ROYAL DISTRICT NURSING SERVICE LIMITED – SUBMISSION IN REPONSE TO PRODUCTITY COMMISSION DRAFT REPORT – CARING *FOR OLDER AUSTRALIANS*

ABOUT RDNS

Royal District Nursing Service Limited (RDNS) is the largest and oldest provider of home nursing and health care in Australia, with services in Victoria, Tasmania, New South Wales and New Zealand. On any given day RDNS has over 9,000 clients in admitted status, with 70% of those clients over the age of 70 years. We have an in-depth understanding of how the current service system operates, the needs of older Australians, and the gaps.

SUMMARY OF RDNS FEEDBACK

We commend the Productivity Commission on its draft report *Caring for Older Australians*. We believe that this report picks up the key issues that need to be addressed if the aged care service system is to meet current and future challenges. We would welcome the opportunity to play an active role within the proposed implementation taskforce.

The key issues arising from the draft report that we believe need further consideration are:

1. **Pricing**: We believe the one-price approach could lead to cherry-picking of clients and those with more complex needs being left behind or lost in the system. RDNS strongly advocates liaison with providers and expert clinicians when setting the price structure. If the set price does not reflect the true cost of quality service delivery for a customer base in different geographies with different service requirements, it may have the opposite effect to what is intended. Customers may not be faced with a diverse group of quality providers with interesting and exciting service offerings – but a few providers offering the bare minimum.

2. **Choice**: As our population ages and our aged become more complex at the time they present for care, who will choose for those clients who cannot choose for themselves? What happens when client needs change and their provider is unable to meet this changed need?

3. **Implementation of the Gateway**: Consideration must be given to the capacity of the care system – consumers, providers, funders and regulators – to embrace the magnitude of change proposed, otherwise greater fragmentation and confusion for care recipients could result. We would recommend a staged implementation to trial new systems and procedures. The Commission also needs to consider who will be the default carer for clients who cannot get a provider to accept them.

4. **Policy and processes**: The development of policy and procedures is necessary for consistency across providers; managing assessment and re-assessment, and avoiding duplication. RDNS advocates funding providers for aged care research and evaluation.

5. **Workforce**: Aged care requires a competitive salary structure in order to meet the staffing demand in future years. Funding for both study leave and backfilling positions while study is undertaken is critical for supporting a skilled workforce.

6. **Governance**: More detail is needed on the role of the new agencies formed as part of this reform, such as defined reporting structures, and consideration as to any structural separation of the pricing authority from compliance and enforcement.

FEEDBACK IN DETAIL

We have provided feedback under the key recommendation areas outlined in the draft report.

A framework for assessing aged care

RDNS supports the emphasis being placed on independence, wellness, consumer-directed care and affordability. As the Commission has stated, there is an obvious need to also make the system easy to navigate and streamlined, and to assist informal carers who continue to perform a critical role within this system.

Our experience working in promoting wellness and restoration with the Active Service Model (within the Health and Community Care (HACC) program in conjunction with the Victorian Department of Health, and in New Zealand as a provider of Home Based Support Services) has shown that an active service model approach can delay and indeed reverse the level of care required. Initial figures from our work with Auckland District Health Board have indicated an increase in volume of discharges from care as a result of this approach, which has led to increased client independence, and larger numbers of clients graduating to a lower level of care need.

Key issues:

1. **RDNS believes that government will need to provide a universal operational definition of 'person-centred care', so that it can be implemented across all providers. Furthermore, mechanisms to test whether providers are achieving 'person-centred' care would also need to be established.**
2. **RDNS can foresee an issue when an individual client or carer's needs change. For example, what happens if the level of need increases beyond that available from the current provider but the client is keen to stay with the existing provider? Does need override client choice, and if so, who will make that decision?**

Paying for aged care

As the cost of health care rises, co-contribution is inevitable where capacity to contribute is evident. Australians should be able to draw on their assets to assist in funding their care. The introduction of a stop-loss is an important safety net. However, determining a single figure across Australia (e.g. $65,000), does not represent the same financial impost for <u>all</u> Australians as the cost of living can vary significantly between states, and within states. There is also no clarification on whether the stop-loss figure will include out-of-pocket expenses. Another issue is whether older Australians will accept the need to contribute financially to their care, and whether they will have a realistic understanding of the actual cost of care.

There has been much discussion about the potential different cost of 'efficient' care across state boundaries, and indeed within states on the basis of economies of scale, competitive workforce demand, and costs associated with geographic remoteness. The ability to block fund some services

where it is still seen as necessary will address this in part, but geographic location is only part of the challenge. Will ‘efficiency’ recognise the additional costs associated with value-added services to the system – such as services like specialist diabetes care, 24/7 availability? These value-added services come at a cost, and in some circumstances are critical to enable efficient, best practice service delivery and innovative technology. Australians will not receive best practice care if the cost of providing care is set purely on the basis of what care currently being provided ‘effectively’ costs. The system must be sufficiently resourced to remain contemporary, flexible and able to embrace positive change.

