Barwon Health response to the Independent Hospital and Aged Care Pricing Authority - Towards an Aged Care Pricing Framework Consultation Paper

The Independent Hospital and Aged Care Pricing Authority released a Consultation Paper '*Towards an Aged Care Pricing Framework*' on 16 August 2022. The following information is provided in response to the questions raised in the Consultation Paper.

Overarching comments

The draft framework clearly acknowledges that the introduction of aged care activity based funding is a complex multi-year process involving evolution and refinement. It may also draw on concepts from the implementation of activity based funding in Australian public hospitals but will also need to be designed specifically for the aged care system.

A phased implementation process is recommended in recognition of the changes underway in the aged care system as a result of the Aged Care Royal Commission. The design of the initial Pricing Framework should seek to ensure a robust starting point is developed that does not preclude the development of more sophisticated approaches to classification, costing, pricing, and other associated tools.

Appropriate regard should be given to the new aged care classification system, relative immaturity of the aged care data systems and limitations to the scope and accuracy of the available aged care cost when the IHACPA develops its aged care transition plan.

Specific questions – A new funding approach for residential aged care

Q1. What, if any, may be the challenges in using the Australian National Aged Care Classification (AN-ACC) to support activity based funding (ABF) in residential aged care?

The profile of Australian aged care residents has changed markedly in recent years. Residents are older and frailer, with an annual mortality rate of around 32% (Eagar et al. 2020). The care burden associated with frailty, mobility, function, cognition, behaviour and technical nursing needs drives residential aged care resource use.

The AN-ACC combines multiple assessment instruments, including the:

- de Morton Mobility Index
- the Australian Modified Functional Independence Measure
- Resource Utilisation and Braden Scale, and
- Resident assessment based on compounding factors.

The AN-ACC is a sufficiently robust starting classification for transitioning residential aged care facilities in Australia towards a national efficient aged care price.

However, it is expected that there will be a transition period required for staff training and education to occur that is required to support their understanding of the tools, how they are used and how they impact the classification. Results will not be comparable amongst aged care providers until this occurs.

Q2. What, if any, concerns do you have about the ability of AN-ACC to support long term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe?

With only 13 classes, the reported statistical performance and clinical acceptability of the Australian National Aged Care Classification is comparable to other healthcare classifications (Australian National Subacute and Non-Acute Patient (AN-SNAP) classification, Australian Refined Diagnosis Related Groups (AR-DRGs).

The Australian National Aged Care Classification will support efficient aged care funding. It should be used alongside benchmarking and other quality and safety tools to promote cost efficiency as well as highlighting opportunities for the continuous improvement of operations.

Residents at aged care facilities may deteriorate or improve following admission to an aged care facility. When deterioration occurs, there is significant effort required to proactively manage residents within the facility to reduce the risk of adverse complications, and further to reduce health service costs.

The classification should allow for residents to be reassessed and reclassified as their needs changes to ensure the adequate funding of facilities to deliver the right care at the right time. If the funding does not reflect the resource use, it will be difficult for the AN-ACC to drive improvements in safe and effective care.

Q3. What, if any, additional factors should be considered in determining the AN-ACC national weighted activity unit (NWAU) weightings for residents?

No additional factors are proposed to be included.

Q4. What should be considered in developing future refinements to the AN-ACC assessment and funding model?

The IHACPA should ensure that the funding model supports short-term changes where the resident needs/staffing requirement changes significantly to support equitable and efficient funding.

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Should the IHACPA consider an episodic funding approach for aged care, the IHACPA will also need to ensure that it appropriately accounts for the long-stay of residents in its pricing model and funding model.

Specific questions – Principles for activity based funding in aged care

Q5. What, if any, changes do you suggest to the proposed principles to guide the development and operation of the Pricing Framework for Australian Aged Care Services?

Barwon Health supports the principles proposed in the Consultation Paper. However, the principles should be applied equally to guide the development of the aged care national efficient price.

There will be times when there is conflict between the design principles. For example, when 'Minimising undesirable and inadvertent consequences' conflicts with 'ABF pre-eminence', the IHCAPA should prioritise 'Minimising undesirable and inadvertent consequences'.

Q6. What, if any, additional principles should be included in the pricing principles for aged care services?

