Queensland Government

Queensland Health

Enquiries to: David Harmer
Senior Director
Social Policy, Legislation and
Statutory Agencies Branch
Telephone: 07 3708 5574
Our ref: C-ECTF-22/13310
Your ref: D22-11725

Mr David Tune AO PSM
Chair
Independent Health and Aged Care Pricing Authority
PO Box 482
SYDNEY NSW 2000

Email: secretariatihpa@ihacpa.gov.au

Dear Mr Tune

Thank you for your letter dated 16 August 2022, in relation to the Independent Health and Aged Care Pricing Authority consultation paper *Towards an Aged Care Pricing Framework*. The Honourable Yvette D'Ath MP, Minister for Health and Ambulance Services, has asked that I respond directly to you in relation to this matter.

Thank you for the opportunity to provide comment on the consultation paper. Queensland Health values the opportunity to provide input to the process as the Independent Health and Aged Care Pricing Authority develops the new Aged Care Pricing Framework. As the Independent Authority takes on these new responsibilities for aged care, it is important to establish a pricing framework that supports sustainability of the sector and the delivery of safe and quality services for all Australians.

As an approved provider of aged care services operating in thin markets, Queensland Health is particularly keen to ensure due consideration of appropriate funding models for services rural and remote areas and to consumers who have complex needs and challenging behaviours.

Please find attached Queensland Health's submission to the consultation paper.

Should you require any further information in relation to this matter, I have arranged for Mr David Harmer, Senior Director, Social Policy, Legislation and Statutory Agencies Branch, Department of Health, on telephone (07) 3708 5574, to be available to assist you.

Yours sincerely

Shaun Drummond
Director-General
12/10/2022

Level 37
1 William St Brisbane
GPO Box 48 Brisbane
Queensland 4000 Australia

Website health.qld.gov.au
Email DG_Correspondence@health.qld.gov.au
ABN 66 329 169 412

Queensland Health Submission to The Independent Health and Aged Care Pricing Authority (IHACPA)
Towards an Aged Care Pricing Framework Consultation Paper

30 September 2022

About this Submission

On 16 August 2022, Mr David Tune, Chair of the Independent Health and Aged Care Pricing Authority wrote to The Hon Yvette D'Ath, Queensland's Minister for Health and Ambulance Services regarding the release of a public consultation paper, *Towards an Aged Care Pricing Framework*. This submission forms the response from Queensland Health.

Queensland Health

Queensland Health is an approved provider under the *Aged Care Act 1997* (Commonwealth) 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);
- Around 300 operational places in 35 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 200 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 to transition back into the community following discharge from hospital.

In 2020-21, Queensland Health's expenditure on residential aged care was approximately $184 million, including a Commonwealth Government contribution of approximately $54.4 million.

The Department of Health 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 and public health systems, including at the hospital interface.

Overview

As a geographically dispersed state with an ageing population, Queensland Health has an interest in ensuring appropriate funding models are implemented to safeguard the sustainable delivery of residential aged care facilities in rural and remote areas. Without funding incentives for private providers to operate in these areas, it is likely that the state government will increasingly be required to step in as the provider of last resort and fill gaps in the market.

Even with the recent funding uplifts linked to Australian National Aged Care Classification (AN-ACC), Queensland Health's residential aged care facilities and MPHS cannot operate without cross subsidisation by the Hospital and Health Services (HHSs).

Rural and remote aged care services have their own set of unique pricing challenges. These facilities often have low (or highly varied) client volume, and suffer high costs associated with rural and remote service delivery, making service provision unviable for many private providers. The peak body, Aged and Community Care Providers Association has recently reported that up to one third of aged care facilities may collapse due to the obligations linked to the Commonwealth Government's aged care reforms, including increased reporting and workforce requirements.

Queensland Health also delivers residential aged care services to complex and high need clients. Funding/pricing models need to be adequate to support these clients, as well as groups that may have specific needs such as Aboriginal and Torres Strait Islander people and people from non-English speaking backgrounds.

The profile of those accessing residential aged care has shifted in recent times. The profile of aged care residents may be changing. With clients preferring to stay at home as long as possible, their needs may be extremely high by the time they enter residential care. They then tend to stay in facilities for shorter periods. Residents often have co-morbidities and high frailty levels linked to mobility and cognitive issues. The new funding model and associated pricing must reflect such changes in the client profile.

