COTA
For older Australians

Submission to the Royal Commission into Aged Care Quality and Safety

Interfaces between the aged care and the health care system

Prepared by
COTA Australia

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About COTA Australia

COTA Australia is the national consumer peak body for older Australians. Its members are the State and Territory COTAs (Councils on the Ageing) in each of the eight States and Territories of Australia. The State and Territory COTAs have around 40,000 individual members and supporters and more than 1,000 seniors' organisation members, which jointly represent over 500,000 older Australians.

COTA Australia's focus is on national policy issues from the perspective of older people as citizens and consumers and we seek to promote, improve and protect the circumstances and wellbeing of older people in Australia. Information about, and the views of, our constituents and members are gathered through a wide variety of consultative and engagement mechanisms and processes.

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Contents

Issues for consideration

The Royal Commission has identified that in its upcoming hearing to be held in Canberra 9 – 13 December it will investigate the interfaces between the aged care and health care systems. In its announcement for the hearing it has identified that it's inquiry will include[1]:

- The challenges faced by people living in residential aged care services attempting to access health services funded under Medicare or by the states and territories.

- Whether there is a need to improve access to primary health care services (particularly general practitioners, Nurse Practitioners and primary care nurses) for older people in residential aged care, and if so, how this could be achieved.

- Whether there is a need to improve access to high quality secondary and tertiary (sub-acute and acute) health care services for older people in residential aged care, and if so, how this could be achieved

- The challenges faced by people living in aged care in accessing medical specialists, and the harms arising from inadequate access

- Whether it is necessary or desirable to improve how older people are transferred to and from aged care and hospitals, including the appropriateness of rehabilitation and transition care services post hospital attendance

- Whether there is a need for improved data collection, communication and planning in relation to the health needs of older people accessing aged care services, including the interoperability of care management systems

- The sufficiency of access to state and territory funded palliative care services for people living in residential aged care

[1] As outlined at https://agedcare.royalcommission.gov.au/hearings/Pages/hearings/2019/canberra-hearing.aspx accessed 20 November 2019

Introduction

COTA believes improvements to the interface between healthcare and aged care systems are essential. Access to a range of healthcare services inside or outside the residential aged care facility is critical to improving the quality of life of older Australians. Similarly enabling better collaboration between home based aged care services and healthcare services, in particular communication of relevant clinical observations, will help improve quality of life outcomes.

Importantly, access to health care must not be substituted for an expectation that the existing aged care system's funding can deliver full primary care solutions. COTA supports and encourages some of the innovative in-house solutions being delivered in aged care today such as mobile dental services, in house GP clinics and allied health clinics. However, we are deeply concerned by some of the commentary about older Australians in residential aged care which by implication seeks to propose or defend a different set of rights for them compared to the general population to access mainstream healthcare services. We welcome the Royal Commission analysing not only how services may best be structured to be delivered, but also the appropriate mechanisms in which they may be funded.

This submission broadly addresses the issues outlined by the Royal Commission for their Canberra Hearings on 9 – 13 December.

Health Care is a Human Right

COTA Australia asserts that older Australians should have the basic human rights of eligibility to access all health services available to other Australians. Unfortunately, this does not occur for many older people, in particular those within residential aged care. Sometimes this is due the design of Government programs, assuming that those in residential care do not need it, or will receive an alternative, often substandard healthcare service from their aged care provider. At other times this is caused by the practical barriers and/or lack of supports, for example to transport aged care residents to their preferred medical practitioner.

Older people do not enjoy the protections afforded to other vulnerable populations, such as people living with a disability, as currently they do not have the additional protections of an international human rights convention. Further, Australia does not have a broad framework of human rights in the form of a Human Rights Act or Charter of Human Rights, as has been introduced in some state and territories. Currently there are a range of health policy decisions that breach these implied human rights.

While there is a basic level of right to non-discrimination in the form of the *Age Discrimination Act 2004*, the issue of health can at times be exempt from these discrimination protections, leading to poorer health outcomes from older Australians. Under s42 of the *Age Discrimination Act 2004, an* 'exempted health program' may not be required to be provided in a non-discriminatory manner on the basis of age.

