Queensland Government

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C-ECTF-23/8863

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8 SEP 2023

Email: secretariatihacpa@ihacpa.gov.au

Dear Mr Tune

Thank you for your letter dated 17 July 2023, and the opportunity to comment on the Independent Health and Aged Care Pricing Authority Consultation Paper on the Pricing Framework of Australian Residential Aged Care Services 2024-25. I appreciate your organisation's commitment to ongoing and transparent consultation with stakeholders, to ensure pricing advice is robust, appropriate and responsive to changes in the aged care sector, and I apologise for the delay in responding.

Enclosed for your information is a copy of Queensland Health's submission. Queensland Health has taken the opportunity to consult with a range of relevant stakeholders and has included their valuable feedback for your consideration.

Key issues for Queensland from a pricing perspective relate to the geographically dispersed nature of our state, combined with an ageing population. The sustainable delivery of residential aged care in rural and remote areas is an ongoing challenge which requires appropriate funding models. These facilities often have low client volume, and suffer high costs associated with rural and remote service delivery, along with workforce challenges, making service provision unviable for many private providers. If private providers are not incentivised to operate in these thin markets, it is likely the state government will be required to fill growing market gaps as a provider of last resort.

In addition, despite the funding provided by the Australian National Aged Care Classification, Queensland Health's Residential Aged Care Facilities and Multi-Purpose Health Services require cross subsidisation by Hospital and Health Services to continue to operate. Queensland Health Residential Aged Care Facilities often care for residents with high complex needs who require more clinical time, as private providers are unwilling or unable to care for them. Funding and pricing models also need to be adequate to support these clients, as well as groups that may have specific needs such as First Nations people, people from culturally and linguistically diverse backgrounds, and people from refugee and asylum seeker backgrounds.

Queensland is supportive of pricing models that support the long-term viability of all types of aged care service providers, and I look forward to seeing the outcomes of your consultation efforts.

Should you require any further information in relation to this matter, I have arranged for [redacted] to be available to assist you.

Yours sincerely

**Shannon Fentiman MP**
Minister for Health, Mental Health and Ambulance Services
Minister for Women
Member for Waterford

# *Queensland Health Submission to the Independent Health and Aged Care Pricing Authority (IHACPA)*

# *Pricing Framework for Australian Residential Aged Care Services 2024-25 Consultation Paper*

31 August 2023

## About this Submission

On 17 July 2023, David Tune, Chair of the Independent Health and Aged Care Pricing Authority, wrote to the Honourable Shannon Fentiman, Minister for Health, Mental Health and Ambulance Services and Minister for Women, regarding the release of a public consultation paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25. This submission is Queensland Health's response.

### *Queensland Health*

Queensland Health (the Department) is an approved provider under the *Aged Care Act 1997* (Cth) for State operated public residential aged care services. It is responsible for the delivery of:

- almost 1,000 operational places in 16 public residential aged care facilities (RACFs);
- approximately 300 operational places in 36 multi-purpose health services (MPHSs) that deliver integrated public hospital and aged care services in regional and remote Queensland;
- the Aged Care Assessment Program, which is delivered by approximately 244 full-time equivalent (FTE) staff across 14 Hospital and Health Services; and
- 753 transition care places, which provide short term assistance to help older Queenslanders transition back into the community following discharge from hospital.

The Department also plays a role as a system steward, providing policy support for the Queensland's aged care sector. As a provider of public health services, Queensland Health is interested in, and impacted by, Commonwealth Government reforms to aged care, which incur significant financial costs for the aged care sector to implement, and public health systems, including at the hospital interface. For the 2023-24 financial year, Queensland Health estimated its cross-subsidy to residential aged care to be more than $200 million. This is expected to increase to $252 million per year by financial year 2027.

The following responses reflect input from policy specialists, including in intergovernmental relations, as well as 'on the ground' perspectives from Hospital and Health Services in rural and remote areas.

## Responses to Questions in the Consultation Paper

**Question 1 –**

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

**Comments**

The 'Fairness' principle states that equivalent services should attract the same price across different provider types. This comment should be expanded to reflect the care needs of patient cohorts.

