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Dear Mr Tune

RE: Consultation paper on the Pricing Framework for Australian Residential Aged Care Services 2024 - 25

Thank you for the opportunity to provide comment on the Independent Health and Aged Care Pricing Authority (IHACPA) *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25* (the consultation paper).

Although NT Health is not a provider of residential aged care in the NT there is a clear interest in ensuring older Territorians receive access to safe and high-quality aged care services. NT Health has a keen interest in ensuring the new funding meets the needs of people residing in the NT.

There are unique challenges in the NT in the delivery of health and aged care services. This includes vast geographical distances, high rates of social disadvantage, chronic conditions, and reduced life expectancy. These challenges need to be reflected in the aged care pricing model to ensure equitable access through service delivery costs being accurately reflected.

NT Health's submission is at Attachment A and provides background and feedback on these issues.

Kind regards

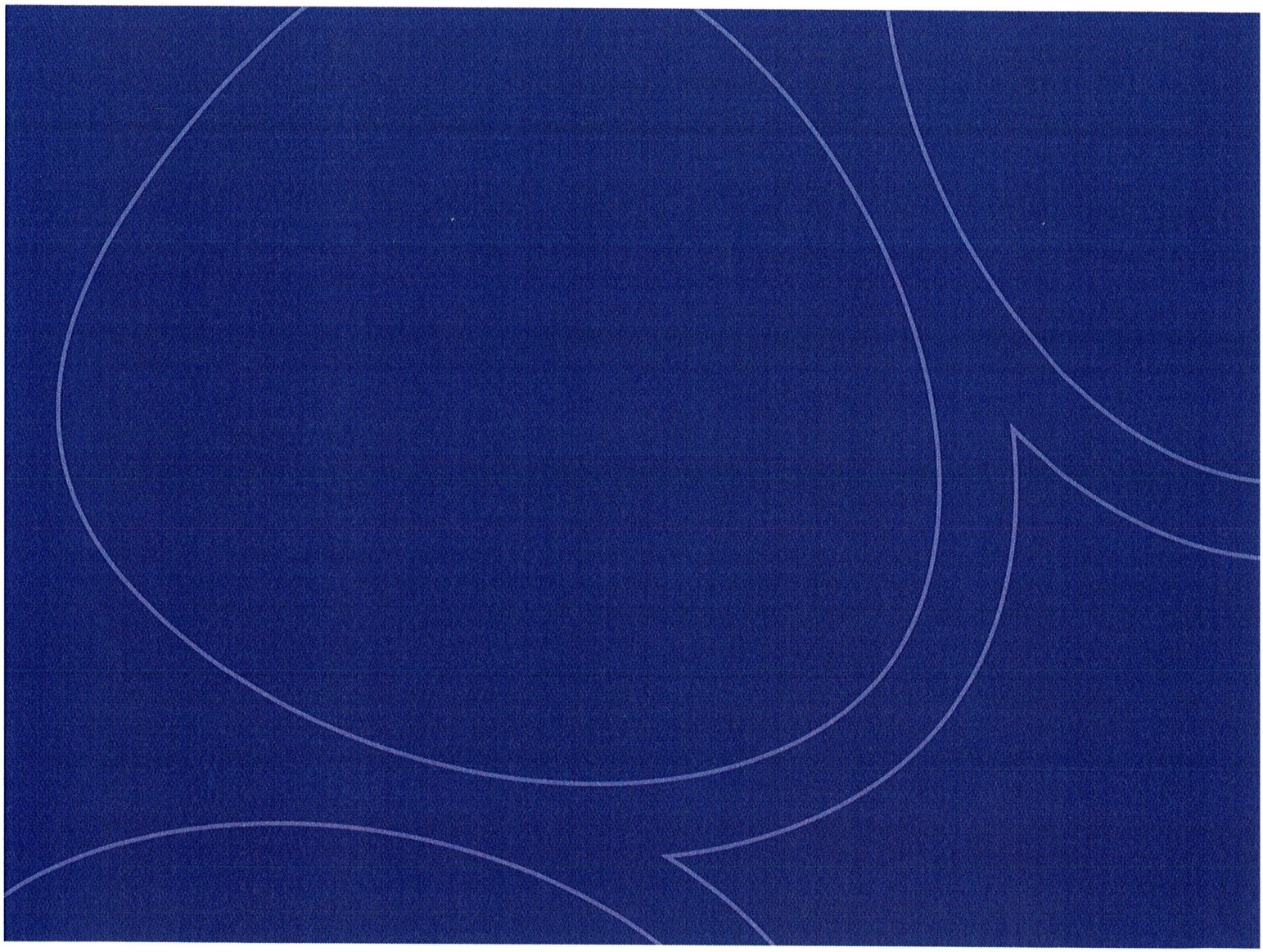
Natasha

NATASHA FYLES

29 AUG 2023

NORTHERN TERRITORY GOVERNMENT

Consultation Paper on the Pricing Framework for Residential Aged Care Services 2024 -25



NORTHERN TERRITORY GOVERNMENT

Foreward

This submission provides feedback on issues highlighted in the Independent Health and Aged Care Pricing Authority's (IHACPA) *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25*, particularly where there may be potential impacts to the financial stability of the Northern Territory (NT) health system resulting from interface issues between health and aged care systems and aged care policy and funding settings in the NT.

Introduction

NT Health supports aged care costing that is consistent and efficient, based on evidence and impartial advice, to ensure equitable aged care services are provided across Australia. While system efficiency is important, also providing person-centred care needs for the individual is essential. The changing and adapting pricing models need flexibility to be adjusted in relation to cost changes, care delivery models and cost structures.

NT Health residents across all regions should be able to access safe and high quality residential aged care services. NT Health is eager to ensure pricing meets the needs of all Territorians.

Compared to the rest of Australia, the NT has a young population. However, the number of Territorians over 65 is projected to increase from around 20,000 in 2021 to around 35,000 in 2041 (NT Treasury 2020). The NT is now Australia's fastest ageing population. With a larger number of older Territorians requiring care, the cost of care will rise as the sector adapts to this rapid growth.