COTA Australia notes that, while a legal opinion was not able to be sought within the timeframe of developing this submission, and also acknowledging that the exemption allows the development of positive programs aimed at older people, this exemption also appears to be the legal basis on which the following forms of direct and indirect discrimination on the basis of age has occurred:

- the MBS Better Access program providing the ability for a GP to refer to a mental health professional specifically excluded people living in residential aged care. Given that the overwhelming majority of people within such facilites are older people this is a form of indirect but

very real discrimination.

- Government recently introduced changes to the Medical Benefit Schedule which prohibits a person 50 years and older from receiving a rebate for an MRI scans of the knees if it is prescribed by a General Practitioner. The result of this exclusion is that an older person must meet the cost of a Specialist appointment in order to receive a rebate on an MRI scan to identify if this person needs to see that surgeon in the first place or meet the full cost of the GP referred scan without a rebate. This is a form of direct discrimination on the basis of age within healthcare.

Access to Medicare-funded primary health care

COTA believes that older Australians should have access to Medicare-funded primary health care on the same basis as every other Australian. When living in residential aged care this may present practical challenges of how to connect the medical practitioner and the older person.

General Practitioner (GP)

Older Australians should have access to Medicare funded primary health care. It should not be expected that a 'cheaper' or 'lesser' level of health care services is provided, simply because it is delivered via aged care rather than through a mainstream health setting.

With the increase of health care professionals within an aged care environment it is essential to ensure structural independence of the health professional from providers to ensure client-focused outcomes remain paramount. Over prescription of chemical restraint by GPs on the request of and/or pressure from aged care staff is one example where the needs and pressures of the residential aged care facility appear to outweigh the needs of consumers.

One of the most significant intersections between aged care and the health system, and one of the most problematic, is timely access to a General Practitioner (GP). COTA Australia has been advised of many suggested reasons for this, including factors relating to the resident's circumstances; to the lack of appropriate built facilities for medical professionals; and to the unwillingness of some GPs to provide service to residents in aged care facilities, and /or GPs who do "see" residents but not with the same attention as patients in their rooms

The most relevant resident circumstance is that they have moved out of their old geographical area and in practical terms are too far away from their former GP. Depending on whether or not their nursing home has arrangements with local GPs, and whether or not they have strong local facility support, the resident may find it difficult to identify and establish a relationship with a local GP that sees aged care residents. We have been aware of situations in which a resident wants to establish a relationship with a new GP, but does not have anyone to transport them to their GP's surgery if the local GP of their choice does not attend residential aged care facilities (RACF). Where there are RACFs who have a number of GPs with whom they have established a relationship, they may also not be suitable, often for language or cultural or vulnerability reasons.

Compounding all these barriers, some GPs have suggested to COTA Australia that there are a range of reasons for their unwillingness to attend RACFs. Probably the most significant is cost: that is, the remuneration does not cover the real cost of attendance, especially if they are visiting are only visiting a single patient. Other impediments are that the facility does not provide suitable space for the consultation and access to current and relevant clinical records is often poor. They report that time is lost looking for

patients who are not ready for their appointment, and cannot be found, with RNs often not available, or not able to provide relevant information. A last area of concern is that in some instances, there is a history of the RACF not following recommended procedures, medication management routines, or access to appropriate allied health supports

Residents of aged care homes deserve and have the right to high levels of access to primary, allied and other health services. Some GPs suggest to COTA Australia the lack of qualified nurses to support the GP and the lack of appropriate funding levels from the Medicare Benefit Schedule act as disincentives for GPs to visit residential care settings. However, other anecdotal evidence indicates that this is not always given high priority by GPs (e.g. expecting residents and staff to be available whenever the GP decides to "drop in on the way home".

Mental Health services

For many years COTA Australia has been aware that too many older Australians do not receive equal consideration as younger people or other adults in terms of recognition of mental illness, diagnosis and treatment. The ageism rife in the Australian community exists as well in the medical professions. Still too often it is assumed that anxiety and depression are an inevitable part of ageing, and indeed other illnesses as well. Old Australians do not receive the diagnosis and treatment they would in younger years. At a roundtable in Parliament House convened by Minister Wyatt in 2017 after COTA's campaign in mental health leading mental health specialist agreed with this.

Older people do in principle have access to certain allied health practitioners (eligible medical practitioners, registered psychologists, eligible social workers and occupational therapists) through MBS funded mental health services such as Better Access and Access to Allied Psychological Services (ATAPS). However, older people experiencing mental health challenges, especially those living in rural and remote areas, encounter multiple issues with gaining well-timed access to the required services, as well as the time and duration limits imposed on service delivery. In addition, to receiving services under Better Access, a person is required to have a Mental Health Treatment Plan developed by their referring medical practitioner.