In addition, it is critical that in pricing aged care services, IHACPA take account of issues such as access and quality and safety. It is also important that pricing models are sufficiently granular and reflect the key cost drivers, including issues such as the additional costs of providing services in rural and remote locations.

The Royal Commission into Aged Care Quality and Safety identified that the aged care sector was underfunded by approximately $10 billion per year in 2018-19 and that 2018 data showed that 25 per cent of facilities were not, or may not be, profitable. As wages in the sector are likely to increase due to workforce shortages and the pending decision of Fair Work Australia, pressures on providers will only increase.

As indicated above, Queensland Health is often required to step in when the market fails, it is keen to ensure IHACPA's pricing models support the long-term viability of all types of service providers.

The below responses reflect issues faced by Queensland Health both as an approved provider, system steward and provider of hospital services at the interface with aged care

This submission therefore reflects input from policy specialists, including in intergovernmental relations as well as 'on the ground' perspectives from hospital and health services, including in rural and remote areas.

Responses to Questions in the Consultation Paper

Question 1 –

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?

Comments

- Some activity cannot currently be classified and counted and, therefore, cannot be funded under ABF, reducing the ability to capture accurate funding.
- A significant amount of work needs to be done to ensure appropriate and effective allied health services for residents.
- The requirements of AN-ACC assessments and care planning processes are different, which creates a challenge in reconciling the pricing.

Question 2 –

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?

Comments

- The National Weighted Activity Unit (NWAU) will not cover the costs for residents with very challenging behaviours, that are mobile, and require a lot of supervision and support.
- The AN-ACC cannot be a 'set and forget' model. The model must evolve to reflect best practice care and changes in models of care.
- There needs to be ongoing consultation with the sector during implementation and continuous monitoring and evaluation to enhance sustainability.
- The model proposes no dedicated funding for preventive, reablement and restorative care which represents a significant gap.
- The Commonwealth needs to fund and support career progression, including appropriate supervision and quality improvement for the workforce. To ensure quality care, there must be a focus on mentoring and maintaining excellence in the sector's workforce.

Question 3 –

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

Comments

- The NWAU weighting must capture all facets of resident care including ongoing allied health care, specialist care, need for equipment etc.
- Any 'extra requirements' arising from the introduction of the new Quality Standards need to be considered. This includes the administrative burden associated with extra reporting requirements.

- All costs associated with complex care needs such as central venous access devices and total parental nutrition must be considered.
- Prices must be regularly reviewed, and all known costs associated with care and service delivery must be incorporated.

Question 4 –

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

Comments

- As noted above, the NWAU will not cover the costs for residents with very challenging behaviours, that are mobile, and require a lot of supervision and support.
- With specific reference to the funding model, it is recommended that IHACPA build on lessons learned from the implementation of the National Health Reform Agreement hospital ABF funding model to inform the Aged Care funding model.
- Analysis of comparable international aged care ABF models should be undertaken.
- There should be consideration of mental health care and behaviour management support, including restrictive practices, in the funding model.
- IHACPA should give due consideration in the model to the variation in enterprise bargaining arrangements, given the cost variation of public vs private resourcing arrangements.

Question 5 –

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?

Comments

- Nil

Question 6 –

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

Comments

- The AN-ACC model should include an itemised incentive payment for preventive, restorative and reablement care, provided by highly qualified and skilled practitioners.
- Consider the inclusion of mental health care and behaviour management, including restrictive practices.
- Rather than additional principles, IHACPA should consider rewording the proposed ‘Quality care’ principle to be more specific about the outcomes that align with community expectations. i.e., quality care for consumers.

Question 7 –

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

Comments

- Although external assessments may address the perceived conflict of interest, providers are best positioned to understand the full care needs of their residents.
- In addition, external assessments are unlikely to reduce the burden of assessment for providers; facility staff must be available throughout the process.
- There is a risk that the proposed short assessment timeframe may not capture the changing needs of a resident over a 24-hour period and that there will be a burden on providers to collate information for funding purposes only. It is unrealistic to assume they would be consistently timely.
- Attempts to standardise care planning assessments risks limiting the autonomy of service providers and their ability to provide care on an individual client basis.

