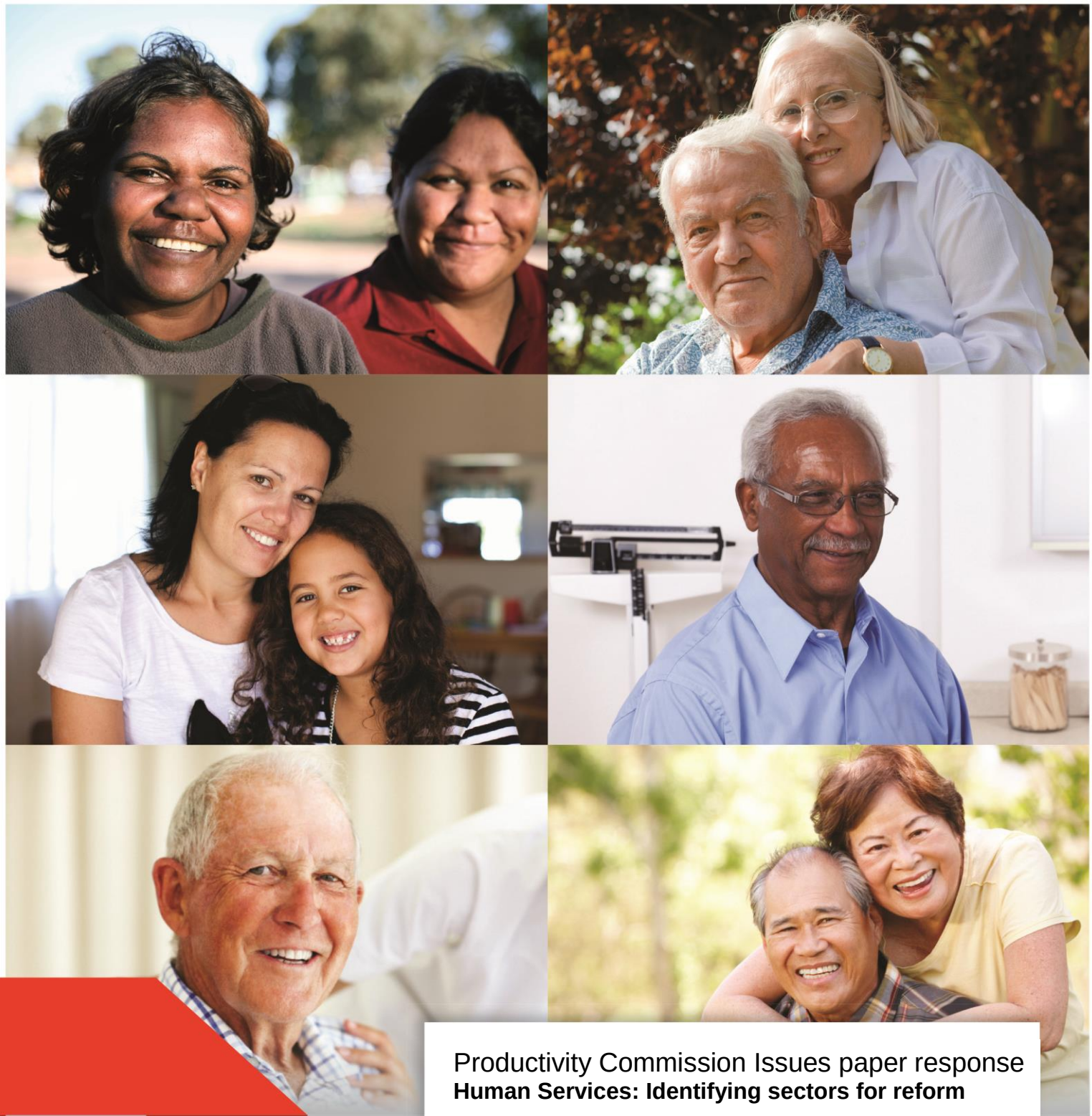


Productivity Commission Issues paper response

Human Services: Identifying sectors for reform

25 July 2016

Silver Chain Group

Silver Chain

silverchain.org.au

A Shared Journey

Contents

"When we learnt that my husband required palliative care we had no idea of the level of support available. Very soon we came to experience the highest quality care delivered by the Silver Chain Hospice Care Service. With their support we were able to provide the care that Geoffrey needed, keeping him home where he wanted to be knowing that help was only a call away.

There were many nights we required visits but the team always provided the surety and comfort we needed to keep Geoffrey at home. To spend the last days of his life with dignity, surrounded by his family was the most precious time that we will always be grateful for.

This service needs to be replicated to ensure the community receives appropriate care at the end of life and it must be a more cost efficient way of delivering services."

Professor Fiona Stanley AC,FAA, FASSA
Telethon Kids Institute.
Distinguished Research Professor,
University of Western Australia.
Vice-Chancellor's Fellow, University of Melbourne.

POSITIONING SILVER CHAIN'S RESPONSE

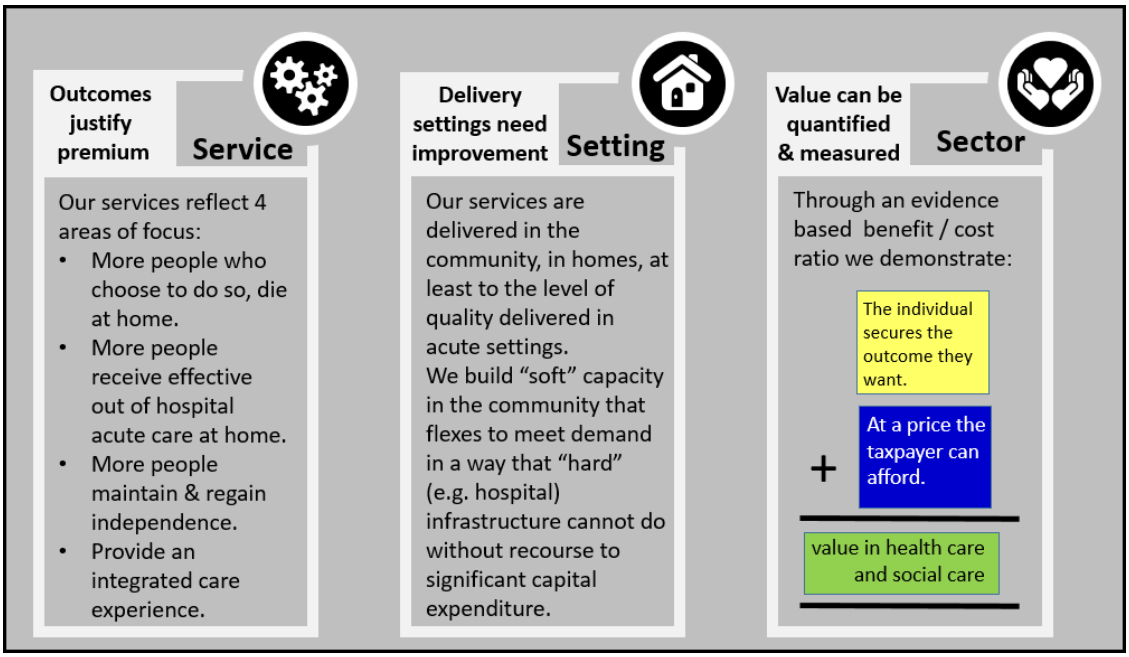
Factors that inform Silver Chain's opinion

Silver Chain welcomes this opportunity to respond to the Productivity Commission's Issues paper "*Human Services: Identifying sectors for reform"*. Silver Chain Group is one of the largest in-home health and community care providers in Australia. With over 3,000 staff and 400 volunteers, the organisation assists over 62,000 people in Western Australia, South Australia, Queensland and New South Wales to remain in their own homes and communities every year.

We acknowledge the impact in Australia of the globally significant trend of increasing burden of chronic disease, ageing population and the cost of contemporary medical treatments and technologies rising at a rate in excess of Gross Domestic Product growth[1], and trust that this response is of utility to the Productivity Commission in completing the study report identifying services within the human services sector best suited to the introduction of greater competition, contestability and user choice.

Our considered opinions are arrived at through relationships established delivering services to our clients, the nature of the settings we work in and our overall experience within the health and social care sectors (see Diagram 1 below).

