LEADING AGE SERVICES
AUSTRALIA

The voice of aged care

SUBMISSION TO: INTRODUCING COMPETITION AND INFORMED USER CHOICE INTO HUMAN SERVICES: REFORMS TO HUMAN SERVICES

Productivity Commission Draft Report: Overview and Recommendations

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Leading Age Services Australia (LASA)

Leading Age Services Australia (LASA) is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. Our vision is to enable a high performing, respected and sustainable age services industry delivering affordable, accessible, quality care and services for older Australians. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

Thank you for the opportunity to comment on the Productivity Commission Draft Report *Overview and Recommendations*. Should you have any questions regarding this submission, please do not hesitate to contact Marlene Eggert on email: marlenee@lasa.asn.au or phone: 02 62301676

Introduction

Thank you for giving Leading Age Services Australia (LASA) the opportunity to comment on *Introducing competition and informed user choice into human services: Reforms to human services*. *Productivity Commission Draft Report: Overview and Recommendations*. LASA believes palliative care to be a core activity for the aged care sector. For this reason, LASA considered the provision of feedback to the *Draft Report* to be an important opportunity for improving Australians' end-of-life care. LASA consulted with Members and Member feedback has informed this submission.

Draft Recommendation 4.1

State and Territory Governments should ensure that people with a preference to die at home are able to access support from community-based palliative care services to enable them to do so. To achieve this, State and Territory Governments should:

LASA general observations to Draft Recommendation 4.1: LASA is concerned that many people who wish to die at home are unable to do so because they cannot access community based palliative care services that deliver 24-hour 7-day service provision.

LASA supports that State and Territory Governments implement community palliative care services that are funded to fully meet community demand for such services on a 24 hour, 7 day a week basis. State and Federal Governments need to work out how the state funded community-based palliative care services proposed by the Productivity Commission articulate with federally funded services such as the Commonwealth Home Support Programme (CHSP), Home Care Packages (HCPs) and GP services.

LASA believes that CHSPs for people receiving end-of-life care require supplementation to account for the higher organizational and service delivery costs incurred in the delivery of this care. Organizational costs may be incurred through attending interagency meetings, development and maintenance of collaborative care protocols and staff education specific to end-of-life care. Higher costs in service delivery arise because people generally experience a high demand for care at the end of their lives.

Access to an end-of-life supplement may be facilitated through verification by a palliative care physician, palliative care nurse practitioner, clinical nurse consultant or clinical nurse specialist. LASA members consider that an end-of-life supplement should be of greater financial value than the cognition supplement because of the higher costs providers incur as identified above.

- *assess the need for additional community-based palliative care services*

LASA supports the development of additional community-based palliative care services based on an assessment of need in the community.

- *design services to address identified gaps in service provision*

LASA agrees that services should be designed to address identified gaps. Dying is a human experience deeply embedded in cultural and/or religious beliefs and/or ways of life. Any identification of gaps should pay attention to the diversity of Australia's community to determine whether groups exist in the community whose cultural, religious or way-of-life needs are unlikely to be met by mainstream services.

- *use competitive processes to select providers (or a single provider) to deliver additional community-based palliative care services*

LASA agrees with the Productivity Commission that competition and contestability are a means to an end and should only be pursued when they improve the effectiveness of service provision[1].

LASA cautions that the benefits of a competitive process will only accrue to governments and the community if selection criteria and processes are designed and implemented to closely take account of identified service needs and service gaps. Competitive processes should also pay close attention to the quality of outputs tendered for and how the quality of these outputs will be measured. Further, in rural and remote areas a lack of service providers may make it impossible to implement services via a competitive process. In this case State and Territory Governments should become the providers of additional community-based palliative care services.

- *monitor and evaluate the performance of community-based palliative care services to ensure that those services deliver integrated and coordinated nursing, medical and personal care, and provide access to care and support on a 24 hour a day, 7 days a week basis.*

LASA believes that a community-based palliative care service needs to incorporate staff with specialist training in palliative care. Further, allied health professionals make an essential contribution to palliative care and thus should be included in community-based palliative care teams.

In geographical areas of high demand such a service may be able to recruit and employ the suite of nursing, allied health, medical and personal care workers required for the delivery of an integrated and coordinated service. However, LASA considers that in less densely populated regions state-funded, multidisciplinary palliative care teams may need to incorporate a Medicare funded palliative care physician, palliative care nurse practitioner and GP, federally funded respite care workers and self-employed allied health professionals. Performance monitoring and evaluation of services assembled across different levels of funding may create difficulties because the employing organizations or professionals are accountable to different funders. LASA believes that States and Territories need to develop clear frameworks for performance monitoring and evaluation that take account of community-palliative care teams that are assembled across self-employed service provision as well as federal, state and territory funding pools.

- *ensure that consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.*

LASA believes that these safeguards must be in place regardless of service volume. Community-based palliative care delivers its services to individuals, their loved-ones and friends at a time of extreme physical and emotional vulnerability. Additionally, the relief of breathlessness and pain requires drugs of addiction (Schedule 8 Poisons such as morphine and fentanyl) to be present in the household of the dying person. These drugs fetch premium prices when sold illegally in the community. Peoples' vulnerability and the medications required to be kept in the household make strong safeguards and oversight essential for all community palliative care services regardless of their stage of development. LASA considers it vital that funding of these services acknowledges the absolute requirement for providers to engage in tight monitoring of their service quality.