Activity based funding in aged care is reliant on accurate and detailed cost information. To better reflect the cost of care provision, jurisdictional clinical costing teams require access to classification scores for each resident so differential costing can be applied to patients with higher care needs. Currently, Queensland Health only has access to bed-day data. This means its Residential Aged Care Facility residents appear to cost the same regardless of their individual care needs. This situation may not be specific to Queensland, and it is likely the pricing determined through available data poorly reflects the cost of services throughout the public sector.

**Question 2 –**

**Do the current Australian National Aged Care Classification (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 delivery). What evidence is there to support your answer?**

**Comments**

To facilitate accurate costing and enable the critical examination of cost differentials, jurisdictional costing teams require access to the full functional, cognitive and physical capability scores. Costing at this level will identify if there are areas of the classification model that may need to be reviewed with subgroups of residents having a higher cost within that classification class.

Currently AN-ACC classes do not consider that two residents in the same class may require disparate amounts of time to receive the same care with the same resources. For instance, residents who wander or actively exit, require greater attention from staff than other residents in the same AN-ACC class. Queensland Health's Healthcare Purchasing and System Performance Division has reviewed data for Class 4-7 residents, with and without compounding factors, within a local Residential Aged Care Facility. The cohort of patients with compounding factors required more care minutes than average. This will impact the true cost of care delivery. Queensland Health will continue to investigate this issue with input from the relevant facility.

Palliative care categories should be extended to include residents diagnosed with a terminal illness even though they may live longer than three months. This time frame is currently required by IHACPA's classifications.

Further consideration should be given to including priority communities in AN-ACC weightings. This would assist the delivery of equitable, accessible and quality culturally appropriate care to:

- First Nations people;
- People with culturally and linguistically diverse backgrounds;
- People with a disability; and
- People who are refugees or asylum, seeker backgrounds.

**Question 3 –**

**What, if any, factors should IHACPA consider in future review of the AN-ACC classes?**

**Comments**

Patients with compounding factors and complex issues will require more clinical time which is not included in the classification. This should be considered in any future reviews of the classification. Facilities providing these services often have difficulty attracting staff with the appropriate skills mix, therefore higher-level staff, or agency staff, may be utilised which generates additional costs for the same care.

Currently, the AN-ACC model adjusts the cost of care for Aboriginal and Torres Strait Islander peoples living in remote areas. However, most Aboriginal and Torres Strait Islander peoples live in urban centres. The cost of providing care to Aboriginal and Torres Strait Islander peoples living in Modified Monash Model (MMM) categories 1-5 should be adjusted.

Extra support is needed to provide those residents with dementia living in mixed diagnosis services with leisure and lifestyle activities. These residents also require increased staff supervision.

**Question 4 –**

**Are there any other legitimate or unavoidable costs associated with a permanent resident's stage of care? For example, entry or departure from a service.**

**Comments**

The following legitimate and unavoidable costs should be considered:

- Patient transport costs in rural and remote areas where transport from a residential location or another facility is required. This cost can be high and should be considered separate to the long-term residential cost and funding.
- The development of a care plan and social care by providers engaged with residents and their families.
- Variation in Enterprise Bargaining arrangements given the cost variation of public versus private resourcing arrangements.
- The inclusion of more Aboriginal and Torres Strait Islander Health Workers in the staff mix depending on the volume of First Nations residents.
- Additional costs associated with cultural and linguistic diversity needs.
- Additional costs associated with ability aids. There can be a high variation in supports used for patients with limited mobility, for example, stroke support.
- Additional costs due to supply chain impacts as a result of current economic/COVID impacts.
- Dementia diagnostics affects classification levels and the support that is required to differing classifications.

**Question 5 –**
**Are there any other legitimate or unavoidable costs associated with a respite resident's stage of care? What evidence is there to support your answer?**

**Comments**

The legitimate and unavoidable costs listed for question 4 are also applicable for this resident cohort. Along with these, other legitimate and unavoidable costs for respite residents include:

- Higher costs associated with the care requirements of a deteriorating resident needing higher care levels but for whom either a review of care needs is yet to be undertaken or is awaiting approval of a revised care package at the appropriate level for their current needs.
- Respite residential care for people with dementia needs to be considered because such residents are at higher risk of incidents.