Following a substantial public and private campaign by COTA Australia, the 2018-2019 Federal Budget "More Choices for a Longer Life" package contained a new initiative targeting the provision of psychological therapies for people with diagnosed mental illness (or at risk of developing mental illness) in residential aged care using the commissioning function of Primary Health Networks. COTA Australia also participated in the design and development of the solutions being introduced over a four-year period, beginning a slow roll-out from January 2019. These include 'in-reach' services, evidence-based and time-limited psychological therapies adjusted to suit older people, collaborative partnerships, and the need for all strategies to be equitable and efficient. It is important to note that the program cannot duplicate other services already in place such as the MBS Better Access Initiative. While gaining this program (albeit not funded enough because of resistance by some senior players within government) was regarded as a "win" for residents access to mental health services, the need to fight for a special program is an indictment of the failure of core mental health services to address aged care resident needs.

Improving access to primary health care services and how this could be achieved

General practitioners

Dealing with this issue is critically important as access to GPs in residential aged care helps to ensure that

known and emerging medical conditions are treated within the care facility, reducing the likelihood that residents will be transferred to hospital, where they are at greater risk of hospital acquired infections.

The reasons that timely access to GPs is so important include that:

- Improved access to GPs means that issues requiring intervention are identified earlier, avoiding deterioration, or potentially premature death, of the older person and the greater costs of more high level or intensive responses later.
- Unnecessary hospitalisations are avoided. A study in WA found that review by a GP could have prevented up to 63% of inappropriate presentations, and the capability of nursing home staff to routinely perform uncomplicated PEG tube or IDC insertions could potentially have prevented another 24%.[2]
- The availability of Nurse Practitioners and primary care nurses can reduce the reliance on GPs for a range of issues and, if more immediately available, with less stress to residents and at lower cost.

Options to achieve improved access to primary health services

Possible options to achieve this include:

- Changes to the Medicare Benefits Schedule (MBS) to provide a Medicare number for GP visits to RACFs that takes account of the additional costs of providing this service and serves as an incentive to doing so as part of GPs normal patient load, not "on the way home".
- RACF provides dedicated space for GPs to consult with residents, and processes put in place to ensure availability of RN, handover of relevant clinical information (in both directions) and requirement that all prescribed medications and treatments are place in care plan and monitored.
- RACF IT systems or Client Management Systems (CMS) to include contact details for relevant nurses and Nurse Practitioners and their availability.
- Promoting and supporting models/forum for regular interaction and communication between the GP, RACF and local nursing services.

Nurse Practitioners and primary care nurses

Nurse Practitioners and primary care nurses have a role to play in meeting this need. The Royal Commission has heard extensive evidence of their importance in rural and remote settings in particular, where they can augment the role of the GP. Nurse Practitioners are Registered Nurses with post-graduate qualifications, usually a Masters degree, who have undertaken a practical, clinically-based Master's Specialty, which in aged care is frequently in gerontology or as a geriatric nurse practitioner.

Multiple witnesses gave evidence in the hearings in Perth, Darwin and Broome as to the value of having access to Nurse Practitioners in areas where there may not be a doctor, or not a doctor on 24/7 call. Unlike a Registered Nurse (RN), a Nurse Practitioner can prescribe basic antibiotics, for example for a urine infection, or redo a medication chart. In addition to that, Nurse Practitioners are qualified to monitor the acute and chronic illnesses of the residents and support facilities in providing palliative care. They also

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[2] Judith C Finn, Leon Flicker, Eileen Mackenzie, Ian G Jacobs, Daniel M Fatovich, Shelley Drummond, Michelle Harris, D'Arcy C D J Holman and Peter Sprivulis, *Interface between residential aged care facilities and a teaching hospital emergency department in Western Australia*, Med J Aust 2006; 184 (9): 432-435. || doi: 10.5694/j.1326-5377.2006.tb00313.x
Published online: 1 May 2006

have an education role, with both families and staff.

