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Ms Joanne Fitzgerald
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Independent Health and Aged Care Pricing Authority (IHACPA) Aged Care Towards a Pricing Framework Consultation Paper

Dear Ms Fitzgerald

Thank you for the opportunity to respond to the Independent Health and Aged Care Pricing Authority (IHACPA) Aged Care Towards a Pricing Framework Consultation Paper.

We write in our capacity as researchers at the Australian National University. Natalie Bryant is a Sir Roland Wilson Pat Turner PhD Scholar and a Yuin woman from the South Coast of New South Wales. Her doctoral research investigates Australian health system structures in the context of race and self-determination. Dr Francis Markham is a non-Indigenous scholar whose research and teaching focuses on a range of Indigenous public policy issues, including administrative and funding arrangements.

The response to the Consultation Paper broadly addresses how Aboriginal and Torres Strait Islander Australians will be impacted by the change to an activity based funding approach to aged care funding.

Whilst it is acknowledged that the role of IHACPA is relatively narrow in terms of providing advice in relation to aged care pricing matters it is important to consider the broader impact these decisions have on Aboriginal and Torres Strait Islander Australians.

There is an opportunity for IHACPA to prevent the further marginalisation of Aboriginal and Torres Strait Islander Australians by ensuring that they have a role in the development and implementation of policies that affect them.

The challenges for Aboriginal and Torres Strait Islander Australians

It is well understood that Aboriginal and Torres Strait Islander Australians do not have the same life expectancy as non-Indigenous Australians. There was approximately eight years difference in the life expectancy of an Aboriginal and Torres Strait Islander Australian compared to non-Indigenous Australians when this was last measured using data collected between 2015 and 2017. Death registration data from 2016-2021 suggests that this gap may be widening, with Indigenous standardized death rates increasing from 9.0 to 9.9 per 1,000, while non-Indigenous standardized death rates have fallen from 5.4 to 5.0 per 1,000.[1] A lack of culturally appropriate health care across the life course contributes to this life expectancy gap.

While there is a significant discrepancy in life expectancy there is an increasing proportion of Aboriginal and Torres Strait Islander Australians in the older age categories. Over the decade from 2011 to 2021, the estimated number of Aboriginal and Torres Strait Islander people aged 65 years or older rose from 29,700[2] to 53,300 in 2021.[3] In plain quantitative terms, the demand for aged care from Aboriginal and Torres Strait Islander people is growing incredibly rapidly.

Many Aboriginal and Torres Strait Islander people also require services that are tailored to their particular needs and preferences. As has been noted for many years, "due to their poorer health status and higher levels of socioeconomic disadvantage, Aboriginal and Torres Strait Islander elders have health care and support needs that differ from those of other older Australians."[4] Models of care need to recognise and support Indigenous practices and values associated with caregiving.[5] As a result the need for culturally appropriate aged care is becoming increasingly important.

There are many challenges for Aboriginal and Torres Strait Islander Australians in the aged care system. This includes, but is not limited to:

- Navigation of the My Aged Care system
- Culturally appropriate assessment

[1] Australian Bureau of Statistics (2022). Deaths, 2021. https://www.abs.gov.au/statistics/people/population/deaths-australia/latest-release
[2] Australian Bureau of Statistics (2013). Estimates of Aboriginal and Torres Strait Islander Australians, June 2011. https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3238.0.55.001June%202011?OpenDocument
[3] Australian Bureau of Statistics (2022). Estimates of Aboriginal and Torres Strait Islander Australians. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release#age-and-sex-structure
[4] House Standing Committee on Aboriginal Affairs. "Effectiveness of Existing Health Care Programs and the Adequacy of Western European-Type Health Services." Australian Government Publishing Service, 1979, 113.
[5] The models of care appropriate to Indigenous non-residential care are likely to be transferable to a considerable degree to the age care sector. See Puszka, S., Walsh, C., Markham, F., Barney, J., Yap, M., & Dreise, T. (2022). Community-based social care models for indigenous people with disability: A scoping review of scholarly and policy literature. *Health & Social Care in the Community*.