Question 8 –

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

Comments

- Consider the introduction of a cap on Daily Accommodation Payments and Refundable Accommodation Payments payable to providers to encourage providers to focus on quality care provision, rather than profits.
- though slightly off topic, there is often confusion and hesitance from potential residents and their families on the cost associated with care prices. There needs to be easy to navigate, transparent and well explained pricing guides.

Question 9 –

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

Comments

- There needs to be clear costing for any additional services.

Question 10 –

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

Comments

- Aged care is very costly, and its numerous associated systems are extremely complicated. The QFR should be used to identify the true costs of care and these factors should be considered when delivering an aged care price for government beds.
- Aged care pricing should be indexed annually and reflect the rising costs of living.

- The cost of workforce shortages should be included in the pricing (i.e., higher wages are needed to attract staff).
- There is an opportunity to start from the actual cost of service provision rather than rely too heavily on what providers are currently spending. IHACPA could generate its own research for this purpose, or it could utilise existing reports such as those prepared by Deloitte for the Royal Commission into Aged Care Quality and Safety. The key consideration should be to accurately reflect the costs of providing quality care that meets the Aged Care Standards, reflecting that these costs will vary between residents and locations (e.g., rural and remote compared to metropolitan centres).

Question 11 –

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?

Comments

- In the short term, 'phasing' (or adjustments) should be considered after six months to reflect the true costs of providing care. In the long term, best pricing should include adequate funding for rural and remote sites equivalent to the true (or actual) costs as identified through the QFRs. While there is reference to this factor within the considerations, it needs to be the 'true costs'. The 'best price' needs to reflect all services, regardless of their characteristics.
- Given that it is evident how under-funded aged care currently is, much greater emphasis should be placed on best-practice pricing than cost-based pricing in the initial stages. Over time, a gradual shift towards cost-based pricing might be justifiable, but only when cost-based pricing becomes close to parity with best practice pricing.
- The gap between the two methods may be significant. However, this should not be a relevant consideration and closing this gap may become a de-facto policy objective.

Question 12 –

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

Comments

- The QFR should be used to identify the true costs of care and this should be considered when delivering an aged care price for government beds.
- There needs to be the application of lessons learned from hospital pricing, as well as looking at comparable international aged care activity-based pricing.
- As noted in the consultation paper there is a lag in cost data availability. Therefore, there is a need to ensure suitable mechanisms are in place to make appropriate adjustments to indexation which are not reflected in historic costing data.
- It is also important to ensure that a theoretical indexation rate is compared to actual growth in costs.
- In the absence of empirical evidence from QFR and Aged Care Financial Report (ACFR) – which may not provide any incentive to become more efficient, IHACPA

should investigate suitable indexation rates that can be applied to aged care service delivery.
- Indexation methodology should be able to adequately reflect the highest cost residents and locations.
- The methodology should consider staffing resource levels and FTE increases due to the reforms. Consideration should also be given to public sector wage policy increases.
- The sector would benefit from standardisation of fees and charges to reduce competitiveness and enhance the focus on quality of care.

Question 13 –

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

Comments

- This system allows for the 'draw back' of funds based on efficiency. However, it does not take into consideration factors that may be 'out of one's control' (such as environment, location, etc.) and therefore the best price may not be enough to maintain the facility.
- This model rewards innovation where efficiencies can be made, however, smaller providers may struggle with this.
- Consideration must be given to additional costs as a result of supply chain issues, due to current economic impacts and COVID-19.

Question 14 –

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

Comments

- This approach does not take into consideration factors such as disasters, low client volume, recruitment and attraction issues and/or huge overheads and therefore the best price may not be enough to maintain a facility.

Question 15 –

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

Comments

- There needs to be specific costing for higher acute residents such as those requiring central venous access devices and total parenteral nutrition.
- Adequate consideration needs to be given to the true costs of mental health care and behavioural management.
- Facilities should be encouraged to provide their clients with more healthcare, such as giving intravenous antibiotics. This will increase the scope of practice of registered nurses within aged care facilities (and likely increase job satisfaction) and will enable in-home care and improve hospital avoidance, which will benefit clients.