NT Health are not providers of residential aged care, and all residential aged care in the NT is operated by non-government providers. On 30 June 2021 there were 559 operational residential aged care places in the NT. Nationally the total operational residential aged care places exceed 250,000. The NT comprises 1% of the Australian population but has less than 0.2% of residential aged care places. The NT's small population, lack of economy of scale and vast geographical area creates considerable barriers to achieving an efficient price in the delivery of aged care.

Older people live in the major urban centres of Darwin, Alice Springs, Katherine, Tennant Creek and Nhulunbuy as well as remote locations; 70% of people who live remotely are Aboriginal and reside in one of 600 communities and remote outstations. There are significant barriers to accessing hospital and specialist clinical services in these areas. In urban locations there is a greater need to meet aged care service demand for people who are homeless or at risk of homelessness; culturally and linguistically diverse populations; and non-Aboriginal males. Contrary to the national trend, the NT is the only jurisdiction with more men than women in the >65 age cohort.

Aboriginal Territorians

Aboriginal people in the NT experience high rates of social disadvantage, poverty and low levels of health literacy; these factors contribute to higher rates of poor health and mortality compared to non-Aboriginal people. Chronic conditions are estimated to contribute to 77% of the life expectancy gap between Aboriginal and non-Aboriginal populations.

Aboriginal people are more likely to require aged care earlier in life than non-Aboriginal people. In recognition of this, Aboriginal people aged from 50 years and over can access Commonwealth aged care programs.

The longer-term care and management of older Aboriginal people is an increasing challenge. With the ageing population and improvements in life expectancy, there is also significant growth projected in the older Aboriginal age groups. By 2041 the proportion of Aboriginal people in the older age groups is projected to nearly triple, increasing from 3.1% to 8.7%. It is estimated that the dementia prevalence in

Aboriginal and Torres Straight Islanders is 3-5 times higher than rates Australia wide. This presents additional challenges for a range of services including dementia care, aged care, opportunities to age 'on country' and access to palliative care services.

Many of our remote aged care services are National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) places provided by private providers. This program is currently working well to support the needs of Aboriginal people in remote communities. Home Care Packages and Community Home Support Packages are often provided by local councils in remote areas. There were 146 operational NATSIFACP places at 30 June 2020. In 2019 the NT accounted for 461 of the 1,072 national NATSIFACP places, 156 of these places were for residential aged care.