Diagram 1: Silver Chain Group's foundations



Underpinning our views is our firm belief that existing systems of care produce inefficiencies and ineffectiveness which adversely impact quality of life and care for many Australians every day. For example:

- Many people currently receiving the most expensive hospital-based end of life, often in Intensive Care Units (ICU's) could, with the right service, be managed well and with dignity at home, for significantly less financial outlay and surrounded by those people they choose to be with.
    - ***Short coming***: Ineffectiveness and inadequate user choice

[1] AIHW (2015). *Health expenditure Australia 2013–14*. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

- A number of current programs delivered under the banner of 'restorative care' are intrinsically unsuited for a model of care that should target an outcome of independence, but instead deliver standardised care which all but encourages dependence.
    - ***Short coming***: Inefficiency, ineffectiveness and inappropriate contestability.
- Potentially preventable hospitalisations where better primary care integration would see those individuals treated in a community setting, including at home, with no compromise to quality, at lower cost and significant improvement in experience. There were more than 600,000 potentially preventable hospitalisations in Australia in 2013-14, accounting for (6.2% of all hospital admissions[2]).
    - ***Short coming***: Inefficiency, ineffectiveness and inadequate user choice.

Innovation should be a business as usual function

The Commission's issues paper makes the connection between competition, contestability and user choice with the goal of an increase in innovation and consequent improvement in efficiency and outcomes. These connections are well proven in other sectors, not the least of which being commercial markets.

Silver Chain Group believes innovation which results in efficiency gains and improved user outcomes can be driven by any service provider who acts with determination to constantly improve quality and efficiency, and can adapt to the changed circumstances and the needs of cohorts they support. The following summary serves as an example of innovations within Silver Chain Group, in areas where we look to influence the system within the current regulatory and competitive environment.

Services

In Western Australia (WA) in 1999, Silver Chain Group launched Australia's first restorative home care program in direct response to being unable to meet the demand for services.

The Home Independence Program (HIP) was designed to assist older people living in the community to optimise their health and everyday functioning, thereby reducing or removing the need for ongoing care[3]. We have continued to develop this program as a world class restorative (or reablement service) which utilises evidence based targeted interventions. Specifically, our service is:

- Outcome-based not episodic
- Home-based not institutional
- Capacity building not dependence making
- Flexible not prescriptive
- Inclusive not exclusive
- Integrated not a bolt on
- Timely not delayed
- Inter-disciplinary not multi-disciplinary

The last point indicating our service as interdisciplinary reflects our recognition that value is a combination of delivering outcomes the client wants at a cost the taxpayer can afford. We have developed a service over time using health professionals with broad clinical capabilities who work within a clinical governance model that engages multi-disciplinary inputs as required, rendering the service far more cost effective without compromising quality.

[2] AIHW (2015). *Admitted patient care 2013–14: Australian hospital statistics*. Health services series no. 60. Cat. no. HSE 156. Canberra: AIHW.
[3] Lewin. G. (2011). Restorative Home Care Services. *Journal of Current Clinical Care*, March/April 2011.

Settings

Australia has amongst the best trained primary care physicians in the world. However, their contribution relative to other developed economies is increasingly limited to the provision of elementary primary care services and as gatekeepers for the secondary and tertiary systems.

A more efficient health care system would draw on this underutilised capacity in general practice to manage the health needs of acutely ill Australians within the community. In WA Silver Chain Group operates a "virtual" Hospital in the Home (HITH) service. In combination with our acute end of life palliative care this results in a specialised "virtual hospital" of around 700 beds.

We think of this as "soft" infrastructure, spread throughout the community and able to be increased or decreased in bed size based on demand, something unable to be said of the "hard" infrastructure of centralised hospitals. Silver Chain Group has promoted the idea of a similar 500 bed community based "virtual hospital" to an East coast state which will soon open a new tertiary hospital that will likely be at capacity shortly after the doors are open.

Sector

In Australia, while the majority of people would choose to die at home, only approximately 14% do so. In WA, this figure is 70%, due in part to a partnership between Silver Chain Group and WA Health, where Silver Chain Group provides a comprehensive palliative care service to people in their own homes.

Silver Chain Group is actively progressing innovation and increased choice in the NSW health sector through a nationally contested opportunity run by the NSW Office of Social Impact Investment (a NSW Department of Treasury office) and NSW Ministry of Health. We have been selected as one of two providers to engage in a Joint Development Phase (JDP) from a pool of over twenty submissions.

We have taken our evidence-based modelling that reflects the value of our in-home palliative service in WA, and have applied that value modelling to the NSW metropolitan health care sector. Our modelling projects that every $1 of funding into a comparable service in NSW would generate $1.44 of bed capacity in metropolitan public hospitals, capacity that once liberated can be used by an individual who is deemed to be appropriate for a hospital-based intervention. We believe this evidence based approach to measuring the benefit/cost ratios (monetised in net present value terms) is critical to demonstrating and measuring value creation in the sector.

Conclusion

Reform is necessary. To ignore this is to fail to capitalise on significant clinical expertise and high quality service delivery in a health and social care system regarded rightly as one of the best performing in the world. To ignore the opportunity for reform will present a burden on current and future taxpayers which is as predictable as it is avoidable. The system can be improved. Consumer experience, demographic shifts, economic and technology trends mandate that it must be improved.

Silver Chain Group welcomes the opportunity to maintain a dialogue with the Productivity Commission in this significant initiative.

RFI 1 – WHAT CONSTITUTES IMPROVEMENT?

The Commission is seeking participants' views on what constitutes improved human services. Do the concepts of quality, equity, efficiency, responsiveness and accountability cover the most important attributes of human services? If these are the most important attributes, how should they be measured or assessed?

QUESTION: Do these concepts cover the most important attributes of human services?

Silver Chain Group response:

The Commission's use of Le Grand's[4] concepts is sound. However, a service could be efficient (ie it does things right), but not necessarily effective (ie it does the right things).An additional focus should be consideration of service effectiveness. This component acknowledges that many Human Services could be delivered in different settings, that is whilst many treatments are provided efficiently in hospital settings they could (and should wherever clinically appropriate) be delivered in a community or primary care setting. This increases the need for a more integrated, joined-up approach to the delivery of services.

The objective of more joined up models of care is underpinned by a greater focus on the experience of the individual and their achieving an outcome they want – ie a person centric and directed approach - rather than an episodic approach to care.

Funding, specifically bloc funding, can incentivise an episodic approach to human services. Particularly where service acquittal is based on service outputs (eg numbers of people treated, hours of service delivered, numbers of instances of care) rather than outcomes achieved.

An effective service is one that implements a model of care that has the potential to cross multiple agencies within a human service setting and potentially multiple human service settings, eg a model of care that crosses health care, education, housing and job placement settings.

QUESTION: How should they be measured?

Silver Chain Group response:

We believe that a standardised "apples for apples" comparison should be made to determine the efficacy of like service providers on the outcomes they achieve. We further believe service providers should be allowed flexibility in how they achieve their outcomes, particularly in dealing with complex health care and social care issues. One observation of complex problems - manifest in vulnerable and at risk populations, communities and individuals - asserts the relationship between cause and effect can only be perceived in retrospect, not in advance[5].

Service provider flexibility in how they achieve targeted outcomes need not compromise accountability for performance and quality. Measuring service improvement can be achieved through a value-based approach which still take account of inputs and outputs, but places more emphasis on service outcomes. Value can be defined as helping the individual secure the outcome they want (for example, optimising a person-centred benefit) at a cost the taxpayer can afford.

[4] Le Grand, J. (2007). *The other invisible hand: Delivering public services through choice and competition*. Princeton University Press: Princeton, USA.
[5] The Cynefin framework developed by Snowden and colleagues (Kurtz & Snowden, 2003; Snowden, 2000, 2002, 2005; Snowden & Boone, 2007).

This value could be captured within a benefit/ cost ratio and within the construct of a performance based (eg Payment by Results) contract.

It is acknowledged that inputs and outputs are more easily measured than outcomes. An output being assessed easily as part of a retrospective acquittal (eg "We delivered Mary five episodes of care this month"), an outcome takes time (eg "Mary is now more capable in caring for herself, as a consequence her daughter has now secured part time work feeling confident her mother is suitably cared for and we have prevented Mary being admitted to hospital saving the equivalent of 12 hospital bed days.").

In a system where there is more demand than supply (eg public hospital beds, prison accommodation, social housing, etc.), there should be recognition of the ability of services to provide an alternative, more appropriate and 'joined up' resource capacity. For example providing individuals who choose to die at home the ability to do so - through the provision of a high quality, capacity building, community based end of life care service – will liberate capacity in public hospitals, capacity that can be used by someone who would otherwise be waiting for that space.