One of our biggest concerns is that in setting a consistent ‘efficient’ price there is a risk that complex clients who require more intensive care or those that are most vulnerable and in need of more care and assistance, are overlooked by service providers in favour of those clients who are simpler and more cost effective to service. Who will pick up this challenging group of clients? We suspect that unless there are specific measures in place, these clients will deteriorate and effectively require premature admission to the more costly environment of residential aged care or require frequent long stays in the acute hospital system, adding further to the hospital burden.

During the process of setting the price for services it will be vital that the Australian Aged Care Regulation Commission (AACRC) involves service providers and expert clinicians to ensure that a realistic price is set, and that processes are in place for re-evaluation of the cost to reflect the true cost of service delivery, otherwise the recent experience of residential aged care providers pulling out of the industry could be repeated. It is important that the price reflects a quality, person-centred model of care which embraces the overall health and wellbeing needs of the client through a restorative approach.

Pricing also needs to reflect the e-health reality of providers. As the push and the demand to move to a smarter e-health environment intensifies, providers will need to have the capacity and resources to increasingly function as ‘e-health providers’.

Being an e-health provider means having capacity to:

- Provide and monitor services using a variety of ICT technologies
- Collect and share (as required) client data where care is shared (key to integration)
- Skilling the workforce to understand and use ICT in the delivery of care
- Develop and implement appropriate privacy and security safeguards around the collection, storage and usage of data.

The move to an e-health environment will require significant investment in infrastructure and recurrent resources. Pricing needs to account for this factor to ensure that aged care providers are not left behind.

Key issues:

1. **Will the one price leave those clients requiring a higher level of care and assistance more vulnerable, as providers could overlook them in favour of others who are more cost-effective to service?**

2. **Involvement of service providers and expert clinicians when setting the pricing structure, and flexibility to allow for inclusion of value-added services.**

3. **Does the proposed stop-loss include all out-of-pocket medical expenses or relate purely to the cost of care?**

Care and support

RDNS supports the move to consistent intake and information provision as suggested through the establishment of the Australian Seniors Gateway Agency (ASGA). In 2005 we established a nurse led central intake process through our Customer Service Centre (CSC). The centralisation of calls and information into RDNS has had a number of benefits which include:

- Consistency of messaging and response across the organisation
- Centralised recording of patient information
- Better utilisation of RDNS resources (freeing up resources and sites; ability to draw upon a larger pool of resources)
- Flexibility of response
- Transparency and visibility – meaningful and organisation-wide KPIs which can be tracked and audited.

Each month the RDNS CSC receives over 19,000 calls and processes around 3,000 referrals. RDNS has also provided the Access Point service in Tasmania since February 2009, which services the whole state.

The establishment of the RDNS CSC was a multi-year project with staged implementation, allowing for modification and adjustments throughout the process. From our experience, we would suggest that the Gateway concept be piloted to allow for modifications to be easily adopted, rather than making changes regularly across the entire network of agencies.

We acknowledge that the Commission has not outlined in this report the detailed operations of the proposed Gateway. However, we feel that it is appropriate that we raise some concerns and questions that we believe are critical in order to achieve success with this recommendation.

It has been suggested the Gateway should function separately from service providers. In our experience with the Department of Veterans Affairs (DVA) Veterans' Home Care program, where RDNS is one of a panel of providers whilst also undertaking the ASGA-type function, we have shown that with appropriate tools, processes and measures in place to ensure equity of referrals across the panel of approved providers, this can be achieved without such separation.

The Commission outlines that one of the major issues in this area is the timeliness of assessments. Our concern with the proposed Gateway is the potential for delays in service provision both in terms of waiting lists for ASGA intake (due to capacity within the agency), and delay in providers

responding to referral of a client by ASGA. Recall and re-assessment arrangements are still undefined and therefore their impact on capacity must also be considered. Who will provide care in the interim if clients sit in the space between referral from ASGA and commencement of care by the referral recipient? In such a circumstance is it important that the Gateway organisation can provide interim care? If so, any intended separation between assessor and care provider will not be possible. It is acknowledged in the report that initial care coordination will be provided by the Gateway, but what if a suitable care provider is not initially available? How will the Gateway ensure timely assessment and referral, and timely receipt of care by the third party care provider?