NT Health have encouraged residential aged care services across the NT to provide their individual feedback to this consultation.

Consultation Questions

1. What, if any, changes do you suggest IHACPA consider for the residential aged care pricing principles?

NT Health notes the overarching principles and policy intent in the introduction of the IHACPA aged care pricing. NT Health request IHACPA consider the following in relation to the aged care pricing principles.

Overarching Principle 1 - *Access to Care: 'Funding should support timely and equitable access to appropriate aged care services, for all those who require them.'*

NT Health recommends IHACPA consider how these factors will be addressed in an environment where there is:

- Current and persistent high occupancy rates in Residential Aged Care facilities (RACF) in the NT.
- Currently the Australian National Aged Care Classification (AN-ACC) assessment workforce is only provided by one organisation that does not always have assessors available in the NT. This results in timeliness issues in relation to AN-ACC assessments being completed when situations change, or an individual is seeking respite. There are also increased costs associated with transporting the assessor to the place the assessment is required, as well as accommodation. This can become even more costly in regional places such as Katherine.
- A need to consider rural and remote factors – bring geographic equity of access to ensure rural and remote services are established and supported when often too small to achieve minimum efficient size.

Overarching Principle 3 – *Fairness: 'ABF payments should be fair and equitable, based on resident's needs, promote the provision of appropriate care to residents with different needs and recognise legitimate and unavoidable cost variations associated with this care. Equivalent service should otherwise attract the same price across different provider types'.*

NT Health requests flexibility in this approach to address the unique operating environment in the NT, costs to operate in remote locations should be considered, caution should be given not to result in reduced quality.

Overarching Principle 5 - *Maintaining agreed roles and responsibilities: 'ABF design should recognise the complementary responsibilities of each government agency and department in the funding and management of aged care services, as well as providers in delivering aged care services.'*

NT Health acknowledges many Australians have increasingly complex care needs requiring services from acute, primary, disability and aged care systems. This growing complexity, particularly the interface between systems, requires better coordination to improve access to services, reduce preventable hospitalisations and avoid premature residential care admissions.

NT Health request these roles are better defined and how IHACPA propose to reflect these responsibilities in the aged care pricing framework, particularly to avoid negative impacts to the interoperability of public hospitals and the aged care system in a timely and sustainable way.

NT Health supports the premise that care delivery should reflect and respond to innovation and changing needs of aged care recipients.

System Design Principle 3 - *Promoting harmonisation: 'Pricing should facilitate best practice, person-centred provision of care in the appropriate setting'.*

Whilst the principle of harmonisation underpins the notion that funding systems should not incentivise the delivery of care at specific sites or settings, NT Health believe the pricing framework should be designed to incentivise care closer to home and therefore recommends the pricing model incorporate incentives to reduce the barriers that prevent older people from receiving care close to their home, families, and communities.

System Design Principle 4 - *Minimising undesirable and inadvertent consequences: 'Pricing should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.'*

NT Health agree with the principle 'Pricing should minimise susceptibility to gaming, inappropriate rewards and perverse incentives'. To further avoid inadvertent consequences IHACPA could consider measures to ensure assessment remains independent.

System Design Principle 6 - *Person-centred: 'Pricing adjustments should be based on characteristics related to people receiving care'.*

NT Health suggest this principle be moved to the overarching principles as a person-centred approach is foundational to safe and high-quality care.

2. ***Do the current AN-ACC classes group residents in a manner that is relevant to both care and resource utilisation? (That is, require the same degree of resources to support their care delivery). What evidence is there to support your answer? What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?***

NT Health notes the 13 class groups established within the AN-ACC and proposition of consideration of pricing advice for the AN-ACC classes for July 2024 following the provision of client data and an increased understanding of the data.

The future collection of accurate cost data for residential aged care will be critical to support classification and pricing refinements. It is essential this includes a representative sample of cost data that includes regional and remote areas across the NT. This will aid in determining any cost differentials by facility size, type, or location, as well as cost differentials associated with specific residential groups and AN-ACC classes.