- Steps must be made to ensure more client-specific care for First Nations people, e.g., this could be the inclusion of more Aboriginal and Torres Strait Islander health workers in the facility's staff mix.
- Due consideration needs to be given to adequately support clients from a culturally and linguistically diverse background.
- Those residents requiring ability aids must be considered. There is a high variation in the different supports used for patients with limited mobility, e.g., stroke support.

Question 16 –

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

Comments

- Those residents with very challenging behaviours, who are mobile, require a lot of staffing input. For example, one HHS has on average 3-9 patients that require specialist staffing and support.
- Evidence should feature in each individual care plan and assessment, and form part of ongoing information management practices.

Question 17 –

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

Comments

- Aged care provision is costly due to a myriad of factors, including being labour-intensive and featuring numerous and complex systems. The QFR should be used to identify the true costs of care for different provider types.
- Rural and remote facilities may not be able to be as innovative as metropolitan facilities. They are more likely to have resourcing issues and with smaller facilities, they are likely to be less efficient through no fault of their own.
- Consideration needs to be given to a minimum workforce for each facility, to ensure a viable service. This workforce can then 'flex up' in line with patient load as required for the level of approved beds.
- There could be some variable components (e.g., consumable costs which grow with increased occupancy) and some fixed components (e.g., base 'hotel' staffing).

Question 18 –

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

Comments

- The QFR can be used as evidence.
- A licensed facility would need to have employed permanent teams to be sustainable as a service provider.
- This relates to the 'best practice' process of determining what should a facility be providing as a RACF with no residents, then add to this the minimum occupancy expected, with the variable price set on those consumable items that occur with increased occupancy.

Question 19 –

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

Comments

- Adjustments should be made over time, as the system matures. The true cost of staff care minutes should be funded to allow individualised care, along with specialists.

Question 20 –

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

- Yes, it should as this is a fundamental requirement of care provision in a RACF. Hotel services would be considered inclusive due to the need for nutrition requirements of residents.
- Costing the provision of care support and services that extend beyond "clinical care" needs and needs to be included in AN-ACC funding as currently assumed that it is covered in the basic daily fees.

Question 21

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

Comments

- Administration costs.

Question 22 –

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

Comments

- The costs associated with transitioning a new resident into permanent residential aged care are:
    - Clinicians for assessments.
    - Administration costs, e.g., Financial Officer to admit the new admission and complete supporting documents – approximately 4-6 hours.
    - Clinical Nurse/ Registered Nurse complete admission documents – approximately 5 -10 hours. Additional workforce requirements to undertake assessments and care planning.
    - Allied health referrals.
    - Operational staff.
    - Lifestyle programs.
    - Hotel-associated – i.e., food, laundry, cleaning, etc.
    - Information technology.
    - Utilities and maintenance of the facilities.

Question 23 –

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

Comments

- The workforce is changing on an ongoing basis, making it hard to maintain stability of all of the related systems.
- There may be an increase in the use of untrained staff across the sector.
- The new skill-mix and 24/7 registered nurse requirements will make resourcing difficult.
- Workers may find it hard to understand ‘the AN-ACC system’.
- There will be new roles and responsibilities of staff due to the new AN-ACC system., which creates uncertainty and flux. For example, there will be a reclassification of key accountabilities and establishing role key performance indicators for all grades of nursing and allied health.
- There needs to be additional education and training on the new funding model outlining the differences in assessments and care planning.

Question 24 –

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

Comments

- Ongoing consideration needs to be given to the changing costs of service throughout Australia, and for high-needs clients.
- There needs to be adequate funding to ensure aged care provision meets community expectations.
- The inclusion of costs related to meeting all legislative reporting requirements.
- Due consideration needs to be given to the cost of education to service providers and ensuring standardised processes nationwide.
- There needs to be investment in service redesign and digital transformation to streamline services and find efficiencies where possible.
- There needs to be due consideration given regarding decisions on what services a provider will cease, continue, or commence delivering.

Question 25 –

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

Comments

- There needs to be more work done to reward facilities that maintain and or improve residents' levels of independence and support our previous statements that residents require specific funding to support active restorative and reablement programs.
- Markers of success for facilities may include:
    - services implementing innovation;
    - decreased 'serious adverse events';
    - increased community confidence and expectations; and
    - client satisfaction.

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