- A lack of culturally safe aged care services
- Geographic barriers

Many of the challenges facing Aboriginal and Torres Strait Islander Australians are a result of the contemporary impacts of colonialism which continues to be felt by Aboriginal and Torres Strait Islander people today. These include generational trauma, institutional racism and lack of access to basic health services across the life course. These challenges extend to the aged care sector.

It has been identified in the hospital costing and pricing framework that there is an additional cost to providing care to Aboriginal and Torres Strait Islander Australians within the public hospital system. It is not unreasonable to suggest that this additional cost will be evident in other care settings. Despite this recognition, Aboriginal and Torres Strait Islander Australians have been rendered invisible in many of the policy decisions in the past. This includes the policy changes that have occurred in public hospitals in relation to activity based funding. It would be a mistake to carry forward this past erasure into the future activity based funding model for aged care.

The importance of having Aboriginal and Torres Strait Islander Australians front and centre in the policy framework

The National Health Reform Agreement (NHRA) has been described as the structural source if institutional racism in the health and hospital services.[6] A significant reason for this is the invisibility of Aboriginal and Torres Strait Islanders in the NHRA and the subsequent policy documents developed by the (then) Independent Hospital Pricing Authority. This includes the Pricing Framework for Australian Public Hospitals in which the only reference to Aboriginal and Torres Strait Islander Australians relates to them being an unavoidable cost to the system therefore requiring a pricing adjustment.[7]

While there may not be any ill-intent behind the invisibility of Aboriginal and Torres Strait Islander Australians, it risks embedding an existing issue —the under-servicing of Aboriginal and Torres Strait Islander Australians — into the federal funding framework. It does not consider the unmet health need of Aboriginal and Torres Strait Islander Australians estimated to be approx. $4.4 billion per year by the National Aboriginal Community Controlled Health Organisation (NACCHO).[8]

[6] Marrie, Adrian. "Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospitals and Health Services: Report to Commissioner Kevin Cocks AM." Submission. Bukal Consultancy Services, 2017, 2010.
[7] Independent Health and Aged Care Pricing Authority. "Pricing Framework for Australian Public Hospital Services 2022–23," 19
[8] National Aboriginal Community Controlled Health Organisation, and Equity Economics. "Measuring the Gap in Health Expenditure: Aboriginal and Torres Strait Islander Australians," May 2022, 3.

It is important to reflect on the impact of the policy framework for pricing of public hospital services. This is because it appears that the overarching pricing principles of the new framework are broadly reflective of the overarching pricing principles applied in the pricing framework for public hospitals. This perpetuates an existing issue of rendering Aboriginal and Torres Strait Islander Australians invisible in policy.

In the hospital funding model, the only reference to Aboriginal and Torres Strait Islander Australians relates to the application of an adjustment to address variation in costs. This is based on historic cost but does not address the issues of unmet need and underservicing. The under-servicing and unmet needs of Aboriginal and Torres Strait Islander people is unlikely to be achieved without additional expenditure above-and-beyond the current per-episode costs of care. Additional resourcing will be required to address unmet needs, and accordingly a funding system that locks in current costs provides no basis for going beyond the status quo to achieve Indigenous health equity.

The proposed new model also does not incorporate any accountability measures in relation to where the additional funding associated with Aboriginal and Torres Strait Islander Australians is spent. It is unclear whether funding allocated through an Indigenous adjustment is spent on Indigenous people. Do these funds go towards programs for Aboriginal and Torres Strait Islander Australians or to improve the cultural safety of mainstream services, or do they simply go into a global budget?

To replicate this existing injustice and once again render Aboriginal and Torres Strait Islander Australians invisible in relation to the policy framework for aged care pricing would be unconscionable.

Furthermore, the National Agreement on Closing the Gap, agreed to by all Australian Governments and by the Coalition of Peaks[9] commits all Governments to a 'full and genuine partnership' when it comes 'policy making that impacts on the lives of Aboriginal and Torres Strait Islander people'.[10] It is undeniable that the proposed policy framework will affect Aboriginal and Torres Strait Islander people. As such, it is incumbent on IHACPA to involve Aboriginal and Torres Strait Islander people in developing the new model and overseeing its implementation.