The ever-changing needs of the client are also raised in the report as an issue that needs to be closely managed. The report does not outline how re-assessments will be managed, both for routine re-assessments and urgent re-assessments. Ensuring this is done in a timely manner is critical and time consuming. The Gateway will need to keep a close watch on those individuals with high-needs, with little/no informal care support as these maybe at risk of getting lost in the system. It is these individuals who will suffer if 'cherry picking' should occur amongst providers. What will become of those clients who are not connected with a provider - who will meet their needs? Will the Gateway agency become the 'default' provider, and if so will that agency be appropriately equipped to meet the client's need?

The Commission needs to consider how the mix of telephonic, internet, and face-to-face services will be met. Will each regional Gateway have caps on the proportion of each mode? As an organisation that commences initial assessment over the phone through our Customer Service Centre, we are acutely aware that the home environment described by the client over the phone can differ greatly from that experienced by our nurses when they attend the home to provide care. In addition, the client's level of functional capacity can also be very different to that described over the phone. Through our work in New Zealand we are aware of a great deal of bad press in the NZ media in the months after some District Health Boards switched to a system of conducting follow-up assessments by phone for older people receiving Home Based Support Services. Where these re-assessments resulted in a reduction or withdrawal of services the families of these individuals became very critical of the system due to the physical detachment of the service from their family member, and what they saw as an inaccurate determination of need due to the telephone-only contact. In many instances much extra information can be gleaned through observation of the client's physical environment, and physically checking their self-assessment of functional capacity.

The Commission has asked whether or not veterans and war widows/widowers should also be incorporated. It is a logical step to consider incorporating DVA assessment processes into the new Gateway regime if the proposed Gateway is for all Australians entering into the aged care sector or wishing to access services from the aged care sector.

If DVA were to be incorporated into the system, it would potentially decrease some of the compliance costs associated with running multiple programs and systems. The challenge for the Gateway and service providers, were DVA inclined to shift the program, would be managing the veterans' expectations, as our experience suggests that DVA recipients generally have very high expectations of the service they receive.

Key issues:

1. **Staged introduction of the Gateway.**
2. **Consideration should be given to the Gateway's mix of telephone, internet and face-to-face services to ensure an appropriate balance. What will be the triggers to flag a need to move from one mode of interview to another?**
3. **Incorporating streamlined processes and models of care in keeping with best practice, as the examples below illustrate:**
   - **In areas such as dementia care the notion of a 'key worker' approach is being advocated, whereby this worker supports the person from pre-diagnosis to palliation and end of life. Would such a role be maintained in this proposed model, and if so would that be the responsibility of the chosen provider?**
   - **Within Victoria much work has been done in the primary health care arena to improve service coordination across services, e.g. Service Coordination Tool Templates and their associated protocols developed by Primary Care Partnerships. Activities have also centred on trying to integrate acute services into these protocols. ASGA could draw upon this work.**

Catering for diversity – caring for special needs groups

Our experience tells us that the aged care population is extremely diverse in characteristics such as ethnicity, gender, socioeconomic status, living arrangements, sexual identity and so on. RDNS clients originate from 154 countries and speak 115 different languages. We are very aware that diversity characteristics can generate disadvantage and marginalisation if not addressed.

We are encouraged by the way the report acknowledges the broad diversity of the Australian population and diversity in preferences and expectations, and specifically identifies culturally and linguistically diverse (CALD), Indigenous, gay, lesbian, bisexual, transgender and intersex (GLBTI), Veterans, and socially disadvantaged groups. However, we would like to see these embedded more clearly within the policy framework, and within the recommendations themselves. It will be important to develop clear strategies to address these areas of potential disadvantage.

From a CALD perspective, RDNS considers itself a very culturally competent and responsive organisation. We use over 3,500 professional interpreters per year, have produced over 600 translated documents (service and health education brochures) and have implemented – through our Customer Service Centre – a unique automated telephone interpreter system for clients and carers to assist with communication and information. RDNS has committed to this investment , as it is vital to ensuring we meet needs of all our clients. We also use culturally appropriate diagnostic tools such as the Rowland Universal Dementia Assessment Scale (RUDAS) to screen for cognitive impairment and dementia.

Key issues:

1. **Inclusion of special needs clients in policy framework.**
2. **Need to build additional costs associated with meeting special needs into funding/pricing. For example, interpreter services are an additional cost, and the conversation also takes twice as long.**

Delivering care to the aged – workforce issues

We support the Productivity Commission in acknowledging the disparity in pay rates between aged care and acute health services. This remains problematic and, while this situation continues, there will still be problems with recruitment. We support the work being done by Health Workforce Australia in establishing the Clinical Placement Networks across the country, but more needs to be done to provide undergraduates with positive and challenging placements within the aged care arena during their education to increase the appeal of aged care as a career when they graduate.

We believe more options and financial support for further education in the aged care sector are imperative. Without this, the sector will continue to miss out on an adequate proportion of high academic achievers. Financial support should not just be provided through study grants, but with the relatively small staffing complement in many aged care services, there must also be money for backfill as without this many providers will be unable to free staff to undertake study leave, and will therefore be stifled in their ability to support and retain a skilled workforce.

