Productivity Commission Inquiry into Caring for Older Australians
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Submission from Royal District Nursing Service
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Royal District Nursing Service (RDNS), a not-for-profit public benevolent institution, is Australia's largest provider of home nursing, and a major recipient of HACC funding in Victoria. With a workforce of over 1,400 staff RDNS contributes significantly to the health, wellbeing and independence of older Australians. In the year ending 30 June 2009, RDNS nurses undertook over 1.7million visits to 33,213 clients with an average age of 76 years (50% were 80+ years). RDNS has recently expanded its services within Victoria and established itself as a provider of services in both New South Wales and Tasmania. During 2009 RDNS established a wholly owned subsidiary in New Zealand and currently delivers services to over 1,000 people in Auckland under a contract with the local District Health Board (DHB).

Figures show that most older Australians requiring care and assistance receive it in the community, however most emphasis, in terms of public / government policy, remains on residential, rather than more broadly based community, aged care. Just as recent reports on the Australian health system have shown a need to transfer emphasis from the acute/tertiary sector to community-based primary health care in order to ensure a sustainable system in the future and improve health outcomes for the community, it is necessary to place more focus on the full breadth of community-based aged care programs in order to manage the future predicted increase in demand for aged care services.

The Productivity Commission's *Caring for Older Australians* issues paper presents a strong case for the need to address the forecast changes in the quantum and qualitative aspects of aged care services. Our submission will focus on four key areas which need to be addressed: funding; service models; workforce; and governance and quality.

Funding

<u>Funding must be more flexible, encourage innovation and focus on the individual's care needs.</u>

Significant change to current systems is required in order to address the increased cost and demand for aged care services in the future. In order to encourage innovation it is necessary to invest in positive change now. A substantial innovation funding 'pool' should be introduced as an incentive for service providers to test and implement different ways of providing high quality care at reduced short and long term cost.

There is currently little evidence of funding being driven by outcomes. At best, funding is on the basis of outputs (such as hours of service delivered). Greater efficiency will be achieved by more focus on outcome measures in the future. As an example, in New Zealand we have been delivering DHB home care services for the last 12 months under a restorative model of care based on outcomes. Independent research currently being undertaken by the University of Auckland is expected to affirm our own understandings

that this innovative outcomes based program demonstrates savings and significant efficiencies for the funder and improved outcomes for clients, including measures of client satisfaction.

Funding in current aged care programs is often delivered through packages. These packages can be inflexible and not linked to the variety of client need. A more dynamic system which is focussed on the need of the individual would provide better client outcomes. The individual client's service needs will generally vary over time, for example it may increase on occasions due to particular health and other crises but return to a lower level of need after a short time. We believe that the current system is unable to efficiently and effectively respond to such short term changes in a timely fashion. In other words, too often current systems fail to adequately respond to varying client needs.

As the so called 'Baby Boomers' reach retirement age, expectations for service provision will increase and this group will expect greater value for money, greater responsiveness and greater quality in the care being provided. Current expectations that most services will be provided at little or no cost to the retiree are probably unrealistic. We need to look for new ways to address needs and expectations. One example could be to consider removing the tax on superannuation when the withdrawal of these funds is specifically used for aged care services. Providing incentives through savings plans to make it attractive for people to put aside money for future aged care need should also be considered. There are probably many ways in which tax concessions could be used as an incentive for individual investment in care, and work should be done to investigate which options would provide greatest financial benefit.

RDNS is one of a number of organisations which have undertaken work recently on the provision of physical aids and healthcare products. In instances such as continence aids and some wound dressings, these products are able to be provided free or at a subsidised cost to clients. Some of these aids and products are very costly and where clients are required to pay for these themselves, the burden of cost on the individual can be significant. There are instances, for example, where the cost of best practice wound dressings for treatment of a chronic leg ulcer can potentially lead to the client compromising on other purchases in order to meet the cost of the best practice treatment, and this may include going without food, or cutting back on use of heating and cooling in order to cut the cost of power. Such situations can lead to further health and wellbeing issues. Clients may also choose lower quality treatment options in order to reduce the cost. This can lead to longer healing times, or indeed lack of healing altogether. Preliminary evidence from a study undertaken at RDNS shows that there are instances where government funding of best practice consumables and equipment can in fact result in a lower cost to government, as improved healing time results in shorter treatment periods, in addition to improved health and wellbeing for the individual client.