Where capacity in the system can be liberated by a more appropriate and cost effective service, this benefit can be monetised and accepted as a valuable public exchequer benefit. Value would not be "banked" on the basis of short term agency budget reduction; rather a direct economic benefit can be attributed – on a Net Present Value basis – future cash flow being projected for the capacity opened up in the system. Capacity liberation is a productivity concept, for example, more outputs achieved for less (or equal) inputs. This value approach recognises the very real effect in the mid to long term on the need to expend capital for new "hard" infrastructure (eg new hospital wings, new hospitals, new prisons, etc.)

It also recognises the benefits of responding to a number of human service requirements in the community where "soft" infrastructure (eg people's houses) is leveraged, soft infrastructure that will vary (services delivered to more houses or less houses) with demand, in a more flexible, and cost effective, way than additional new, expensive, inflexible, hard infrastructure allows. To some extent, this approach also circumvents the contentious dynamics of Federal and State budgets and funding allocation, a dynamic that goes a long way to blocking system reform and service innovation.

It is recognised that there are challenges associated with measuring service improvement through outcomes achieved, including:

- ***Attribution***: Service providers should be able to demonstrate they have been primarily responsible for achievement of the targeted outcome, thus able to secure payment through a performance based contract. This can be achieved through pragmatic counter factual methodology to the satisfaction of funders and service providers.

- ***Timeframe***: Where outcomes are ambitious they can be expected to take some time (eg mid- to long-term) to secure, service providers should be able to demonstrate (in the short term) they are achieving agreed indicators of likely success.

RFI 2 – IDENTIFYING SERVICES SUITABLE FOR REFORM

The Commission is seeking feedback on whether the factors presented in Figure 2 reflect those that should be considered when identifying human services best suited to the increased application of competition, contestability and informed user choice.

Silver Chain Group response:

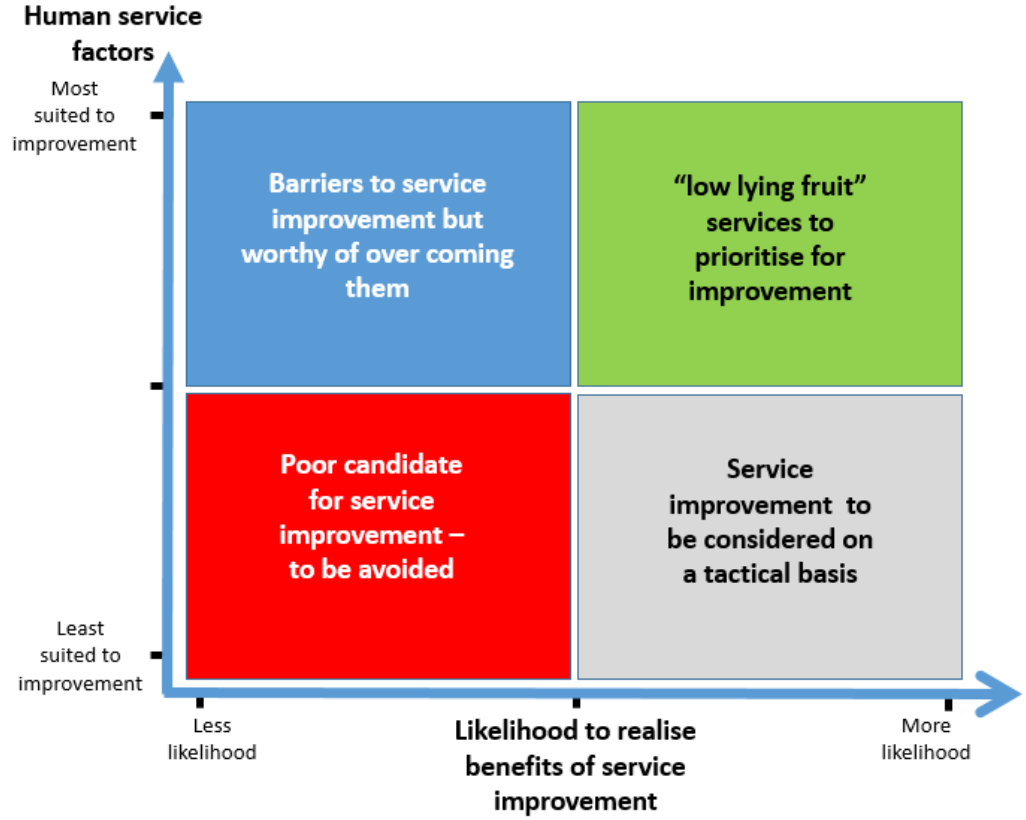
Figure 2 in the Commission's Issues paper appears a suitably comprehensive framework of considerations that could secure service improvements in the process establishing more user choice, greater competition and increased contestability.

Our main response reflects our many years of working to influence a large and complex system, and the varying degrees of success we have had in achieving sometimes fundamental shifts in perspectives, from a centralised hospital to a home-based community perspective. Changing Government policy at both Federal and State levels will without doubt assist a major service improvement initiative. However, policy change isolated from leadership and intent – at senior bureaucratic and clinical levels – is likely to fail to realise all of the potential benefits. From that perspective, the Commission's Figure 2 covers the tangible controllable elements. Less apparent is how these many factors will galvanise enormous systems to change current thinking.

This could be adopted by identification of "early adopters" and strong evidenced based programs run to reflect to the larger group of "close followers" the merits of embracing major policy shifts which openly support moves to implement community and outcomes-focused choices for individual through the promotion of more community centric services.

The following diagram reflects this perspective. The framework factors in the Commission's Figure 2 (Figure 2, page 10) contribute to the vertical axis, while the horizontal axis adds a second dimension which takes into account some less tangible – but no less important critical success factors – such as change leadership, appetite and willingness for change.

Diagram 2: Human Services matrix



In our response to RFI 1 we raised the issue of measuring both the cost of service delivery and the benefits generated from any alternative improved service. For example a service benefit could be hospital bed days liberated by a service enabling individuals to be treated in alternate, more cost effective location, like their home.

The extent of benefit created (as a ratio of the projected service delivery cost) extends the thinking of what services could be prioritised for improvement. In addition, the quality and robustness of the evidence base associated with that benefit would provide the Government comfort that the service was being appropriately prioritised for improvement.

These additive thoughts could go some way to increasing the likelihood of identifying the “low lying fruit” services, those that would reside in the top right hand quadrant of the Human Service matrix shown above.

RFI 3 – WHAT ARE CHARACTERISTICS OF SERVICES WITH GREATEST SCOPE FOR IMPROVEMENT?

The Commission is seeking participants' views on which human services have the greatest scope for improved outcomes from the increased application of competition, contestability and user choice. Where possible, this should be supported by evidence from performance indicators and other information to show the extent to which:

- Current and expected future outcomes — measured in terms of service quality, efficiency, equity, accountability and responsiveness — are below best practice
- Competition, contestability and user choice do not exist under current policy settings, or are not as effective as they could be in meeting the goals of quality, equity, efficiency, accountability and responsiveness

QUESTION: Current and expected future outcomes — measured in terms of service quality, efficiency, equity, accountability and responsiveness — are below best practice.

Silver Chain Group response:

The evidence base supporting our assertions relates to the key service areas we have significant experience of: helping Australians, who choose to do so, to die at home; providing high quality acute care in the home; and providing restorative care in the home. We have the view that all of these service areas have significant scope for a greater level of user choice that is providing a home based alternative to the prevailing hospital/institutionally focused choice. It seems likely that if this choice were more available, the end result would be more providers wanting to contest and compete for contracts promoting service innovation, quality, efficiency, equity accountability and responsiveness.