IHACPA has an opportunity to prevent this issue from occurring again by ensuring that Aboriginal and Torres Strait Islander Australians are engaged in a partnership to develop the policy framework that determines the funding model for aged care services. At a minimum the Aged Care Pricing Framework should reference and reflect on how it will meet the policy goals of the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* and the *Closing the Gap Agreement 2020–2025* including the four Priority Reform Areas. It is noted

[9] An alliance comprised of over 80 Aboriginal and Torres Strait Islander community-controlled peak and member organisations across Australia. See https://coalitionofpeaks.org.au

[10] Australian Governments and the Coalition of Peaks (2020). National Agreement on Closing the Gap. Article 18.

that neither of these major health policies are referenced in the Towards an Aged Care Pricing Framework Consultation Paper.

Without pre-empting the outcome of such a partnership, it would be preferable that the new model to have an overarching principle that speaks to Indigenous equity. This should consider equity of access as well as equity of outcomes. It should go beyond equity as a financial concept.

The pricing model

There are some more specific technical difficulties with the proposed pricing model that also need to be addressed. The existing Australian National Aged Care Classification (AN-ACC) model is based on a very small sample size therefore is possibly misrepresenting the diversity of care provided to Aboriginal and Torres Strait Islander Australians. This relates to both location and type of service.

There were only eight services of 89 that were considered to be providers of specialised Indigenous care, all of which were in remote locations.[11]

Around 81% of Aboriginal and Torres Strait Islander Australians live in cities and regional centres.[12] As with primary care services, it is more likely that urban Aboriginal and Torres Strait Islander Australians will access mainstream services due to limited options. The Aged Care Diversity Framework stated that "most (78%) Aboriginal and Torres Strait Islander older people accessing residential care do so through mainstream organisations, as this is the typically the only option in major cities".[13]

Accordingly, by including an adjustment to the base care tariff associated with specialised Indigenous services and remote services (MMM 6-7), the proposed model does not appear to consider urban Aboriginal and Torres Strait Islander Australians. There is a risk that the proposed funding model will not reflect the cost of services provided to Aboriginal and Torres Strait Islander Australians broadly. By failing to accommodate the additional funding required to meet the often unmet needs of Aboriginal and Torres Strait Islander people, it may lock in under-funding of these needs. This would perpetuate the under-servicing of Aboriginal and Torres Strait Islander Australians as well as embed culturally unsafe practices.

[11] McNamee, Jennifer P.; Kobel, Conrad; and Rankin, Nicole M., "Structural and individual costs of residential aged care services in Australia. The Resource Utilisation and Classification Study: Report 3" (2019). Australian Health Services Research Institute. 928, 15.
[12] Authors' preliminary analysis of the 2021 Census and Estimated Residential Population estimates, using 2016 Remoteness boundaries as the official 2021 remoteness structure is yet to be released by the ABS at the time of writing.
[13]Aged Care Sector Committee Diversity Sub-group. "Aged Care Diversity Framework: Aboriginal and Torres Strait Islander Consultation Report," December 2017, 17 as accessed on the Royal Commission into Aged Care Quality and Safety submissions.

The importance of including Aboriginal and Torres Strait Islander Australians in governance structures

It is vital to ensure that there is Aboriginal and Torres Strait Islander representation in the new models governance structures.

IHACPA should ensure that Aboriginal and Torres Strait Islander service providers and peak bodies such as the National Aboriginal and Torres Strait Islander Aging and Aged Care Council Limited, Institute for Urban Indigenous Health and the National Aboriginal Community Controlled Health Organisation are included. A broad net should be cast to ensure that there is inclusion of researchers and other organisations involved in the research of and delivery of aged care services to Aboriginal and Torres Strait Islander Australians.

There does not appear to be any Aboriginal and/or Torres Strait Islander Australian representation of the broader IHACPA committees including the Pricing Authority, Clinical Advisory Committee or Stakeholder Advisory Committee. The lack of representation further embeds the invisibility of Aboriginal and Torres Strait Islander Australians in key policy decisions regarding health care.

The Closing the Gap Priority Reform Three relates to addressing racism in mainstream public services. If there are no Aboriginal and/or Torres Strait Islander voices in the vast committee structure of IHACPA then these issues are likely to remain invisible. Aboriginal and Torres Strait Islander interests need to be engaged as full partners in the development, implementation and monitoring of the new framework.

Regards

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