In describing the provision of appropriate dementia care Professor Gonski, speaking at the Darwin hearing, noted that 'we have a number of geriatricians working with us. That's not always possible in other districts. Some people may have Nurse Practitioners who do a lot of what we do.'[3]

The Royal Commission has heard evidence that there are few Nurse Practitioners in residential facilities but establishing relationships with Nurse Practitioners external to the facility is a very cost-effective way of obtaining critically important support at lower cost. The reason for this is that one Nurse Practitioner can be available to multiple residential facilities. Ms Sandy Green, speaking in Cairns, advised the Royal Commission that she provides services to 13 facilities. And Mr Cohen, speaking in Perth on 27 June described his job in the following way: 'The staff can call me when there is a problem and then I can gather the assessment and implement the appropriate treatment or education or whatever it may be before they call the GP.'

Evidence at the Broome Hearing, from the Chief Executive Officer of the Royal Flying Doctors Service, Dr Martin Laverty:

> *Primary care and aged care are interdependent, they are reliant on each other…primary care, that is, access to doctors, to nurses, to allied health professionals, to dentists, to geriatricians, and primary care plays an essential role in keeping older Australians, and indeed all Australians, well and healthy, and the longer you are able to maintain your health…the longer you are likely to avoid the necessity of access to the formal aged care setting...once an older Australian enters an aged care environment… access to ongoing primary care is essential to that citizen receiving appropriate care… Access to geriatricians, to dentists, to mental health professionals, to palliative care specialists. This is the interdependency between primary care and aged care.* (Interim Report of the Royal Commission, P.185).

Is there is a need to improve access to high quality secondary and tertiary (sub-acute and acute) health care services and if so, how this could be achieved?

Access to hospital services

The Royal Commission has heard evidence of a number of issues with access to hospital services for older people. Multiple difficulties in relation to hospital access have been identified. These include that for many facilities, the admission is often not the most appropriate, or the most desired, option for the resident but has come about because of lack of resources and /or skills to meet the need in the facility. Compounding this there has been significant evidence of poor transition arrangements, in particular inadequate provision of clinical information between the hospital and the facility, and disorganisation in relation to the transport between hospital and facility, including limited information as to who will accompany the resident, what support is provided once the older person arrives at the hospital and what coordination is in place for an older person being taken to hospital with little idea of what is happening to them.

Access to medical specialists

The second component of secondary care, medical specialists, is one that also needs improvement in terms of timely access. Given the profile of the aged population timely access to specialists such as:

[3] Evidence of Professor Gonski. Darwin hearing 11 July 2019

- Gerontologists, (dementia care)
- Geriatricians,
- Cardiologist,
- Rheumatologists,
- Urologists, or
- other specialty physician is extremely important.

To illustrate this point with one example, there are presently around 436,000 Australians living with dementia. By 2056 this number is projected to rise to 1.1 million. The Australian Bureau of Statistics predicts that dementia is likely to become the leading cause of death for Australians in the 2020s.

Poor understanding of the support of older people living with dementia in residential aged care has led to inappropriate and often abusive treatment. This could have been at least in good part ameliorated with timely access to specialists, gerontologists or geriatricians, who could provide information and direction for management and staff, whose lack of understanding has often led to the misuse of physical and chemical restraint. Specialists could provide oversight of medication regimes and advice on other available support options.

Access to Allied Health practitioners

The third component of secondary health care is Allied Health practitioners, an essential part of the support system for older people in many areas. These include:

- Dietitians, (nutrition)
- Physiotherapists (reablement, rehabilitation, pain relief)
- Psychologists (sense of loss, the need to ease the transition into an RACF, older people and family at end of life).
- Speech pathologists (swallowing issues).

Research published as far back as 2002 identified issues that include:

- a lack of uniform assessment has hindered prioritization of clients
- the appropriate mix of funding between primary, secondary and tertiary interventions has not been determined
- The health care needs of older people in residential care have been totally neglected, placing the sector at considerable risk.

It concluded 'There needs to be a fundamental rethink in managing the interface between acute, subacute, community and residential care.'[4] Evidence before the Royal Commission indicates this has not occurred yet.

Considerable work has been done examining integrated, multidisciplinary care. Integrated multidisciplinary care is difficult to achieve between specialist clinical services and primary care practitioners, but is known to improve outcomes for patients with chronic and/or complex chronic physical diseases.[5]

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[4] *Australian Health Review* 25(5) 136 – 139 Published: 2002.