We see the following characteristics of our services as key in making them candidates for State Governments to consider as improved service alternatives:

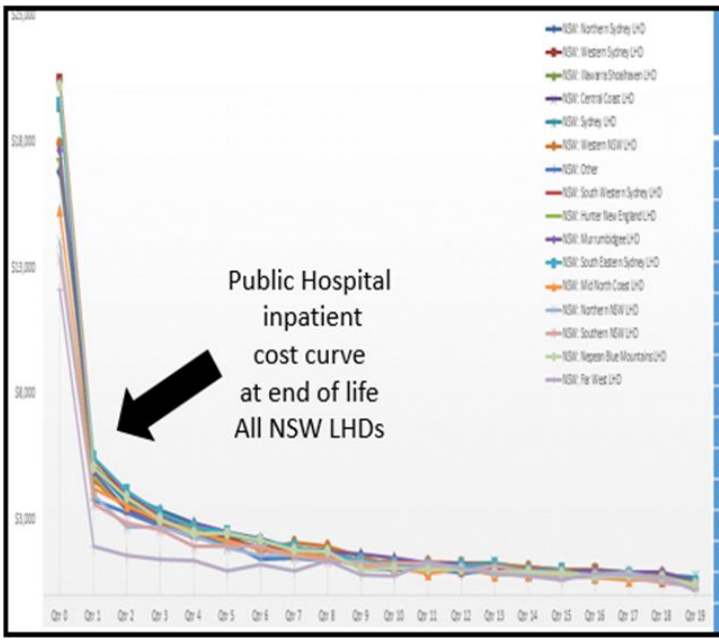
- **Demand**: We can demonstrate that most consumers will respond positively to an alternative choice to the prevailing hospital focused option.
- **Quality**: We can demonstrate no reduction in quality by providing a home based, versus hospital only, choice to consumers.
- **Cost**: We can demonstrate the alternative home based services can be delivered more cost effectively with no reduction in clinical quality or governance.
- **Responsiveness**: We can demonstrate equivalent (often superior) levels of responsiveness with a home based model.

It is important to stress the best outcomes – for the consumer and taxpayer – occur where we work in close partnership with the existing hospital/institutional system. We acknowledge hospitals are appropriate settings when the individual needs or specifically chooses to be there (for example, they may not wish to put their partner or family through a level of stress associated with end of life care) and the nature of their conditions mandates hospital treatment (for example, they have a level of clinical acuity optimally treated in hospital). However, there are many individuals treated in hospital who – provided with the choice of a high quality, efficient, equitable, accountable and responsive service capability – prefer to be treated at home.

In a recent palliative care service analysis our modelling (conducted in the WA metro region across the period 2009 – 2011) resulted in a reduction of 39,684 public hospital bed days, an average of 13,228 hospital bed days liberated each year within metropolitan WA.

To provide the Commission some indication of the cost profile for providing end of life care in hospitals, the shape of the public hospital inpatient cost curve under Diagram 3 below evidences the weighting of public hospital costs towards the last three months of life. While featuring NSW data, the shape of the graph is in no way specific to NSW, with the cost profile phenomenon common in other States.

Diagram 3: NSW Local Health Districts (LHDs) public hospital end of life inpatient costs



LHD	Average Public Hospital Inpatient Cost Prior to Death
NSW: Far West LHD	$ 12,098
NSW: Northern NSW LHD	$ 13,997
NSW: Mid North Coast LHD	$ 15,296
NSW: Northern Sydney LHD	$ 16,756
NSW: Central Coast LHD	$ 17,049
NSW: Hunter New England LHD	$ 17,253
NSW: Murrumbidgee LHD	$ 17,636
NSW: Western NSW LHD	$ 17,898
Grand Total	$ 18,064
NSW: Illawarra Shoalhaven LHD	$ 19,435
NSW: South Eastern Sydney LHD	$ 19,469
NSW: Sydney LHD	$ 19,498
SW: Other	$ 19,580
NSW: Nepean Blue Mountains LHD	$ 20,170
NSW: Western Sydney LHD	$ 20,389
NSW: South Western Sydney LHD	$ 20,487

Beyond the clear economic gain, providing the Australian consumer choice will have a profound social benefit making the case for reform even more compelling.[6]

QUESTION: Competition, contestability and user choice do not exist under current policy settings, or are not as effective as they could be in meeting the goals of quality, equity, efficiency, accountability and responsiveness.

Silver Chain Group response:

The opportunity exists for many State Governments to review policy with respect to the service areas Silver Chain Group currently delivers.

Indeed, the opportunity for policy review goes wider, as evidenced by the National Health Reform agenda and the creation of Primary Health Networks which "*…have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time*."[7].

This primary care objective captures our perspective on where State policy requires review. There needs to be a rethink – mandated by the increasing burden of chronic disease, ageing population and the cost of contemporary medical treatments – on where more choice can be provided to achieve an outcome of right care in the right place at the right time.

[6] McGowan C. (2015). *What is the cost of public hospital care at the end-of-life?* Thesis submitted for Doctor of Philosophy, Flinders University: Adelaide, Australia.
[7] Australian Government Department of Health (2015). Primary Health Networks. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks

RFI 4 – CASE STUDIES OF PREVIOUS SUCCESS

Participants are invited to submit case studies of where policy settings have applied the principles of competition, contestability and user choice to the provision of a specific human service. Such case studies could describe an existing example or past policy trial in Australia or overseas. Participants should include information on the:

- Pathway taken to achieve the reform.
- Effectiveness of the policy in achieving best-practice outcomes for quality, equity, efficiency, responsiveness and accountability.
- Applicability of the case study to the provision of human services in Australia if it is an overseas example.

QUESTION: Pathway taken to achieve the reform

Silver Chain Group response:

Case study - Silver Chain Group's Primary Health Nurse Practitioners

In country regions, Silver Chain Group's strategic direction is to participate in building stronger, healthier country communities. The goal is to do this by providing a continuum of care reducing the need for people to leave their community when their care needs change. We work in a close, collaborative and complementary manner with WA Health's WA Country Health Service (WACHS) and other service providers, utilising our significant expertise and experience in community regional, rural and remote health care, hospital avoidance and substitution services. Silver Chain Group provides a wide range of services across regional WA including primary health and emergency care across twelve State-funded centres from Shark Bay in the north to Eucla in the east.

In 2011, Silver Chain Group applied for and was successful in obtaining Royalties for Regions funding for provision of Primary Health Nurse Practitioner (PHNPs), services to be delivered as part of the Southern Inland Health Initiative (SIHI). The resulting innovative program grew from 1.0 FTE to 4.2 FTE PHNPs delivering evidence-based, value-for-money high quality services in four Southern Inland Health Initiative (SIHI) Primary Health hubs across the Wheatbelt and upper Great Southern regions.

Silver Chain Group's PHNPs are registered nurses who have completed both advanced university study at master's degree level and extensive clinical training to expand on the traditional role of the registered nurse. They use extended skills, knowledge and experience in the assessment, planning, implementation, diagnosis and evaluation of care required.

We refer to their skill set as interdisciplinary, reflecting that they are health professionals with wide ranging expertise able to coordinate and collaborate when required with a multi-disciplinary care team comprising GP's, Medical and Surgical Specialists, Physiotherapists, Dieticians, Occupational Therapists and many others.

The PHNP extended scope of practice and level of clinical expertise enable them to undertake a range of activities that better meet the needs of populations in rural and remote locations that do not have easy access to GP and other primary health services.

For example, the PHNP is able to prescribe medications, order diagnostic tests and refer clients to other health professionals; and also to make claims under the Medicare Benefits Schedule (MBS).

This innovative role aims to:

- Improve client and community focussed clinical outcomes.
- Improve access to treatment.
- Improve community discharge and interdisciplinary coordination of care.
- Provide cost effective care.
- Target at risk populations.
- Provide outreach services into rural and remote communities.
- Provide mentorship and clinical expertise to other health professionals.

The following case provides evidence of the type of comprehensive health care and support being provided, as well as the impact of improved access to treatment, chronic disease management, improved clinical outcomes and avoidance of care escalating to the hospital setting.

Case Study: More than just health – A town wellness approach!

M is a 50 year old man living alone in a small isolated rural town. Referral was made during a regular weekly meeting at his nearest hospital. Presenting problems included a wide range of conditions relate to chronic conditions including mental health conditions. Overall his physical health had been good prior to an acute episode. Mental health and social issues have been prevalent. Due to his past behaviours he was shunned by the community resulting in total isolation.

M also experienced difficulties with travel to Perth for ongoing treatment, ie a general lack of understanding of distance and time for travel resulting in appointments sent for review by surgeon and then by additional specialists often just three days apart. This involved travel costs to and from Perth. The patient's lack of knowledge of services or support available to him would lead him to a sense of despair and hopelessness. Weekly clinic appointments with the local Primary Care Nurse Practitioner (PHNP) provided the opportunity to review how he was coping but also enabled discussion and support around his ability to cope with his multiple health and social needs.

In addition, he was given a contact number for emergencies. Since M has been attending his PHNP's weekly clinic he has not presented to an emergency department (ED) or called an ambulance or other emergency services. His alcohol consumption has reduced as he has begun to cope better with his accumulated social problems. Also, the PHNP spoke directly with M's surgeon by phone and e-mail, highlighting the difficulties he faced with travel and accommodation and lack of funds. His surgeon agreed to admit M for his reviews. Also, she agreed to change protocols so that M did not have to attend pre-admission clinic two weeks prior to surgery but was admitted the day prior.