No additional principles are proposed to be included.

Q7. What, if any, issues do you see in defining the overarching, process and system design principles?

There are no significant issues with the overarching, process and system design principles.

Specific questions – Developing aged care pricing advice

Q8. What, if any, concerns do you have about this definition of a residential care price?

Barwon Health supports the proposal to set the price to initially reflect the direct care minute requirements as well as other factors required to support minimum care standards and quality improvement. As highlighted in the Consultation paper, some facilities will need to sustainably increase the current level of care to meet this requirement in the short-term.

Once facilities have achieved the direct care minute requirements, further refinements may be applied once the critical elements of classification, costing and counting become embedded across the aged care system to support the development of a true national efficient residential aged care price.

Q9. What, if any, additional aspects should be covered by the residential aged care price?

Barwon Health supports the proposed exclusion of capital, depreciation and leasing costs, which are funded through refundable accommodation deposits (RADs) and daily accommodation payments (DAPs).

Barwon Health supports in-principle the exclusion of: costs for extra services which are funded through extra service fees; and costs for additional services which are funded through additional services fees. However, extra services vary from place to place. When determining a true national efficient residential aged care price, the Independent Hospital Aged Care Pricing Authority should have regards to this whilst making relevant adjustments to the costing data.

Q10. What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?

Barwon Health supports the proposed approach and level of the residential aged care price.

Q11. How should 'cost-based' and 'best practice' pricing approaches be balanced in the short-term and longer-term development path of the Independent Health and Aged Care Pricing Authority's (IHACPA) residential aged care pricing advice?

The Consultation Paper acknowledges that many aged care providers are currently not meeting minimum care, quality and safety standards

Barwon Health supports the proposed short-to-medium pricing approach which combines elements of both 'cost-based' and 'best practice' pricing. This approach will ensure aged care providers will have sufficient funding along with a period of transition to lift their minimum care, quality and safety standards.

The blended approach should be based on the available cost data and adjusted to recognise the immaturity of the system. Overtime as the level of uplifts in care minutes and quality arising from the aged care system reforms are fully implemented (no earlier than October 2024), the approach can transition to an efficient cost-based approach.

Q12. What should be considered in the development of an indexation methodology for the residential aged care price?

Any methodology must ensure funding stability and predictability for aged care providers. The indexation methodology should:

- be sensitive to changes in cost
- minimise unnecessary variation

The methodology should also be flexible enough to make annual adjustments to the final aged care price cost data to reflect material and unforeseen changes such as:

- future changes to required care minutes
- adjustments to wages made by the Fair Work Commission
- mandatory changes that result in significant cost impost
- pandemics and other major events

Q13. What, if any, additional issues do you see in developing the recommended residential aged care price?

An aged care national efficient price will need to be set based on historical costing data that may be up to three years old and extrapolated to develop the contemporary price. Consideration will need to be given to major events such as the COVID-19 pandemic. Considerations need to be made not only for the impact of the event but also what changes or innovations that have arisen as a result of the major event.

For example, the increased utilisation of personal protective equipment (PPE) and other risk reduction strategies in the delivery of care will change the nature of "business as usual" into the future. This needs to be considered in the overall pricing and funding approach

The health effects of COVID-19 are also not yet fully understood and it cannot currently be determined what the impact on both aged care and healthcare services will be in the future.

Furthermore, robust and reliable activity based funding systems rely on consistent data. The IHCAPA will need to provide very clear definitions and standards for aged care costing to ensure that all services cost in the same way.

Barwon Health also recommends a two-year shadow period when significant changes are proposed by the IHCAPA noting that changes to classifications and costing methodologies are lengthy and resource intensive.

Specific questions: Adjustments to the recommended price

Q14. What, if any, changes are required to the proposed approach to adjustments?

Barwon Health supports the proposal that the price should not be solely driven by historical costs of delivering care but any adjustments must be evidence based and transparent.

However, the need to make adjustments to the price to account for legitimate and unavoidable variations in the cost of delivering care needs to be balanced with the need to limit/minimise unnecessary variation signals to aged care providers.

Q15. What, if any, additional adjustments may be needed to address higher costs of care related to resident characteristics?