Service models

<u>New models of care are required that encourage independence for clients and integration between service providers.</u>

Currently service models are too often centred around what service providers can/will provide rather than what is required by the individual client. This must be addressed to improve client outcomes.

One of the problems with the current system is the large number of service providers. Whilst breadth of choice is sometimes seen as desirable, consolidation of providers can achieve a more flexible and dynamic service system through efficient economies of scale, better management of quality outcomes and more efficient staffing models.

The current large number of diverse providers in Australia makes it difficult and challenging for clients and their carers to navigate the system, and link with the providers who can best provide services needed for the specific individual. Although there are various services providing a centralised point of contact, clients and carers still find it difficult to navigate the aged care system. In Victoria much effort has been put into service coordination, as demonstrated by the development, through funding by the Victorian Department of Health, of the SCoTT documents and protocols, however the system remains complex and confusing for many in the community. Whilst it appears that work in Victoria has resulted in better service coordination, much more effort is required to produce the level of integration and team work required to meet quality and quantum demands in the future.

Many current programs encourage dependence on a service provider. Even HACC support and maintenance services, although aimed at maintaining independence in the home environment, often result in a level of 'dependent independence' through the restrictive nature of the funding available. All too often we see providers being funded to go to the home and undertake care *for* the client, not *with* the client, and with an in-built 'continuing care' expectation rather than a plan to 'regain independence'.

Early work on the benefits of models focussing on independence has been demonstrated through programs such as Home Independence Program (HIP) in Western Australia and the Active Service Model in Victoria, but these initiatives will only be effective if it is understood and accepted that a higher level of resource is required in the initial stages of service provision in order to work with the client to actively encourage the client to take control and build knowledge, confidence and competence in order to increase the true level of independence.

There are also various opportunities to introduce more technology into the aged care system, however many services and providers are not able to embrace such innovations at this time. Many small service providers have limited infrastructure, which exacerbates their capacity to capitalise on the benefits of available technology. From a client perspective, with the ageing of the Baby Boomers it will be possible to increase the role of technology for these clients, due to their greater proficiency and interest in new technologies in comparison with existing aged care clients. More needs to be done to identify how we can maximise the potential benefits from this opportunity.

The residential aged care and the broader community care sectors can learn from the development of Hospital in the Home (HITH) programs. Where possible, services should be brought into the facility or home of the client rather than taking the client out of the facility/home and into the likes of hospital. Providers such as RDNS already have specialist expertise to provide HITH care post-hospitalisation, and this could be extended to prevent the need for hospitalisation in the first place if funding for such services were available. With the ongoing challenge of managing hospital demand, programs to prevent potentially unnecessary presentations to hospital would benefit all elements of the health system. In addition to relieving pressures on hospital beds and

emergency departments, this also allows hospitals to focus on what they do best – acute care.

Another learning from the development of HITH is that such programs should build on existing infrastructure. There are many examples where hospitals, funded for HITH have then established their own HITH services, thereby duplicating the infrastructure and models of care already available in existing community based services, such as district nursing services. To optimise quality and efficiency, existing services should be supported rather than duplicated. It is therefore important that in establishing new programs, representatives from all key areas of the health system are engaged, i.e. recognising that managing hospital demand is not just the arena of hospital staff – the solution to managing hospital demand will be found, predominantly, in the community/home setting.

In looking to the future it is also important, of course, that early intervention and prevention are seen as crucial elements in reducing demand and burden of disease in the future. So aged care policy can not focus on current recipients alone, but needs to link in with policy and programs across all areas of health and wellbeing in order to reduce future burden and manage expectation across the entire population.

Workforce

Aged Care fails to attract the volume and quality of health professionals that it requires. Incentives must be introduced to attract and retain high calibre staff.

The workforce challenges facing the aged care industry have been well documented. Some strategies are already in place to mitigate, at least in part, the likely shortfall of practitioners in the future. Changes in scope of practice are already showing some benefits, through the endorsement of enrolled nurses for medication administration for example. There is a need to continue examining how we can best utilise available staffing resources whilst ensuring safe care is provided. This will require increased effort to provide interdisciplinary team-based care so that the most appropriate use of scarce health professional resources is achieved.