The PHNP made contact with community members to support and encourage M resulting in community support for a range of activities. M now feels like a valued community member and is beginning to repay by helping others in the community.

QUESTION: Effectiveness of the policy in achieving best practice outcomes for quality, equity, efficiency, responsiveness and accountability.

Silver Chain response:

The PHNP program in the SIHI region has demonstrated a range of benefits to individuals using the service and communities they live in, including:

- ***Improved clinical outcomes***: The PHNPs often provide care coordination for individuals who need access to multiple health and social care providers, and who may have experienced challenges in coordinating their own care. The PHNP's work extensively to build collaborative relationships and links with regional community and health and social services, allowing them to build capacity within the system to respond appropriately to complex care demands at a local level. The PHNPs work with individuals to facilitate and build their own self-management capabilities around referrals to other providers, transport, chronic condition management and ongoing access to medications, thereby supporting improved health outcomes.

- ***Improved access to treatment and chronic disease management***: For example, the PHNPs participate in chronic condition management to assist clients to manage their condition through diet and exercise, monitor progress through diagnostic testing, and prescribe medication as required.

- ***Delivery of cost effective care:*** When considering the impact of Silver Chain Group's PHNPs on reducing unplanned hospital admissions it should be noted that the average cost per day-bed for admitted patients in small rural hospitals is $1,365 and the average cost per case-mix adjusted separation for non-tertiary hospitals is $5,879[8]. The average cost per ED attendance is $696[9]. In comparison, analysis undertaken by SCG suggests that the hourly cost of delivering PHNP services varies from between $80 to $180 depending on volume and geographic location showing that even a lengthier PHNP consultation is a far more cost effective option.

- ***Target at-risk populations***: For example, the PHNPs provide outreach services for individuals with mental health issues, focusing on physical assessment and education around lifestyle. This improves this at-risk population's access to primary care and their own ability to self-manage co-morbidities which can occur in association with mental health issues. Individuals with mental health diagnoses are seen at home in collaboration with a mental health practitioner, a physical assessment is undertaken, diagnostic work up undertaken, and the client is prepared for upcoming psychiatric review. This is beneficial for the clients, in that they often do not have transport and can be isolated from services, can reduce the number of psychiatrists visits required as the client is ready for review and medication monitoring.

- ***Provision of outreach services into rural and remote communities that are significantly marginalised by their health access:*** The PHNPs provide care in under-serviced locations across the SIHI region of WA on a regular basis. Other than Silver Chain Group, these communities have only sporadic access to medical practitioners, or need to travel long distances to their nearest permanent medical practitioner/ hospital.

- ***Provision of mentorship and clinical expertise to other health professionals:*** This is particularly targeted at growing sustainable local capacity within the health workforce where there are existing gaps, and is a highly important activity as it is resulting in improved flexibility and responsiveness of the sector. For example, in Corrigin there is no female GP. As a result, Silver Chain Group's PHNP has taken a significant number of pap smears and

[8] WACHS Annual Report 2013-14.
[9] Ibid

has assisted with training the local RN on practicalities of taking pap smears. The RN has attended training in Perth and is now able to independently provide pap smear clinics.

RFI 5 – SERVICES MOST RELEVANT FOR USER CHOICE

The Commission is seeking information on which human services have these characteristics:

- Service recipients are willing and able to make decisions on their own behalf and, if not, another party could do so in the best interest of the recipient
- User-oriented, timely and accurate information to compare services and providers can be made available to users so they are able to exercise informed choice or, if not, this could be cost-effectively addressed
- Service recipients (or their decision makers) have sufficient expertise to compare alternative services and providers or, if not, this barrier could be overcome
- Outcomes experienced by a service recipient and their family and friends in past transactions can inform which service and provider they choose in the future.

QUESTION: Service recipients are willing and able to make decisions on their own behalf and, if not, another party could do so in the best interest of the recipient

Silver Chain Group response:

In all the core service areas Silver Chain Group participates in, we see individuals being able to make choices for themselves or engage other parties, most typically family, to act in their best interests. We believe across the range of our services; and working in partnership with Federal and State services, we can offer significantly more choice to all Australians.

Looking at hospital-based palliative care in NSW, we have concluded from NSW Health data for 2011-2012:

- There were that 49,801 deaths.
- 38,282 individuals accessed hospital care in the last year of life.
- This resulted in 165,000 hospitalisations.
- These hospitalisations cost NSW $1.009 billion

Research indicates that up to 90% of people would choose to die at home if able to access high quality end of life care in their home. Yet only 14% of Australians currently die in their homes.

The case for Hospital in the Home (HITH) services and short-term restorative care is no less compelling. Given service availability, setting support (via agreements and partnerships with State health services) and overall sector reform (via individual outcome and taxpayer value), user choice in our specialist service areas will improve materially.

QUESTION: User-oriented, timely and accurate information to compare services and providers can be made available to users so they are able to exercise informed choice or, if not, this could be cost-effectively addressed.

Silver Chain Group response:

There is always opportunity for Governments to maintain information and quality comparative resources with service providers contributing standardised quality and performance data (ie *MySchools* (www.myschool.edu.au) and *MyAgedCare* (www.myagedcare.gov.au).
However, we are unsure of how cost effective such an approach could be, given the range of services and service providers in the health care sector alone. We refer later in this response to our view that a tipping point has been reached with respect to how consumers are prepared to interact with service providers via the Internet. There is a view that brand is no longer being considered as a proxy for product quality, consistency and value. In their publication, "*Absolute Value*", Simonson and Rose reflect that the rise of brands was a response to a historic, information-poor environment[10].

Their view is that consumers are now making choices on quality and value they associate with products (or specific services) rather than overall company brand. Online consumer research conducted by Price Waterhouse Coopers in the US concluded 88% of survey respondents research a product online via their PC before buying.

Consumers live in an information rich era, supplemented by the ubiquitous presence of social media. It seems reasonable to conclude these trends will contribute significantly to user-oriented, timely and cost effective reviews of specific services. Accuracy of information is perhaps the more vulnerable component of this new consumer era on the Internet, for that Silver Chain Group leverages more traditional methods like net promoter score, customer satisfaction surveys and client quality workshop sessions.

QUESTION: Service recipients (or their decision makers) have sufficient expertise to compare alternative services and providers or, if not, this barrier could be overcome.

Silver Chain Group response:

As stated above, the consumer has more information available to them today than in any other era. The word-of-mouth and anecdotal of yesterday is now supplemented by opinions and perspectives – not always accurate – shared via social media.

With increased competition comes the requirement for service providers to better communicate their value proposition, that is, what makes their service distinctive? It could also be assumed that where services attract larger fees or funding, service providers will make greater efforts to inform potential clients of the additional benefits associated with their service offering.

The public's tolerance for services that over promise or under deliver is appropriately low. The provider, who adopts a less than ethical or quality attitude in their service delivery, attracts significant reputational risk given the ubiquitous social media tools now at the consumer's disposal.

[10] Simonson, I. and Rosen, E. (2014). *Absolute Value: What Really Influences Customers in the Age of (Nearly) Perfect Information*. Harper Business: USA.

QUESTION: Outcomes experienced by a service recipient and their family and friends in past transactions can inform which service and provider they choose in the future.

Silver Chain Group response:

Silver Chain Group's opinion has been informed by working with clients, their families and carers through the most vulnerable time in their life, including their end of life experience. It is our perspective that in Human Services, clients respond to providers who strike the appropriate balance between the provision of high quality clinical care, a desire to help the client secure a positive outcome and a level of humanity which is impossible to attribute a monetised value to. These attributes, in our experience, are the principal drivers of future decisions for all parties we encounter through the delivery of our core services.

RFI 6 – SERVICE TRANSACTION CHARACTERISTICS

For specific human services, the Commission is seeking information on the nature of service transactions based on these characteristics:

- The nature of the relationship between the service user and the provider.
- Whether the service is used on a one off, emergency or ongoing basis.
- Whether the service can be provided remotely.
- The extent to which services to an individual can be unbundled whether there is a strong case for the provider to supply multiple services to an individual with complex needs.

QUESTION: The nature of the relationship between the service user and the provider.

Silver Chain Group response:

The user/provider relationship (including goals) may be documented in a care plan, but the extent to which it is primarily a human relationship is modulated by both parties through specific episodes of care. In restorative care it is important service delivery is provided on a timely basis, before the onset of any new or additive condition becomes established. A service user response of "*This is just another functional loss and all part of the ageing process*" requires challenging given the principal objective is of restoration (increased independence), not the support of degradation (increased dependence).