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[1] Productivity Commission (2017) *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services Draft Report Overview & Recommendations* p.2

Draft Recommendation 4.2

The Australian Government should:

- *remove current restrictions on the duration and availability of palliative care funding in residential aged care so that palliative care is available to residents who have pre-existing high health care needs, and for periods of time that align with those in the health care system.*

LASA agrees with the Productivity Commission that the delivery of end-of-life care should be core business for residential aged care facilities. LASA members observe that residents tend to move into residential aged care later in life and live there for a shorter period of time than in previous decades. In its Draft Report *Overview & Recommendations* the Productivity Commission reports that 60 000 people die in residential care each year. LASA believes that this trend may accelerate as the Federal Government launched *Increasing Choice in Home Care* in February 2017 which aims to assist people to remain living at home longer.

LASA strongly supports the removal of current restrictions on the duration and availability of palliative care to residents who have pre-existing high health care needs and live in aged care facilities. LASA agrees that the period of time for palliative care funding should align with that articulated by the Australian Commission on Safety and Quality in Health Care. In LASA's view, residents' demonstrated need for palliative care should be the only factor determining whether funding for palliative care is provided for residents.

Members inform LASA that currently many providers fail to claim palliative care under the Aged Care Funding Instrument (ACFI) for two reasons: (1) they already receive maximum funding making them ineligible for additional funding under ACFI, and (2) they require a directive from a clinical nurse consultant or clinicals nurse specialist in pain or palliative care or from a medical practitioner and a pain assessment to receive ACFI funding for palliation. The required directive is difficult to obtain for providers. As ACFI funding for palliation is provided for a short period only the effort to obtain the directive required exceeds the benefit gained for the resident. Further, validators from the federal Department of Health claw back funds obtained for palliation under ACFI if they consider palliation to have been provided for too long. Such claw backs constitute a financial risk for providers.

- Provide sufficient additional funding to residential aged care facilities to ensure that people living in residential aged care receive end-of-life care that aligns with the quality of that available to other Australians.

LASA believes that enabling residential aged care facilities to provide end-of-life care can in part be achieved by aged care assessments referring to specialist palliative care services if the assessment indicates that the resident is in the last 12 months of life. A defined financial palliation supplement would enable residential care facilities to purchase more and better end-of-life services and expertise for its residents.

Draft Recommendation 4.3

The Australian Government should promote advance care planning in primary care by:

- *Including the initiation of an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers. At a minimum, this would require the general practitioner to introduce the concept of advance care planning and provide written material on the purpose and content of an advance care plan.*

LASA general observations to Draft Recommendation 4.3: LASA welcomes the Productivity Commission's recommendations for funding under Medicare to include a conversation about advance care planning in the '75 plus' health check.
However, LASA would extend Recommendation 4.3 to include better promotion of advance care planning in all health care and aged care settings. This approach could be supported by a community campaign similar to that conducted by the Federal Government to improve organ donation rates. Such a campaign could provide positive messages demonstrating the benefits of an advance care plan being in place in times of crisis because the plan gives loved-ones and treating health care professionals a clear indication as to an individual's wishes for health care.

- *Introducing a new Medicare item number to enable practice nurses to facilitate advance care planning.*

LASA supports that nurses working in general practice have access to a Medicare item number to engage in advance care planning with people. Further, LASA members considered that the Federal Government should review available Medicare items to ensure items are available that support GPs and practice nurses in delivering palliative care in the community setting.

Draft Recommendation 4.4

The Australian Government should amend the aged care Quality of Care Principles to require that residential aged care facilities ensure that clinically trained staff hold conversations with residents about their future care needs. This should include helping each resident (or their family or carers) to develop or update an advance care plan (or to document that the resident would prefer not to complete an advance care plan) within two months of admission to the facility.

LASA advocates the development of an advance care plan at any stage of a person's life, not just on entering an aged care facility. In aged care end-of-life conversations include not just peoples' expectations for their medical care but also their remaining life goals and emotional and spiritual concerns.

LASA believes that in the aged care setting all direct -care workers and not just clinically trained staff should feel comfortable to engage in conversations about such end-of-life issues. For this reason, LASA advocates that all direct-care staff should receive training in end-of-life related conversations. This training may be offered at different levels with basic training in conversations about end-of-life issues available to all aged care workers through the VET sector, for example. More advanced training for clinical staff would include the development of an advanced care plan.

LASA observes that the development or updating of new residents' advance care plan by clinically trained staff is usual business in residential aged care. However, the existing suite of tools to capture and express individuals' wishes about their end-of-life care also includes an Enduring Guardianship and an Enduring Power of Attorney (medical and financial). LASA encourages the Productivity Commission to consider recommending that health care workers and aged care workers are trained in the full suite of documents required to clarify a person's wishes should they be unable to speak for themselves. Further, LASA encourages the Productivity Commission to recommend that States and Territories undertake harmonization of the legislation underpinning these documents.

Draft Recommendation 4.5

The Australian, State and Territory Governments should ensure that there are sufficient data to enable governments to fulfil their stewardship functions by monitoring how well end-of-life care services are meeting users' needs across all settings of care.

Governments should work together to develop and implement an end-of-life care data strategy that leads to the provision of, at a minimum, linked information on:

- *place of death*
- *primary and secondary diagnosis*
- *details of service provision at time of death (what, if any, health or aged care did they receive, at what level and for how long)*
- *whether they had an advance care plan.*

LASA agrees that an informative data set is essential to governments' service planning and delivery and considers that the elements identified for the proposed data set in Recommendation 4.5 should be sufficient to support these activities. However, details of service provision at time of death should also include whether and for how long specialist palliative care services were involved. LASA suggests that Births, Deaths and Marriages registries may collect this information either on their death certificates or as part of the process of data collection for issuing the death certificate. Again, harmonization of state legislation may be required. The Australian Institute of Health and Welfare may be well placed to collate, analyse and publish this data.