The University of Wollongong reported that differences in fixed care cost between facilities is substantially explained by the degree of remoteness of facility location, the facility size in remote locations and whether they provide specialised care for people from an indigenous background or with a personal history of homelessness.

Adjustments should also be considered for residents with specific and high cost special care needs (e.g. enteral feeding, tracheostomy, complex wounds) that are relatively rare in number (high cost, low volume).

Adjustments should also be considered for residents with needs for specialised equipment as a result of their specific conditions.

Q16. What evidence can be provided to support any additional adjustments related to people receiving care?

Residents with severe mental health or dementia symptoms (e.g. suicidal/behavioural and psychological symptoms of dementia) require higher staffing levels for their special care needs resulting in increased salary and wages costs.

Similarly, residents requiring specialised care such as dialysis and paraplegia care will require additional complex nursing care which also results in increased nursing salary and wages costs.

Q17. What should be considered in reviewing the adjustments based on facility location and remoteness?

Location and remoteness may not necessarily reflect the type and care needs of the residents. The IHACPA should consider an aged care services capability framework which differentiates aged care providers based on the complexity of residents they manage. This is to ensure there are appropriate incentives for providers to accept and care for the most vulnerable and complex residents.

Access to a suitably qualified workforce in specialised units and remote locations can be limited which may result in the increased use of short-term or agency staffing which also increases salary and wages costs.

Q18. What evidence can be provided to support any additional adjustments for unavoidable facility factors?

Access to a suitably qualified workforce in specialised units can also be limited which may result in the increased use of short-term or agency staffing which drives up costs.

Q19. How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?

Barwon Health supports the introduction of adjustments for quality and safety in the long-term that would complement local quality and safety initiatives in aged care. This would require the aged care activity and costing data to be fully compliant and of sufficient quality.

The quality and safety of aged care like healthcare more broadly may be subject to a level of variability year-on-year. Approaches to improving quality and safety considered by IHACPA should be balanced to ensure it not only promotes high quality care but also provide the right incentives for poor performers to continually improve their quality and safety.

The design of the quality and safety adjustments should also consider the facility type and location, specifically those that take on more high-risk and complex residents.

Specific questions – Priorities for future developments

Q20. Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?

Hotel costs should be incorporated into the AN-ACC funding model. The age, location and size of the facility could be considered.

Q21. What should be considered in future refinements to the residential respite classification and funding model?

Funding should not be limited to occupancy but rather the model should consider costs associated with availability to ensure services are available to consumers when they are required in a timely manner.

Supporting older people to transition between health and aged care services is a significant challenge. The funding model should consider appropriate incentives to reduce the delays in the transfer of residents.

Q22. What are the costs associated with transitioning a new permanent resident into residential aged care?

There are significant transitional costs associated with transitioning a new permanent resident into residential aged care. There is are significant initial administrative and clinical costs upon permanent entry into residential age care which include agreements and resident need and care plans.

Q23. How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?

Costing workforce: Reliable and accurate aged care costing information will need to capture the total costs involved in the provision of aged care services to a resident, and assign costs based on resource consumption. This workforce is limited and may be a barrier to obtaining accurate cost data to quickly develop and refine price weights.

Collection and standardisation of assessment tools: The Australian National Aged Care Classification relies on a number of clinical assessment tools. There is a need to upskill/continually educate the workforce to ensure there is consistent and reliable assessment and documentation.

Q24. What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?

The IHACPA should also consider developing pricing advice that considers the cost of providing care to high-needs special care residents.

Q 25. What would be considered markers of success in IHACPA's aged care costing and pricing work?

Markers of success in IHACPA's aged care costing and pricing work could include:

- Improving the aged care data systems and standards to capture the data underpinning activity based funding (activity and cost data)
- Structural and efficiency improvements in the aged care system
- Improved quality and safety in the aged care system
- Additional industry investment in the aged system, particularly supporting residents with complex needs.

Some of these markers are not exclusively as a result of the IHACPA's work program, but a combination of the IHACPA's work and other initiatives currently underway.

Further information

For further information and follow up regarding this submission, please contact:

Ange Erwin
Chief Nursing and Midwifery Officer, Barwon Health
E: angela.erwin@barwonhealth.org.au

Anna Burgess
Chief Strategy and Planning Officer, Barwon Health
E: anna.burgess@barwonhealth.org.au