[5] Geoffrey K. MitchellA, Letitia Burridge B,D, Jianzhen Zhang B , Maria Donald B , Ian A. ScottC, Jared Dart A and Claire L. Jackson, *Systematic review of integrated models of health care delivered at the primary–*

Options to achieve improved access to secondary and tertiary health services

It is clear that some methods of improving care across the primary–secondary interface are more effective than others.

Element 1: interdisciplinary teamwork.
Effective integration depends on the right mix of interdisciplinary health professionals and roles which predisposes to a well-functioning team.

Element 2: communication and information exchange.
Effective integration involves willingness to share information, and supportive managerial and administrative staff.

Element 3: use of shared care guidelines or pathways.
Pragmatic, locally agreed care protocols were a key component of most of the integrated care models.

Element 4: training and education.
Initial and continuing education, including postgraduate training, is essential for primary care clinicians to facilitate

Element 5: access and acceptability.
The elements of most relevance in the aged care context included, older people's priorities and preferences were respected that improved communication gave them better access to, and continuity of, care in a friendlier, more personal service

Secondary services include both hospital care and medical specialists, and allied health practitioners, and in some instances properly trained and accredited Nurse Practitioners. All of these are vitally important to older people in residential facilities.

Possible options to achieve this include:

- Addressing the appropriate mix of funding between primary, secondary and tertiary interventions, specifically as this applies in the context of RACF access, be made a priority of government.
- Changes to the Medicare Benefits Schedule (MBS) to provide a Medicare number for GP visits to RACFs that takes account of the additional costs of providing this service and serves as an incentive to doing so as part of normal patient load (rather than "on the way home").
- Embedding a range of Allied Health practitioners within a facility or in smaller facilities on an 'on call' basis, as part of the RACF model of care.
- RACF IT systems or Client Management Systems (CMS) to include contact details for relevant GPs, dentists, nurses and Nurse Practitioners and allied health providers and their availability.
- Promoting and supporting models/forum for regular interaction and communication between the RACF and local nursing and allied health services.

The harms arising from inadequate access for people living in aged care in accessing medical specialists

Probably the most extreme example of the harms arising from inadequate access to medical specialists

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secondary interface: how effective is it and what determines effectiveness?, Australian Journal of Primary Health, 2015, 21, 391-408.

occurs in relation to access to gerontologist and dementia specialists. The lack of input from dementia specialists has resulted in poor or no staff training in dementia, little understanding of the manifestation of behaviours that are confronting in those living with dementia, inability to respond effectively, and adoption of harmful, even abusive and criminal, practices.

Given the communication barriers of some older Australians with dementia in residential aged care it is critical that the assessment of need for accessing medical specialists is monitored in an ongoing manner.

Is it necessary or desirable to improve how older people are transferred to and from aged care and hospitals, including the appropriateness of rehabilitation and transition care services post hospital attendance?

The Royal Commission has heard evidence of a number of issues with poor transition arrangement for older people when transitioning between hospital and their residential care service, which indicate that improvement in this regard is both necessary and desirable.

Particular issues that have been identified include:

- Poor provision of clinical information, both from the residence to the hospital, and in receiving and recording follow up directions from the hospital to the facility
- Inappropriate transport arrangements, to and from the facility, particularly in regard to who accompanies the resident, what support is provided on admission to the hospital.
- Poor communication with family of the resident, both prior to and on return from the hospital.
- Poor follow up of instructions from the hospital relating to after care.
- Lack of appropriate rehabilitation care on return from hospital.

COTA constantly hears from family members of older Australians who's loved one recently transferred between hospital and a residential aged care facility that the doctors at the hospital tell them one thing, only to have the local doctor or aged care nurse tell them another. This is particularly concerning regarding medication management where the hospital has access to a geriatrician and the residential aged care facility may not. It is unclear to COTA in these situations whether both proposed clinical course of actions are exclusively concerned with the patient/resident's best interests or whether adjustments to the care plan from the hospital are made taking into consideration the resource constraints of the residential aged care facility.

COTA is attracted to suggestions from parts of the health care profession that a 'clinical handover' approach should be adopted rather than a 'discharge' approach that currently occurs. This would we believe reduce the inconsistency of care approaches. We would encourage as a best practice such a clinical handover process should include the older Australian, or where issues of capacity occur their nominated representative.

