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Towards an Aged Care Pricing Framework

AMA submission to the Independent Health and Aged Care Pricing Authority Consultation

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The AMA welcomes the consultation by the Independent Health and Aged Care Pricing Authority (IHACPA). The funding reforms in the aged care sector are long overdue and the AMA hopes that this consultation will contribute to the improvement of funding and service provision in residential aged care, leading to improved health and wellbeing outcomes for older people who receive these services.

From the AMA perspective the key issues in designing and implementing an adequate funding model will be:

- the aged care assessments under the new model and how and by whom they are conducted,
- flexibility of the funding model and how it will enable and support innovation,
- how it will allow for funding of other activities that do not fall under direct care but are important to ensure quality care (e.g. Medication Advisory Committees, clinical advisory committees and similar), and
- its continued evaluation to ensure the best outcomes for older people.

A new funding approach for residential aged care

The AMA has been supportive of the new AN-ACC funding model since it was first developed and proposed in 2019, primarily due to the rigorous research that lies behind it, including the recent commissioning of IHACPA to conduct costing studies to support the future refinement of aged care pricing. The AMA welcomes the plan for a more comprehensive costing study planned for late 2022 that aims to collect cost data from a broader range of facilities. This will be important as aged care facilities differ across the country in their size, type of services they provide and resident mix. In addition, geographic location can be an important determinant of the cost/price of service provision. This type of approach creates the potential to develop best practice models of care for each case mix/class.

The main challenges the AMA sees with using AN-ACC to support ABF in residential aged care will be with the data collection, particularly pertaining to staffing and staffing costs that allow for

adequate provision of care. This must include adequate resources to meet the clinical care requirements for health needs of residents.

According to a study conducted by the Royal Commission into Aged Care Quality and Safety, only around 15 per cent of aged care facilities had the staffing levels that provided good quality care, including a registered nurse on site 24/7.[1] The AMA is aware of the legislative changes that will ensure improved staffing levels from October 2023 and registered nurse on site 24/7 from 2024, however this means that the studies that are done in the meantime to inform the ABF may not provide adequate information. Furthermore, future reforms pertaining to minimum qualifications of personal care workers will require consideration of increased wages in the aged care sector, all of which are not applied currently.

The AMA also argues that factoring the cost of training into funding should be applied to residential aged care in the same way it is for public hospitals. While in the future staff may be required to meet minimum qualifications to work in the sector, the importance of on-the-job training remains high. One illustrative example would be the use of personal protective equipment and infection prevention and control in residential aged care. The relevance of this type of training has been demonstrated throughout the ongoing COVID-19 crisis in aged care.

The AMA is supportive of the AN-ACC NWAU components and formulas, but warns that no matter how robust a funding formula is, if the price paid per activity is too low, or not adjusted to staff wages growth or insufficiently indexed, the funding model cannot generate high quality care and positive resident outcomes. Locking in a fundamentally low NWAU initially with a slow annual growth rate may result in NWAU never reflecting the actual cost of care and never meeting demand. Aged care, like hospitals, needs to be efficient and effective.

The quality of care in residential aged care, as thoroughly demonstrated by the Aged Care Royal Commission, has been compromised by staff shortages and high staff turnover. The aim of the new funding model should be not just to ensure efficiency but also to improve the quality of care and quality of life of aged care residents. Improving quality of care, primarily clinical care, in residential aged care should lead to reduced numbers of hospital transfers and reliance of public hospitals to pick up the cost of inadequate clinical care on site.

Principles for activity-based funding in aged care

The AMA is broadly supportive of the principles for ABF in aged care, both across system design and processes.

However, as with our position on hospital pricing, the AMA believes that efficiency should not trump all other principles. In addition, efficiency in aged care should be balanced against sustainability of not just the aged care system, but also the public hospital system. Having a good quality, appropriately funded aged care system should result in reduced reliance of aged care providers and recipients on the public hospital system through improved clinical care in the residential aged care setting where appropriate. By 2035 Australia is projected to have over one

[1] https://agedcare.royalcommission.gov.au/sites/default/files/2019-12/research-paper-1.pdf

million of people over the age of 85.[2] According to the data, 53 per cent of admissions into residential aged care in 2020-21 were for people over 85,[3] with residents over the age of 85 making up 59 per cent of all aged care residents.[4] Our public hospital system at the moment is not equipped to deal with the future growth in demand created by the ageing population. Therefore, the AMA argues that residential aged care must be set up in a way that will ensure not just the sustainability of our aged care system, but also of the Australia's public hospital system.

The AMA agrees with the idea put forward in the consultation paper that the effects of incentives built into ABF will be stronger when providers understand them well. As IHACPA would be well aware, the capabilities of aged care providers across the country vary considerably. The new funding model may present a significant challenge to many of them, in terms of understanding and adapting to the new model. Therefore, the principles of administrative ease and stability will be fundamental to providers adapting to the new model.

Developing aged care pricing advice

The AMA is supportive of the pricing approach proposed in the Consultation Paper. As discussed in the paper, the quality of service provision and capability of individual providers to adapt to the new model will vary, and in many aspects is not even comparable with the public hospital system. Therefore, an approach that allows for prices to be set at a level that enables the required care standard to be met is welcomed by the AMA.