In restorative care (for example) the attribute of timeliness and the nature of how the service provider challenges the service user to explore levels of capacity is part of that human relationship. A competent service provider recognises that these (often non-documented) service attributes are part of their outcomes measurement and ultimately training and education process.

From a relationship perspective it is also worth noting that patients with chronic conditions are substantially their own principal care givers as they have control over their level of compliance with medication regimens, lifestyle choices and decisions about various aspects of management of their condition. Many models of chronic disease management therefore have a strong focus on client intervention and collaboration as they play an integral role in the management of their own disease

processes[11]. Interventions that adopt self-management models for chronic conditions such as the internationally recognised Chronic Care Model (CCM) encourage health professionals to collaborate with patients in order to manage fluctuations and improve outcomes in cases of chronic illness[12]. A multidisciplinary collaborative team inclusive of health professionals, carers, community service staff as well as the patient and their family is essential for successful participation in chronic care interventions.

QUESTION: Whether the service is used on a one off, emergency or ongoing basis.

Silver Chain Group response:

Silver Chain Group does provide some episodic support and there are emergency call-outs as part of our palliative care and Hospital in the Home (HITH) service. However our views are informed primarily by the ongoing nature of the support we deliver. Silver Chain Group is a capacity building organisation. We actively build up the capacity of the individuals we support, as well as building up the capacity of their families and carers, who are a critical component of the support team in palliation, restoration and other home-based care. We also focus on building up capacity of the communities we work in, as demonstrated by the 700 bed virtual hospital in the community in WA. Service providers should challenge themselves on the extent to which they build capacity, versus deliver episodic care, notwithstanding that episodic care may be appropriate, of high quality and consistent with acquitting bloc funding obligations. But it must also be delivered with due consideration of the opportunities available to increase capacity.

It can be argued that "one off", less specialist services have a profile more appropriate for competition, contestability and user choice. It could be observed that this is a growing trend manifesting in the US and starting to be seen in Australia around the so-called "uberfication of health care" [13]. The corollary to this position is the evidence base which clearly supports the contention that capacity building creates superior value through improved client outcome and improved economic impact. These capacity building services will often have a higher initial cost profile, than a more commoditised service, therefore an equitable comparison is critical to avoid a rush to the bottom in terms of funding coverage.

One final observation reflects on the linkage between the funding mechanism and the effectiveness of care delivered. For example commentary within the health sector of the causal impact of the Medicare Benefit Schedule on the delivery of "ten-minute medicine." Block-funded service providers acquitting on the basis of having delivered, for example, "sixty three instances of care this quarter, up 6% on the same period last year." An important question to be asked, and one that is supported in the service design methodology known as Results Based Accountability[14], is "what would we do differently if outcomes really mattered?"

[11] Warsi, A., Wang, P.S., LaValley, M.P., Avorn, J. and Solomon, D.H. (2004). Self-management education programs in chronic disease: A systematic review and methodological critique of the literature. *Archives of Internal Medicine*, 164 (15), pp. 1641-9.
[12] Wagner, E.H., Austin, B.T. and Von Korff, M. (1996). Organising care for patients with chronic illness. *Milbank Quarterly*, 74 (4), p.511-44.
[13] See example reference at http://www.hisa.org.au/blog/australian-telehealth-conference-sydney/
[14] Friedman, M. (2009). *Trying hard is not good enough: How to produce measurable improvements for customers and communities*. BookSurge Publishing: USA.

QUESTION: Whether the service can be provided remotely.

Silver Chain Group response:

Silver Chain currently supports regional and remote WA through services such as:

- **Health Navigator**: The Health Navigator (HNAV) service provides virtual care coordination and navigation for individuals living with diabetes, heart disease, heart failure and long term lung conditions such as chronic obstructive pulmonary disease (COPD). HNAV works by establishing linkages that navigate the client to the most appropriate level of care – through support to navigate the health system and self-manage their health. Key to this is the collaborative practice approach with communities and other health providers, and partnering with clients to implement their personal care plan.

  HNAV is delivered virtually via Silver Chain Group Health Navigators. Following an initial face-to-face assessment, all client contact is made either by phone or videoconferencing. This approach means that clients do not need to leave their community or even their home to access the programs. HNAV aims to have a direct impact on health services and patient outcomes in rural and remote locations through offering an alternative service. Through case management and coordination, HNAV has the potential to prevent patient admissions and readmissions to hospitals and EDs through better connecting clients and with their health care providers, eliminating unnecessary duplication, making more efficient use of appointment time and significantly improving access to services.

- **Supporting Aboriginal Health Services**: The Wirraka Maya Telehealth Diabetes Education Pilot Project was a partnership project between Silver Chain Group, Wirraka Maya Health Service Aboriginal Corporation (WMHSAC) based in South Hedland in the Pilbara region of WA, Western Australia Country Health Services (WACHS) and Kimberley-Pilbara Medicare Local. The aim of the project was to assist Aboriginal people diagnosed with diabetes to develop the skills required to successfully manage their condition using a telehealth approach, which an evaluation of the pilot revealed it achieved.

  This approach offers the possibility of adding substantial capacity to extend diabetes education resources available to WMHSAC and its clients, including video/ tablet access to a Silver Chain Group Diabetes Educator. To our knowledge, this is the first time a telehealth approach to diabetes education has been trialled as a partnership between an Aboriginal Health Service and other care providers.

- **Primary Care Nurse Practitioners (PHNPs):** The Southern Inland Health Initiative (SIHI) is an investment by the State Government's Royalties for Regions program that aims to transform health care throughout the southern inland region of WA, including towns in the Wheatbelt, South West, Great Southern, Midwest and Goldfields. Silver Chain Group's PHNPs work as a vital member of the local health team as part of the SIHI . Key to the role is a collaborative practice approach and ability to triage and case manage; as well as their extended scope of practice and level of clinical expertise. These enable them to undertake a range of activities that better meet the needs of populations in rural and remote locations that do not have easy access to GP and other primary health services.

  The PHNP program is working to improve health outcomes through integrated community solutions that are sustainable and maximise the health dollar targeting individual clients with chronic disease, mental health issues and complex health needs. These services have been able to deliver in particular areas of need within the SIHI region where:

  - There are little or no available GP services.

- There is varied access to assessment and care planning for complex and aged care clients.
- There is limited access to physical health assessment and care planning for mental health clients.
- There are limited or no women's health services.
- There are Aboriginal clients in need of improved access to flexible coordinated health care.
- Where palliative clients are unable to access coordinated access to support in their choice to die at home.

The program ultimately promises to deliver exceptional value for money approaches to primary health in rural areas through innovation, evaluation of the intervention(s) and development of a Primary Health Nurse Practitioner Model of Care which is applicable State-wide. A critical success factor for all of these services in remote communities is the extent to which the GP embraces the support of our teams, particularly our PHNPs. We find remote and regional GPs are particularly accepting and embracing of the support the PHNPs can provide.

Our observations as a service provider working to deliver high-quality health and social care in remote areas would be that the success factors include the ability to:

The continuation of the Nurse Practitioner Program within the SIHI region will enable cost effective delivery of improved health access, health outcomes and quality of life for the people living in this region.

Early evidence also indicates that the Program is likely to be effective at reducing other health sector costs such as reduced ED presentations. It has enabled targeting of at risk populations including people identifying as Aboriginal or Torres Strait Islander and people with mental health issues.

Further significant benefits include an optimised health workforce mix; and provision of mentoring, clinical leadership and capacity building for the regional nursing workforce.

- Work positively with existing remote clinical and community services.
- Through leveraging appropriate funding and support, apply innovative technology solutions such as telemedicine.
- Access system funding through stable long-term contracts which support our investment and capacity building philosophy into remote areas.
- Work in partnership with relevant Federal and State agencies and other non-Government providers.

QUESTION: The extent to which services to an individual can be unbundled.

Silver Chain Group response:

Unbundling clinical services has important clinical governance and client outcome implications that require significant consideration. Take by way of example our "shared-care" medical governance applied within Silver Chain Group's palliative care service. This model delivers a differentiating factor for Silver Chain in ensuring enhanced patient outcomes:

- Silver Chain Group operates community based medical governance sitting within our palliative medicine consultants, working in partnership with medical practitioners and other health workers involved with the care of the patient.

- We work with and support GPs to the extent that they wish, ensuring that a client and their family/carers have access to 24 hour care.