Is there is a need for improved data collection, communication and planning in relation to the health needs of older people accessing aged care services, including the interoperability of care management systems?

The Royal Commission has focussed on lack of data throughout the hearings. Good data is essential to

knowing what we are doing. Without it systems cannot be monitored, outcomes cannot be measured, deficiencies will not consistently be seen and improvements cannot be evaluated. Throughout the Royal Commission hearings to date it has been obvious that data systems, sector wide, and in particular within the Department, are completely inadequate.

Another aspect of data collection and planning necessarily involves the digital literacy of older Australians, which impacts their capacity to communicate with the agencies and services they require.

The Australian Digital Inclusion Index (ADII) has ranked Australians aged 65 years and over as the most digitally excluded age group (42.9, or 13.6 points below the national average). According to Roy Morgan research 7 in 10 Australians over 65 years have "gone online" in the past 3 months, but use the internet less frequently than younger Australians, spending an average of 7 hours online per week (ABS, 2015). Sending emails (76%), completing a banking transaction (53%), or paying a bill (48%) are amongst the key activities older Australians complete (Roy Morgan, July 2015). 43% of older internet users accessed social media in the 3 months prior to June 2015 (ABS 2015) with the most popular of these being Facebook (88%) followed by Google+ (16%), LinkedIn (12%), Pinterest (11%), Twitter (4%) and Instagram (2%) according to the Sensis 2015 Yellow Social Media Report.

Importantly as Government transitions its functions to an online delivery method, the potential for older Australians to be disadvantaged from these emerging and dominate communication methods is great. Only 15% of Australians over 65 years accessed government services, or health and medical information, via the internet (Roy Morgan, 2015), or health services. 54% of people over 65 years stated they were "somewhat" or "very dissatisfied" with the concept of interacting with government primarily by digital methods according to the Australian Government's digital transformation office.

Digital literacy and user capability is an important aspect of older Australians increasing their online presence. Over 16,000 reports, involving the loss of $9million, were reported to the ACCC's Scamwatch in 2016, representing 26% of all complaints. Moving government service delivery and communications online will increase the potential for scamming to target older Australians as email becomes the expected method of engagement and communication from government.

COTA will continue to advocate for programs and designs that are inclusive of older Australians and that are developed in a manner that encourages increased adoption and digital participation. It is critical that the transformation to digital services is focused on digital inclusion of participants of all ages and does not leave anyone behind.

Is their sufficient access to state and territory funded palliative care services for people living in residential aged care?

Palliative care is care that helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness, ranging from palliative care when their needs are straightforward and predictable, to specialist palliative care when they have complex and persistent needs.

The Royal Commission has heard of a number of barriers to people accessing palliative services in a timely and appropriate way. One of the issues related to delays in accessing services due to constraints in sources of funding or issues with residential facilities.

Palliative services can be accessed by older people living in the community from their Home Care Program (HCP) Package funds, but the waiting list for Packages, discussed extensively during the Royal Commission

and a subject COTA Australia has lobbied on over many years now, can mean that an older person dependent on this funding to access palliative services may not receive them in time.

Despite this serious wait one witness before the Commission gave evidence that clients who receive palliative care at home receive palliative care earlier than those in residential care. [6]

COTA supports the position of Palliative Care Australia in calling for a National Palliative Care Workforce Strategy across health, disability and aged care systems which must include the role of GPs, nurses, aged care staff, community pharmacy, allied health and other health professionals, and consider the disparities in availability across the States and Territories and across inner regional, rural and remote locations.

COTA believes that a holistic and tailored approach to palliative care is crucial within the context of recent changes to the aged care service landscape, seeing palliative care as unarguably one of the most important services delivered by the aged care industry and vital to protecting the quality of life of older Australians as their lives draw to an end.

COTA recognises that around 75 per cent of people aged over 65 years who die in Australia use aged care services in the 12 months before their death, yet relatively few access palliative care. COTA believes that every Australian deserves access to the highest quality palliative and end-of-life care, whether this be delivered in a residential aged care facility or in their home.

COTA would also like to ensure the contributions of all those involved in the delivery of palliative and end-of-life care and the need to support aged care residents, families and carers through all stages of the illness and in bereavement are recognised.

[6] Evidence of Dr Elizabeth Reymond, Deputy Director, Metro South Palliative Care Service, Perth, 27 June 2019.