The input of informal or family carers is often under-valued, so it is encouraging to see emphasis being placed on meeting the needs of such carers. The impact of the full-time role of caring can have considerable effect on the health and wellbeing of the individual. There are often significant financial implications that further compound the problem, whether associated with the necessity to cease paid employment to increase the caring role, or the out-of-pocket costs associated with the client's various treatments. The government should look at the benefit that could be achieved through a 'return-to-work' program for those who have finished the full-time carer role but due to extended leave from the workforce find it difficult to acquire suitable employment due to the period of absence. Assistance of this nature would provide a significant incentive to these individuals whilst potentially assisting with some of the workforce challenges facing Australia in the future.

Key issues:

1. **A competitive salary structure is vital for aged care so that it can compete for quality staff with the acute care sector.**
2. **More support for both study leave and backfilling of positions during study leave.**
3. **Consider return to work programs for full-time carers when they are looking to get back into employment.**

Regulation – the future direction

The four functional areas – compliance and enforcement; pricing; information collection and dissemination; and complaint handling and review – outlined for the Australian Aged Care Regulation Commission (AACRC) are essential for the new-look aged care system. Can all four of these functions sit comfortably within one organisation or, to avoid any potential conflict, should, for example, compliance and enforcement be separate to the pricing authority? Furthermore, there is no detail on the reporting structures for the AACRC, and whether it is responsible for regulating the proposed Gateway.

Regulation must reduce the current burden imposed on many aged care providers, particularly those who currently receive funding from many different sources. It is important that the system of regulation is a supportive one which facilitates opportunities for providers to comply and continuously improve, and one which recognises innovation and excellence, ensuring that improvements are shared and built into the framework. Providers will be keen to see that it is not just an exercise in replacing one set of regulations with another.

As well as sharing and celebrating what is good about the system, there is also necessity to deal with those that fail to meet the standards required. Where non-compliance has been identified through the audit process, in reporting such breaches it is important that the response from the non-compliant agency is also made apparent. Media reports of breaches in residential aged care do not often provide such balance, and in a situation where the client/carer will be making decisions regarding potential care providers, it is important that they have access to both perspectives in such circumstances.

Key issues:

1. **Who will the AACRC report to?**
2. **Will the AACRC be responsible for regulating the proposed Gateway**?
3. **Is there any conflict with one organisation managing both pricing, and compliance and enforcement**?

Aged care policy research and evaluation

As we indicated in our previous submission, we believe that greater emphasis – and grant funding – must be provided to aged care policy and evaluation, so that high quality service delivery and innovation can be fostered. The impact that improved community care can have on demand for more expensive acute care, particularly when dealing with older people with multiple chronic diseases, makes a strong case for the need for a larger proportion of research moneys to be invested in this area.

As a large provider, RDNS is frequently requested to contribute to government policy directions, law reform commissions and expert advisory groups. None of this activity would be possible without the provision of funding at a level that enables staff the time to research and participate. There is a real risk that without contributions by providers such as RDNS, changes arising from the activities of

groups such as the Law Reform Commission may not meet the community needs because key stakeholders have not been actively involved.

Large amounts of data are collected, and it is important that this valuable information is used effectively to advance our knowledge and understanding of the aged care area.

Key issue:

1. **Consideration of funding providers for contributions to external policy and evaluation processes.**

CONCLUSION

We believe the changes outlined in the draft report should lead to significant reform and overall improvement in the care of older Australians. At this present time of major change in health, aged care and disability it will be important to ensure that reforms are linked and staged so that changes in one arena align with those happening in other areas of the care continuum.

Consideration must be given to the capacity of the care system – consumers, providers, funders and regulators – to embrace the magnitude of change proposed in the space of time proposed, otherwise greater fragmentation and confusion for care recipients could result.

Our major concern in the area of pricing is whether it is possible to set a single price that reflects the true cost of quality service delivery for a diverse customer base in different parts of the country with different requirements. We do not wish to see any client left behind.

We also view the move to a customer-centric model with more consumer choice positively, but are concerned about how consumers and potential consumers will find out about various providers, and who will choose for those clients that can't choose for themselves.

We have found that our centralised entry point with the Customer Service Centre has helped clients access services and ensure a co-ordinated approach. Our concern with the implementation of the Gateway would be coping with workload, ensuring it does not add extra time to the assessment and re-assessment process, and the issue of who cares for clients who can't find a provider to accept them. We would like to see a piloted and staged implementation of the Gateway to ensure the systems and processes are in place and have been tested before a nation-wide rollout takes place.

We believe that the draft report is a significant first step in improving the service system, and would welcome the opportunity to play an active role within the proposed implementation taskforce.

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