- Clinical governance provided through a team comprising a Palliative Medicine Consultant, Registrars and GPs with support from Nurse Practitioners.

- On-call medical support is available to the patient, and to stand-up nursing services which will work through the night.

- Should a client require a hospital admission during their episode of care, the Clinical Nurse Consultant Manager (CNCM) will work with the medical governance team and the inpatient facilities to ensure that the client is admitted to the most clinically appropriate bed, or a facility such as a palliative designated bed or inpatient palliative care unit.

- The team will then also work proactively with the inpatient facility to support transition back to community as soon as is clinically possible, and based on patient choice, and will continue to provide support to the carer and family.

We would suggest to the Commission that a spectrum exists within service provision covering commoditised services which could be unbundled to those services where it would be hard to see patient outcome and clinical governance not being compromised through unbundling.

QUESTION: Whether there is a strong case for the provider to supply multiple services to an individual with complex needs.

Silver Chain Group response:

Silver Chain Group believes that there is a strong case to be made for a provider to supply multiple services where it can be demonstrated that:

- The client outcome would be improved by doing so (for example, benefiting from improved consistency, continuity and integration of care – the “one stop shop” benefit). An unbundled service component could be delivered cheaper on a stand-alone basis by another provider; however the resulting user outcome may be significantly less.

- Clinical governance would otherwise be compromised where the service provider does not have direct accountability and some level of quality control over a component service within the overall care model.

- The service provider is a credible and capable provider of the services in question.

RFI 7 – SERVICE SUPPLY CHARACTERISTICS

The Commission is seeking information on the supply characteristics of specific human services including:

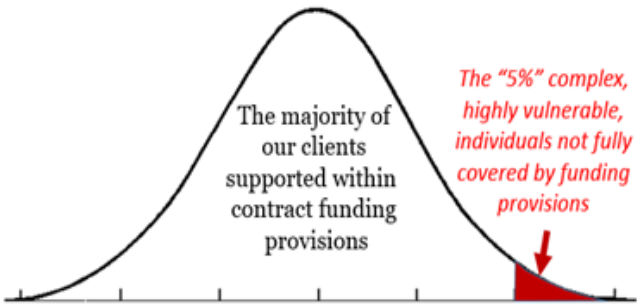
- Economies of scale and scope — in terms of costs and service quality — that may be lost by having a larger number of competing providers
- The potential for service provision to be made more contestable because there is capability beyond an existing provider that could pose a credible threat to underperformance
- Whether there are barriers to providers responding to change, or new suppliers entering the market, that limit the scope for increased competition, contestability and user choice or, if they do, what could be done to address this
- Technological change that is making competition and user choice more viable
- Factors affecting the nature and location of demand, such as geographic dispersion of users, the distribution of demand among different types of users, particularly disadvantaged and vulnerable users, and anticipated future changes in demand.

QUESTION: Economies of scale and scope — in terms of costs and service quality — that may be lost by having a larger number of competing providers.

Silver Chain Group response:

It is reasonable to expect that any service provider which increases in size, through the delivery of more instances of care to more people, will pursue economy of scale improvements. In addition, a service provider would, in an increasingly competitive environment, leverage economies of scale and increased efficiencies in areas such as back office, clinical systems, logistics and technologies. Silver Chain Group has a history of pursuing both economies of scale and increased efficiency, irrespective of levels of competition we have encountered. Beyond our long standing and consistently applied desire to innovate, increasing pressure from a variety of funders to do more with less has resulted in a constant state of service review. We are committed to a process of ongoing improvement in efficiencies and economies of scale we can leverage for the benefit of our clients.

This portfolio approach – juggling our cost to serve - represents a capitated funding application to a bloc funded contract. In the strictest terms of that bloc funded contract, we are over servicing some of our most vulnerable clients. This is not an ideal situation, but something we do without hesitation directed by our ethics and mission. Increased competition could make a non-optimal approach unsustainable.



Scope of service delivery is a separate factor and one we feel the Commission may wish to consider. Ethics and mission have significant impacts on the approach we take to individual instances of care. Our over a century of experience reinforces the reality that some clients need more than others. Every day Silver Chain Group teams deliver more care for an individual than originally anticipated, based on the complexity of their health and social care needs. Government changes to funding arrangements have restricted our ability to apply flexibility to those clients who – from time to time – require extra care.

QUESTION: The potential for service provision to be made more contestable because there is capability beyond an existing provider that could pose a credible threat to underperformance.

Silver Chain Group response:

We don't believe any service provider should be delivering services which they are not capable of delivering in a high quality, efficient and cost effective manner. This view holds, regardless of competitive or regulatory landscape. In an outcomes based environment service partnerships and collaborations reflecting any given outcome are more likely to require aggregation of capabilities that cross not only clinical disciplines, but also sector disciplines. For example, Silver Chain Group is not an employment agency, but a situation could be envisaged where our Social Care team establishes an alliance with an employment service to secure paid work for the carers of our clients.

QUESTION: Whether there are barriers to providers responding to change, or new suppliers entering the market, that limit the scope for increased competition, contestability and user choice or, if they do, what could be done to address this.

Silver Chain Group response:

There are new markets that Silver Chain Group seeks to enter, to replicate the significant impact we have had within the WA and South Australian (SA) health and social care sector. This will require us to replicate the system-wide relationships we hold in WA, SA and elsewhere.

We need to convince leaders within the existing hospital system to look at the issue in a fundamentally different, less hospital centric way.

Changing attitudes within the hospital system is a barrier that stands between an unsustainable future and a much more patient centric and cost effective outcome.

Over the course of several decades we have nurtured a strong collaborative partnership with WA Health, including the three WA Area Health Services who manage the system, and with the individual hospitals providing secondary and tertiary care in WA. We have also formed strong working relationships with the GP community and the new primary health care commissioners, the Primary Health Networks. Silver Chain Group is committed to making an unprecedented impact on the health and wellbeing of all Australians. In order to achieve this goal it is our considered opinion that significant cultural change will be required by funders and service delivery agencies to create value in the health and social care sectors, that value being defined as supporting individuals to secure outcomes they want at a cost the taxpayer can afford.

Silver Chain Group is already identifying leaders who are philosophically aligned with our service, setting, and sector perspectives reflected in our positioning chapter to this response document. We operate within two systems – the largely State-managed hospital system, and the Federally-funded primary and aged care system). This can create, if not conflicts of interest, then certainly navigational challenges for service providers and individuals.

Two of the most quoted examples of a seamless client experience; system efficiency and effectiveness of outcomes – Kaiser Permanente in the US and the Canterbury Health District in New Zealand – are considered to be "complete" systems. Both are integrated from the ground up rather than discrete primary, secondary and tertiary environments subject to State and Federal imperatives that don't always align with the interest of either patient or taxpayer.

QUESTION: Technological change that is making competition and user choice more viable.

Silver Chain Group response:

Most industries offer some degree of self-service to consumers, the health industry, whilst generally being slow to adopt this, is now demonstrating a tipping point that has either passed or is now upon the sector. Technological change is making competition and user choice more viable. Silver Chain Group has long believed in the meaningful role technology plays in health and social care. In 2015 we divested our in-house developed ComCare technology capability – now a recognised leader in the provision of client and resource management solutions for health, aged and community care in Australia and New Zealand – to Telstra Health, where it is now integrated within their HealthConnex business[15].

We have a number of initiatives underway consistent with the "uberfication of healthcare" phenomenon. Specifically we are looking at technology platform approaches to tackle a number of health and social care challenges such as reducing social isolation in the elderly and enabling families and care recipients to find care providers based on consumer preference.

We have conducted market testing research indicating that elderly consumers will engage with technology where they get utility from the experience. Age, in our opinion, is not a barrier to the ongoing impact of technology and the internet on the health and social care sectors.

Silver Chain Group does not doubt the prodigious impact technology will have in terms of competition and user choice.

We are actively progressing alternative approaches tackling challenges like social isolation and the demand for enhanced care in the social care sector.

QUESTION: Factors affecting the nature and location of demand, such as geographic dispersion of users, the distribution of demand among different types of users, particularly disadvantaged and vulnerable users, and anticipated future changes in demand.

Silver Chain Group response:

Australia has long grappled with the dichotomy of being a highly urbanised country with a remote rural population deserving of health outcomes no different from their metropolitan peers. Into that mix goes the needs of one of the most globally vulnerable groups in our remote Aboriginal communities. Many consider the health issues faced by some of our communities as intractable. It is within this context that Silver Chain Group fully supports the Commission's efforts to improve competition, contestability and user choice, recognising the future is ours to change.