NT Health recommends IHACPA consider the following refinements to the AN-ACC assessment and future AN-ACC classes:

Culturally safe access to quality aged care services for Aboriginal people

Barriers to accessing effective aged care services include racism, lack of cultural safety and communication barriers between staff and patients. Aboriginal people suffer from rates of dementia at 3-5 times the national average at a younger age and are more likely to have other chronic health conditions including diabetes, kidney disease and heart disease. Driving better health outcomes for

the most vulnerable of cohorts requires equitable access to effective services that can support individuals with increasing complexity in their health conditions.

There are opportunities for reform through a strategic approach to improve the responsiveness of aged care providers to the care needs of Aboriginal people. IHACPA could investigate an adjustment into the national funding model to incentivise residential aged care facilities located in inner regional and cities (Modified Monash Model (MMM) 1-4 areas) to improve accessibility for Aboriginal people.

Individuals who have English as second language or are non-English speaking

Communication and understanding an individual's needs are essential in providing safe and quality aged care. Understanding the costs associated with providing care to people with limited or no English language skills, including the use of interpreters or language specialists, along with cultural connections should be considered by IHACPA to ensure funding models are inclusive of these services.

Cost input pressure - Staffing

The AN-ACC funding model incorporates nursing care minutes requirements based on the resident's AN-ACC class. National staffing shortages may limit the ability of residential aged care providers from meeting the required care minutes. There is potential that staffing shortages will unfairly penalise aged care providers in the NT. A shortage of workers in the aged care sector also means that care may not be properly delivered in these settings, which can lead to greater pressures on hospitals.

IHACPA should consider the potential consequence associated with staffing shortages for regional and remote providers including in some instances the cost of hiring agency staff and paying staff housing costs. Consideration of relevant exemptions may be warranted.

Allied Health professional's role in preventing hospitalisations and improving people's functionality and independence is not addressed within the AN-ACC funding model. To consider costings and future benefits of allied health services, and understand quality care provisions, the utilisation of allied health care minutes should be monitored. The AN-ACC should also address potential funding-related barriers to accessing allied health workers in the residential aged care sector, given the more competitive price rates available in the NDIS.

Residential Respite Considerations

In the NT there is limited access to residential respite opportunities, impacting on individuals and their carer's ability to stay at home longer instead of entering permanently into residential aged care. Admission to residential respite aged care is a significant time of change and requires a large amount of administrative work and is associated with disruptive costs. The current funding model only provides an initial one-off entry adjustment to individuals entering permanent care and not respite. All older people in care whether permanent or respite, deserve to receive care planning, handover and monitoring along with adequate services for their complex health conditions.

IHACPA should examine the administrative costs associated with admissions to respite and consider these in AN-ACC funding models.

Residential respite classification is identified using the de Morton Mobility Index (DEMMI) using only mobility indicators to identify classification levels. This does not capture the needs of people living with mental health conditions or dementia that require a high level of management however are mobile. This impacts negatively on services providing respite to this population as does not allow adequate funding to be provided.

3. ***Are there any other legitimate or unavoidable costs associated with a permanent resident's or respite residents stage of care?***

Legitimate and unavoidable costs should extend to consideration of cost drivers of treating older people living in remote locations, Aboriginal people living in non-remote areas and older Australians with high rates of co-morbidity. Additional barriers to care for these cohorts may include racism, lack of cultural safety and communication barriers between staff and patients.

In scoping the cost of services NT Health agree costing studies should include administration and overheads across care, hotel and accommodation costs. With a five year aged care reform agenda still being rolled-out administrative burden for residential aged care providers is not yet fully understood. Monitoring these administrative costs is important to ensure providers are not overwhelmed.

4. ***What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?***

NT Health suggest IHACPA apply the findings from its Indexation Review for National Efficient Price and National Efficient Cost of hospital services to inform the most appropriate indexation methodology for residential aged care pricing.

5. ***What, if any, evidence, or considerations will support IHACPA's longer-term development path for safety and quality of AN-ACC and its associated adjustments?***

The Royal Commission recommendations were directed to establishing an aged care system that will consistently deliver high quality and safe care to older Australians. Additional consideration should be given to incentivise quality and safety in the AN-ACC funding model.