The aged care sector continues to suffer from an image problem within the undergraduate health professions. The most recent Commonwealth budget has introduced some positive measures to improve on this, such as funding for more clinical placements in aged care and the introduction of Graduate Nurse Programs in this area. It will be important to ensure that these are introduced in such a way as to provide a high standard and positive experience for these new entrants to the industry, to encourage them to remain in this vital sector. The standard of these programs needs to be comparable with that available in the acute sector in order to attract and retain high quality health professionals, otherwise we will see a continued draw of students and graduates to programs in the acute sector where they perceive greater opportunities. At present a view held by many nurses for example, is that unless their graduate year is undertaken in a tertiary facility (hospital) they will not have the same breadth of opportunities available as their career develops after this first year.

In this year's Commonwealth budget funding was introduced to encourage GPs to provide more services within residential aged care (RAC), and also funding was allocated through Medicare for practice nurses to increase their presence in RAC and

the broader community setting. There is no doubt that increasing services provided within RAC is a positive step, but we question why practice nursing, in particular, has been targeted. This is where the limitations of falling for the attraction of using only existing funding streams comes into play: Whilst other service providers such as district nursing services and other community based providers can already provide this service, the requirement of a provider number for Medicare restricts access to this funding and will inevitably lead to duplication of services.

Another issue with the new focus on practice nursing in the community setting is that existing community based providers, such as district nursing services, already have the infrastructure in place to ensure the safety of staff when working out in the community, i.e. out of the controlled environment of a general practice clinic, and can also ensure services are continued and able to adapt to changing needs and demands due to a larger pool of trained staff. Individual general practices will not be able to provide this same level of support – and it is already in place for other programs anyway!

Governance and Quality

The aged care sector requires a robust governance framework to ensure quality outcomes for clients, and to achieve this there must also be increased emphasis on evidence-based practice and research.

There is a high level of regulation already in place in residential aged care, but far less so in the community setting. The issue of governance and quality is an important one when dealing with high need, vulnerable populations such as exists in aged care. It is important however, that frameworks and systems are positive and consumer-focussed, if community based services are to be regulated in a similar manner to that currently applied to RAC, sufficient resources must be available to support and develop service providers rather than focussing on a system of accreditation based on sanctions and actions taken against non-compliant providers.

Once again the size of service organisations will play a part due to economies of scale. The investment required to ensure good governance and quality frameworks can often be more efficiently and effectively managed by larger organisations. Likewise, training and professional development are important elements in maintaining quality. This requires infrastructure and resources. Whilst organisational size does not of itself equate with efficiency and high quality, with a robust framework in place larger providers can potentially offer appropriate support and oversight to produce quality outcomes.

Quality practice must be underpinned by research and evidence. Currently there is a poor evidence base for many of the practices within aged care. A greater proportion of the total available funding for research must be allocated to aged care if we are to improve the quality, efficiency and effectiveness of aged care services in the future. A culture of clinical enquiry must also be fostered if the findings of research are to be translated into innovation and the pursuit of best practice.

There has been talk recently of moves to regulate personal care workers. There are pros and cons to this. There is of course already a certain level of self-regulation that occurs in organisations such as RDNS but such processes can be variable across the broader sector. Assuming that a primary aim of regulation is to protect the public, it becomes hard to question that it is anything but a good step. But the issue is more about the right

model - that is, to provide protection to aged care recipients without an inordinate financial and administrative burden for providers or individual practitioners.

In Conclusion

The current aged care system in Australia has a strong foundation, but if we are to meet forecasted increased demands, in terms of both quantum and quality, major reform is required. Community-based care centred on increasing and maintaining independence and well-being is pivotal to ensuring sustainability, not only of aged care but many other elements of Australian society, most notably the health system. Providing incentives to high calibre health professionals in order to retain them in aged care, and encouraging innovation and best practice will ensure we have the leadership required to provide improved client outcomes. Programs must be client-focussed and dynamic in order to meet the changing needs of clients and their families.