Hon Amber-Jade Sanderson MLA
Minister for Health; Mental Health

Our Ref: 76-25555

Mr David Tune AO PSM
Chair
Independent Health and Aged Care Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Via email: submissions.ihacpa@ihacpa.gov.au

Dear Mr Tune David

I am pleased to provide a Western Australian Government submission to the *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25.*

I urge Independent Health and Aged Care Pricing Authority (IHACPA) to implement pricing strategies that address the unavoidable costs for regional and remote service providers in Western Australia (WA), caused by isolation, population dispersal and Aboriginal disadvantage.

Most of WA's regional and remote aged care services are Multi-Purpose Services, jointly funded by Commonwealth and State Governments to be providers of last resort. The current Australian National Aged Care Classification for residential aged care is not suitable for Multi-Purpose Services that require the certainty and flexibility of block, rather than activity based, funding.

I call again for IHACPA to implement an adjustment to Modified Monash Model remoteness ratings for locations surrounded by remote or very remote areas that have lower than expected funding outcomes, in line with the Isolated Towns Adjustment applied to National Disability Insurance Scheme pricing.

I continue to advocate for Commonwealth aged care funding to cover the full cost of aged care services, including patients with very complex care needs, which I expect will be reflected in IHACPA's pricing advice. Western Australian residential aged care providers continue to advise me that the Australian National Aged Care Classification funding increases are being outstripped by cost growth.

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Recently, I have specifically advocated for Commonwealth funding reform to the jointly funded aged care Transition Care Program (TCP), which provides restorative care to older people following a hospital stay. The Western Australian Government has undertaken major reform of the WA TCP to ensure it better meets demand and supports patient flow from hospital. To support the sustainability of TCP, Commonwealth TCP subsidies must be increased to reflect the real costs of delivering quality aged care transition care services, noting the Commonwealth's contributions to this jointly funded program are dropping from 65 percent to 58 percent. Further, to support the effectiveness of TCP, Commonwealth TCP funding must be reformed to appropriately account for acuity and to specifically price admission and discharge activities. IHACPA's aged care pricing insights should be leveraged in any Commonwealth reform of TCP pricing.

In addition, WA is leading the nation in supporting Aboriginal Community Controlled Health Organisations (ACCHOs) to deliver TCP services. ACCHOs and other providers need incentives to enter thin markets and provide culturally appropriate care, particularly in non-metropolitan locations.

Overall, I welcome IHACPA's development of a robust and independent pricing framework that drives safe, quality care, reduces demand on public hospitals, and forms part of a systemic Commonwealth approach to broader sector and hospital interface reform.

I look forward to a partnership approach between IHACPA, State and Commonwealth Government's, WA's aged care sector, and older Western Australians to deliver reform, including the development and refinement of the pricing framework.

Please refer any queries on this submission to [redacted].

Kind regards

p.p.

HON AMBER-JADE SANDERSON MLA
MINISTER FOR HEALTH; MENTAL HEALTH

Attachment A: WA submission on the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25

CC: Hon Mark Butler MP, Minister for Health and Aged Care
Hon Anika Wells MP, Minister for Aged Care

14 SEP 2023

The Government of Western Australia (WA) welcomes the opportunity to provide feedback on the Independent Health and Aged Care Pricing Authority's (IHACPA) *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25.*

1 What, if any, changes do you suggest the Independent Health and Aged Care Pricing Authority (IHACPA) consider for the residential aged care pricing principles?

WA appreciates IHACPA's partial strengthening of the 'Access to care' principle, consistent with the feedback WA provided to the IHACPA's *Towards an Aged Care Pricing Framework* consultation paper in 2022. However, this principle should be further amended to become the 'Access to *person-centred* care' principle, to:

- establish beyond doubt that all Australians, no matter where they live, should be able to access quality aged care services, as per the Royal Commission into Aged Care Quality and Safety (Royal Commission) Final Report's overall reform direction
- align with the System Design 'person-centred' principle and broader social care reforms, including implementation of the WA Government's Sustainable Health Review.[1]

The funding principles should consider and support the provision of care where economies of scale are not possible, such as for smaller providers and thin markets/remote locations. The StewartBrown March 2023 Aged Care Financial Performance Survey notes that over 60% of regional and remote providers nationally experience an operating cost loss of more than $5,000 per bed per annum.[2] This finding was based on a sample with an average of 80 beds per facility and highlights that even with larger providers, economies of scale do not guarantee viability in regional and remote areas. Residential aged care facilities (RACFs) in regional and remote WA sites have lower bed numbers and are therefore at greater risk of being unsustainable.

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 care delivery). What evidence is there to support your answer?