Residential Aged Care Quality Indicators are reported quarterly. Consideration of these indicators is recommended to incentivise quality, and understand any impacts costing is having on services' ability to provide quality and safe care for residents.

As Aged Care needs across Australia continue to change, there continues to be an appetite for innovative changes in service delivery, to ensure safety and quality standards are not only being maintained but services are striving to achieve beyond. Incentives for providers to be innovative to better support monitoring, care and support along with workforce solutions would benefit service delivery.

6. ***How could, or should the AN-ACC model be modified to be used for NATSIFACP and are there any factors that aren't accounted for under the AN-ACC model?***

Considerations for a funding model such as the AN-ACC for flexible services such as NATSIFACP need to consider the variety of services currently being provided by these organisations. The model will need to reflect that each service is likely to be providing different services and programs for their clients.

When considering modelling for these funding types it will need to include review, monitoring, consultation, and evaluation of current NATSIFACP services in remote and very remote communities to analyse the current costing situations.

In very remote communities these services rely heavily on the remote clinic for any health-related needs, and the interface between remote clinics and NATSIFACP services needs to be recognised in the costing. This modelling will need to include price adjustments to reflect the disparity in health outcomes experienced by Aboriginal people residing in rural and remote areas.

NT Health believes that activity-based funding models may not be the best model moving forward to provide adequate funding for flexible aged care for remote Aboriginal and Torres Strait Islanders.

Block funding for regional and remote areas is likely to be able to better support regional and remote areas with lower demand to ensure service sustainability.

As per Recommendation 52 of the Royal Commission into Aged Care Quality and Safety, block funding Aboriginal and Torres Strait Islander aged care pathways on 3–7-year cycles is recommended. This ensures annual assessments occur of the actual costs incurred and using advice from the Aboriginal and Torres Strait Islander Commissioner.

7. ***What, if any, care-related costs are impacted by service location that are not currently addressed in the BCT weighting?***

The BCT weighting is only available for residential aged care in MMM 6 or 7 regions, however doesn't apply to less remote areas.

Regional and remoteness implications

Regional areas lack economies of scale, additional infrastructure costs, and smaller population sizes all resulting in serious viability issues.

The NT has vast distances with limited access to respite placement opportunities, either planned or emergency type. To enable equitable access to respite care in the NT, consideration of person transport is fundamental to ensuring remote and very remote residents receive equitable access to aged care services.

Including transport costs to a respite opportunity across a region would increase an individual's access to residential respite and improve equitable opportunities for individuals to access respite services.

Homelessness

In the NT, different forms of homelessness are experienced when compared to other places across Australia. Homelessness in the NT is often related to overcrowded housing.

Homelessness rates in the NT are 12 times that of the national average, and 88% of the homeless population in the NT are Aboriginal people. Overcrowding accounts for 80% of homelessness in the NT. Severe overcrowding is when 4 or more additional bedrooms are required. The rate of severe overcrowding in the NT is 483.5 per 10,000 people compared to the Australian rate of 21.8 per 10,000 people. If the 'severely' overcrowded homeless operational group is excluded from homelessness estimates, the NT rate remains very high (115.9 per 10,000 people) compared with Australia overall (27.9) or Queensland, the state with the next highest rate of 29.9.

Aboriginal Australians

In Australia around 81% of Aboriginal people live in cities and regional centres, however the current BCT only includes an adjustment of specialised Aboriginal support in MM6 and MM7 regions. This doesn't account for the increased health complexities of Aboriginal and Torres Strait Islander individuals in urban and regional centres and the costs that are likely to be associated with this. This is likely to imbed culturally unsafe practice. With only 5 Aboriginal Community Controlled residential aged care services across Australia, and NATSIFACP only being in remote areas, Aboriginal people are more likely to access mainstream services.

NT Health request IHACPA quantify the cost components of delivering residential aged care services in regional and remote areas that may differ from services in metropolitan areas including:

- cost of agency staff
- transport costs for goods, resources and individuals
- cost of accommodating staff
- costs associated with increased levels of staff turnover, such as training and onboarding
- homelessness (including from overcrowded houses)
- culturally safe care
- increased cost of delivering aged care to Aboriginal people in MM1-5 regions
- increased costs of delivering aged care to Aboriginal people where less than 50% of people identify as Aboriginal