**Question 6 –**
**What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?**

**Comments**

In the public sector the indexation should be in alignment with the hospital sector given the workforce are under those terms.

IHACPA should consider the cost of supplies and services for rural and remote areas, as well as the increased costs required to attract and retain staff in these locations.

**Question 7 –**

**What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this?**

**Comments**

The additional costs associated with the provision of care to residents who require specialised services, is directly impacted by the availability of staff with appropriate skills to care for these residents amongst the facility's existing permanent employees.

**Question 8 –**

**What, if any, care related costs are implicated by service location that are not currently addressed in the Base Care Tariff (BCT) weighting?**

**Comments**

The BCT adjustments for services with MMM categories 5-7, services provided to Aboriginal and Torres Strait Island peoples and remoteness based on approved beds are welcome. In addition to these adjustments, IHACPA should consider the percentage of staff providing care who are not permanent employees and are supplied by medical locums or nursing agencies. Attraction of permanent staff is very difficult resulting in a significant reliance on this costly type of staff.

IHACPA should consider the BCT weighting for MMM category 4 due to challenges in finding staff, the costs of temporary staffing and the infrastructure maintenance required at many of these facilities.

It is also worth noting that implementing and maintaining full nursing coverage costs more at smaller facilities than larger facilities and therefore smaller facilities may require the additional weighting to cover extra costs.

**Question 9 –**

**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?**

**Comments**

A resident with dementia may need more support than others. Thus, the long-term development path for associated adjustments should be based on the needs of residents and related costs.

**Question 10 –**

**How could, or should the AN-ACC model be modified to be used for Multi-Purpose Services (MPS) and are there any factors that aren't accounted for under the AN-ACC model?**

**Comments**

Some stakeholders have reservations around an AN-ACC model being modified to fund Multi-Purpose Services. Often Multi-Purpose Services have been established to address a lack of aged care alternatives in smaller communities. They also provide long-term community-based services. Unlike Residential Aged Care Facilities, Multi-Purpose Services tend to have a small number of residents and their available places fluctuate. Due to these factors block funding may be more appropriate than activity-based funding for these services.

If the AN-ACC model is to be modified for use in a Multi-Purpose Services setting, IHACPA must recognise the unique characteristics of these facilities and focus on providing support and guidance. There needs to be a clear delineation between patients who would be classified under the Australian National Subacute and Non-Acute Patient Classification and AN-ACC. To support this analysis, IHACPA should include Multi-Purpose Services in the activity reporting and the dataset for the National Hospital Cost Data Collection. This will allow IHACPA to better understand the cost profile of Multi-Purpose Services patients before introducing any changes to existing funding model arrangements.

A significant issue with Multi-Purpose Services is the lack of technology and administration support compared to similar services operating in established facilities that went through the Aged Care Funding Instrument.

**Question 11 –**

**How could, or should the AN-ACC model be modified to be used for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and are there any factors that aren't accounted for under the AN-ACC model?**

**Comments**

Queensland recognises that the provision of aged care in regional and remote Australia comes with unique challenges. Though BCT weightings recognise the increased costs associated with providing care in rural and remote locations and to residents with complex needs, Queensland understands funding needs to adapt to keep up with demands, changing costs and other pressures.

Before the AN-ACC model can be considered for the NATSIFACP, Queensland Health would encourage consultation with First Nations Residential Aged Care Facility providers to get further advice towards modifying this program. The additional costs associated with providing culturally acceptable health care services must also be considered. As noted in question 4, the cost profile of health services may differ due to the inclusion of more Aboriginal and Torres Strait Islander Health Workers in the staff mix.

**Other comments**

IHACPA should consider the implementation of financial compensation for Infection Prevention and Control leads. A mandatory payment would be reported through the Quarterly Financial Report.

Under the current model there is little incentive for providers to implement a 'wellness model' with existing funding. A mechanism for Allied Health needs to be built in.

The consultation paper states that IHACPA will also use the Aged Care Financial Report (ACFR) and the Quarterly Financial Report (QFR) data along with other data to support costing and pricing work. Queensland Health suggests there may be benefit in exploring whether there has been any reconciliation between these reports and the total cost of services for Local Health Networks providing aged care services.

----------*End of submission*----------