As outlined previously, factoring in the uplifts in care minutes and quality levels into the cost of care will be crucial. The 'best practice' approach must take into consideration not just the minutes of care defined under the new staffing ratios, but also the upskilling of the workforce, continuity of care – knowing that the continuity of care contributes to improved health outcomes,[5] and on-the-job training (such as infection prevention and control or improving English language proficiency of staff for example).

The AMA's main concern with the new proposed funding model pertains to the potential effect it may have on the quality of services in those facilities that are already providing high quality care. The previously referenced Aged Care Royal Commission's research into staffing levels and star rating of aged care facilities found that around 15 per cent (15.4) of all aged care facilities provided service that would fall under the 5-star category.[6] With the new funding model, there is the potential that those aged care services may be negatively impacted. Therefore, the recommended residential aged care price must be such that enables and upholds the best practice model, and allows for those providers who provide lower quality care, to be brought to the level of best performers.

Adjustments to the recommended price

[2] https://treasury.gov.au/sites/default/files/2019-03/IGR_2010_Overview.pdf
[3] https://www.gen-agedcaredata.gov.au/Topics/Admissions-into-aged-care
[4] https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care
[5] https://www.scielosp.org/article/rsp/2014.v48n2/357-365/en/
[6] https://agedcare.royalcommission.gov.au/sites/default/files/2019-12/research-paper-1.pdf

The AMA is generally supportive of the approach for recommended price adjustments as outlined in the consultation paper, where the characteristics of the person receiving care are given preference over the facility related adjustments. However, and as explained previously, in this period of significant aged care reform and improving the standard of care across the sector, facility related adjustments should be given due consideration.

The AMA is supportive of the proposed adjustment for location and costs due to provider structure. Currently, the AMA cannot see any additional adjustments for unavoidable facility factors.

Regarding adjustments for safety and quality, the AMA would welcome further IHACPA work in this space, to inform any long-term planning. It is the AMA position that sentinel events and preventable hospital complications should be as low as possible, but we disagree that funding penalties are an effective way of achieving their reduction in public hospitals. We maintain this position in relation to residential aged care.

With the growing, ageing population living with multiple chronic health conditions, the reduction in sentinel events will only be possible with better funded and better supported primary care and care in the community. While aged care homes have responsibilities to their residents in terms of clinical care, the AMA fails to see any significant strategy implemented by the Government that will address improving access to primary care for aged care residents. Without appropriately funded primary care enabling regular access to GPs for residents of aged care facilities, and without direct involvement of GPs in residents' healthcare planning, we will continue to witness poor health outcomes for older people living in residential aged care.

The reliance of aged care homes on public hospital emergency departments and hospitals to pick up patients who are not receiving adequate clinical care in-home remains high. A long-term planning strategy by IHACPA could investigate how the two systems interact and how and where aged care homes are failing in provision of care that leads to hospital transfers. However, the aim of any such strategy should not be to financially penalise aged care providers but rather to identify best practice and how to support improvement in aged care homes that are failing their residents. Again, without improvements in primary care provision and access to GPs in residential aged care, some of these problems will not be fixed, and aged care providers have no influence over the broader Government's GP policy. Therefore, they should not be financially penalised for its failings.

Priorities for future developments

Hotel costs should not be incorporated into the AN-ACC funding model. If they are, the aged care providers should be required to report on that expenditure and show that the funding was actually used for hotel services.

Regarding further IHACPA work on exploring the appropriateness of the AN-ACC model to support its use in multipurpose aged care services in rural and regional areas, the AMA believes that this will require further consideration by Health Ministers, so as to ensure that any change to the

funding model ensures continuity and sustainability of these services, that are already stretched to the limit and many of which are struggling.

It is essential that government policy and resources are tailored and targeted to cater to the unique nature of rural health care and the diverse needs of rural and remote communities to ensure they receive timely, comprehensive, and quality health care.

AMA members argue that there should be at least one residential aged care facility in every rural town that has a hospital facility. Sometimes these will be multipurpose services, and other times they will be standalone facilities, dependent upon local circumstances. Such an arrangement would prevent older people from being transferred to other towns and communities. These transfers result in less frequency of visits by family members and friends due to distance and cost, which can lead to withdrawal, depressive symptoms and behavioural disturbances in older people. Therefore the sustainability of aged care services, including multi-purpose services, in rural areas services remains crucial.

The AMA is aware of the issues multipurpose services were faced with previously when required to meet the Federal Government requirements for service accreditation, when the new Aged Care Quality Standards were introduced in recent years. The multipurpose services were in need of supports and training to adequately implement the new standards, though this support was not received.[7] It will therefore be critical that when and if they are required to adapt to the new funding model, they are provided with all the relevant supports they may need.

The AMA is supportive of a costing study by IHACPA that that includes residential respite. The key consideration should be the assessment conducted for funding purposes, how quickly they can be deployed, and the sustainability of the provision of respite services. Providers should not be disadvantaged or opt out of providing these services because the funding model impacts their sustainability.

The AMA welcomes IHACPA work on developing a five-year vision to guide sustainable forward looking funding reform of aged care. We look forward to contributing to that consultation in the future.

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7 https://www.ama.com.au/sites/default/files/documents/AMA_submission_to_the_Royal_Commission_into_Aged_Care_Quality_and_Safety_FINAL.pdf