The graph under Diagram 4 reflects the projections by the Australian Institute of Health and Welfare (AIHW) of projected areas of health cost expenditure in the three decades from 2003[16]. Significantly just 21% of that projected cost increase is from population growth, with 79% relating to the other drivers noted.

[15] See http://www.eostech.com.au/news/36/Telstra-Health-to-acquire-EOS-Technologies
[16] AIHW (2008). *Projection of Australian health care expenditure by disease, 2003 to 2033.* Retrieved from http://www.aihw.gov.au/publication-detail/?id=6442468187

Diagram 4: Drivers in health care costs, 2003-2033[17].

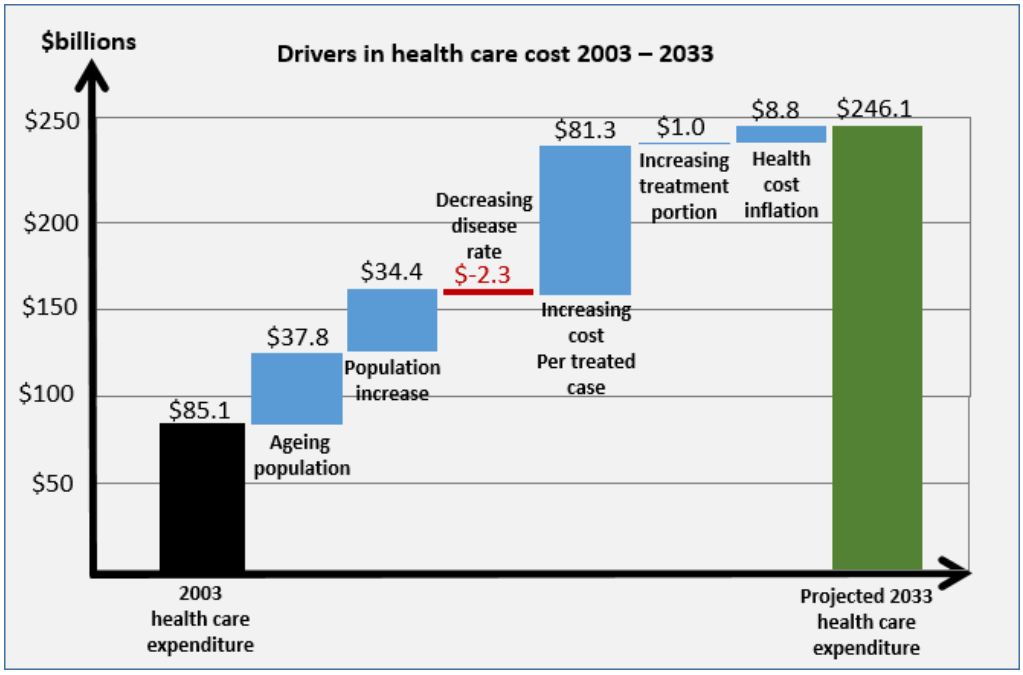


Figure 3 supports Silver Chain Group's choice to adopt a strategy focussing on influencing the system in the following areas:

- All Australians who choose to do so, are able to die at home.
- All Australians should have the choice to receive exceptional out-of-hospital acute care at home.
- All Australians should be given the opportunity to maintain and regain independence.
- All Australia should experience seamless integrated care, where they are the directors of their care plan.

Health systems working with us and other non-Government providers to adopt approaches to these aspirations can have a material impact on the two largest cost components in the chart above, namely the $37.8 billion projected for our ageing population, and the $81.3 billion projected for the increasing cost per treated case, many of which could be treated more cost effectively – with no loss in quality in the community.

[17] AIHW (2008). *Projection of Australian health care expenditure by disease, 2003 to 2033.* Retrieved from http://www.aihw.gov.au/publication-detail/?id=6442468187

RFI 8 – SERVICE COST & REGULATORY CHARACTERISTICS

For specific human services, the Commission is seeking information on:

- The costs that consumers would incur by becoming more active in selecting the services they receive, adapting to changes in how providers supply services, and switching services when a decision is made to do so.
- The regulatory arrangements and other initiatives that governments would have to modify or establish as part of their stewardship role, including to inform users about alternative services and providers, maintain service quality, protect consumers (especially disadvantaged or vulnerable users) from being exploited, and to fine-tune policies in response to any problems that emerge.
- How the compliance costs faced by service providers will be affected by changes in government stewardship, and the adjustment costs that providers will bear in order to shift to a more user-focused model of service provision.
- The extent to which such costs are one-off or an ongoing impost.

QUESTION: The costs that consumers would incur by becoming more active in selecting the services they receive, adapting to changes in how providers supply services, and switching services when a decision is made to do so.

Silver Chain Group response:

Silver Chain Group are unclear at this stage as to the nature of costs that may be incurred by users in selecting services they receive. Earlier in this response we referred to a US research survey which found that 88% of people surveyed research a product online before buying. It could be observed that the consumer is now more than used to researching through a variety of online channels and, to the extent there is a cost associated with their time in conducting their own research, they are quite comfortable spending time in that activity.

QUESTION: The regulatory arrangements and other initiatives that governments would have to modify or establish as part of their stewardship role, including to inform users about alternative services and providers, maintain service quality, protect consumers (especially disadvantaged or vulnerable users) from being exploited, and to fine tune policies in response to any problems that emerge.

Silver Chain Group response:

We are unclear at this time on the suite of initiatives which Governments would need to pursue to maintain appropriate levels of stewardship whilst driving reform that facilitates more choice, competition and contestability. However, in Silver Chain Group's experience we work in partnership with clients and State Governments. We ensure service quality and protecting consumers with respect to our core services is managed through a "Shared Care" model as part of the joint clinical governance we embrace with the State health departments we work with. While a home-based setting is appropriate for some, specifically those who choose to seek help that is available in that setting, it may not be appropriate for others.

The Commission may wish to consider whether this "Shared Care", joint governance approach is applicable to other Human Service sectors. It would seem reasonable to conclude that the best outcomes for both the individual and the taxpayer are achieved through a more integrated approach that extends quality issues – and joint accountability - over the full service continuum.

QUESTION: How the compliance costs faced by service providers will be affected by changes in government stewardship, and the adjustment costs that providers will bear in order to shift to a more user focused model of service provision.

Silver Chain Group response:

We incorporate clinical compliance and governance within our core service delivery costs. We have already made observations (refer to *RFI 7 - Service Supply Characteristics*) around the loss of flexibility in some of the more contemporary funding approaches that remove the flexibility we once had to provide increased service when a client's condition requires it. Other areas where we envisage additive service provider cost in the move to a more user-focussed and person-centric approach include:

- **Service redesign**: The term "person-centric" is used much in the Human Service sector, yet there is still considerable evidence of highly episodic care often attributable to a bloc-funded acquittal requirement focussed on metrics such as instances of care, as opposed to more tailored, person-centric outcomes. Being able to establish a truly person-centric model of care will incur costs associated with designing and implementing a patient-led, outcome-based model of care.

- **Building the evidence base**: Particularly important to any funder attempting to make an "apples for apples" comparison on the efficacy of various competing services is the ability to present a clear indication of:

  - **Cost-to-serve**: This can be a non-trivial exercise when resources are deployed across multiple programs. Regardless, it is an important metric for service providers to maintain.

  - **Benefit:** This again is a non-trivial piece of information relating to the nature of the outcome achieved and the extent to which it displaces cost from another part of the system. For example, our palliative care service results in increased bed-days-created, a metric that State health departments can, and do, monetise.

  We anticipate consumers of services will be increasingly interested in a service provider's evidence base of the benefits they create for the fee incurred. Being able to establish a defensible evidence base for these metrics will incur a cost, manifest in the analysts and researchers who inhabit this domain of expertise.

- **Value propositions**: Human Services are in nature far less commercials than, say, financial services. Regardless, just as with commercial services, the service provider now has to make clear why the consumer should select their service. What is their distinctive value proposition? Being able to establish distinctive value propositions will incur a cost.

QUESTION: The extent to which such costs are one off or an ongoing impost.

Silver Chain Group response:

Competition, once introduced, will remain eternal. Furthermore, Human Services is an environment in continuous change reflecting the demands of funders, consumers and society in general. Our balanced view is that the costs incurred would be ongoing in nature, such that service providers – at any given time – are able to communicate how they will effectively influence positive outcomes for both the clients they help, and the system they operate in.