status and should initiate a medical review that involves a geriatrician (41).

123. In summary, in clinical service delivery, training, workforce and governance, geriatricians have shown and will continue to show the importance of working within an interdisciplinary, integrated care model to best provide excellence in healthcare for complex, frail older Australians across the care continuum.

Signed: _____

Date: 8 OCTOBER 2019

Witness: _____

Date: October 8th 2019

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