For regional and remote locations IHACPA pricing needs to consider costs of staff retention and additional employment positions, i.e. accommodation and Fly In Fly Out models that are being used more often to attract staff and maintain legislated staffing levels. It also needs to consider the cost of technology used in delivering care.

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[1] Sustainable Health Review, 2019. *Sustainable Health Review: Final Report to the Western Australian Government*, Department of Health, Western Australia, available from: https://www.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Sustainable%20Health%20Review/Final%20report/sustainable-health-review-final-report.pdf [accessed 18 August 2023]

[2] StewartBrown, 2023, *Aged Care Financial Performance Survey Report March 2023,* available from: https://www.stewartbrown.com.au/images/documents/StewartBrown_-_Aged_Care_Financial_Performance_Survey_Report_March_2023.pdf [accessed 25 August 2023]

For most regional and remote facilities, a model based on activity-based funding (ABF) will be insufficient to support an aged care provider due to regional costs and lack of scale. Further, an ABF model will probably not attract new service providers to areas of unmet need and enable choice and control for older people.

The AN-ACC needs to incentivise residential aged care providers to enter and remain in thin markets. Smaller providers that struggle for viability under an ABF methodology might choose to exit the market. Where this occurs, it could leave some regions with limited or no access to RACFs, which in turn would increase emergency department presentations via aeromedical or road public patient transport and public hospital admissions. Noting that public hospitals are already facing chronic demand pressures, further barriers to the timely hospital discharge of older people requiring care at an RACF will place additional strain on the public health system.

To de-risk the market for a provider, a level of funding certainty is necessary. An aged care provider cannot wait for residents to arrive while carrying workforce overheads and establishing service infrastructure. An aged care provider in regional and remote areas will also need to provide services to meet every resident's specific needs. This may require sub-contracting allied health, including pharmacy, and the use of virtual health care.

The WA Country Health Service (WACHS) is a legislated provider of public hospital services and an approved provider of aged care services in WA's regional and remote areas. WACHS is not a competitive provider but operates in communities where a need is not being met by the private market. WACHS's aged care services in regional and remote areas are delivered in integrated sites that include acute and sub-acute services which incur substantially larger overheads than stand-alone RACFs. Consistent with the experience of other regional and remote service providers, WACHS incurs higher salary and operating costs compared to metropolitan services.

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

Factors to consider include:

- Predicted allied health service need must be built into future reviews of the AN-ACC classes
- High cognitive care needs do not necessarily correlate to high mobility needs and this needs to be reflected in the AN-ACC model
- Any changes to AN-ACC classes should be subject to shadow pricing for a minimum of two to three years so that the true cost of service can be understood.

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

Fixed costs at regional and remote sites are considerably higher than for their metropolitan counterparts. Costing aged care is particularly complex and

multidimensional in a regional and remote setting and residential aged care pricing should take this into account.

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?

Building on the response to question 4, WA notes the residential respite care funding model should incentivise RACFs to offer this care option and support quality handover and care planning. Currently, many RACFs prioritise permanent residential places over respite places, as permanent places provide a more secure and longer-term funding stream. The Royal Commission noted that respite is primarily used as a "try before you buy" test before entering permanent care, rather than a break from usual care arrangements.[3] Based on consultation with WA aged care providers, it appears there is insufficient funding to support respite clients.

The WA Government has recognised this funding gap and is trialling a top-up of Commonwealth funding with state funds through the WA Residential Respite Pilot (Pilot). A key part of the State Government's Ambulance Ramping Strategy, the Pilot supplements funding for patients being admitted to temporary respite care until a permanent residential aged care placement is available. These one-off payments to approved providers are:

- $1575 for patients who chose to remain with the aged care provider for permanent aged care
- $1825 for patients who transition to another aged care provider for permanent aged care.

While still at an early stage of implementation, the Pilot has delivered:

- an additional 270 respite beds into the market in WA across 73 aged care facilities
- 40 long stay patients successfully admitted to respite via this respite pathway since early July 2023
- more than 400 hospital bed days freed up for patients who need hospital care.

The South Australian Government has also recognised the funding gap for residential respite care and has recently implemented a similar model to WA's Pilot.

The State Government would be happy to share the Pilot's evaluated outcomes with IHACPA and welcome the opportunity to work with IHACPA and the Commonwealth Government to incentivise and support the full use of patient centred respite for Western Australians, including those in the community or in hospital who are medically fit for discharge but whose supports at home are insufficient and/or time is required to establish these supports.

It is not clear why the one-off adjustment payment for permanent residents is not also applied to respite residents. The activities and costs incurred on entry for both types

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[3] Royal Commission into Aged Care Quality and Safety, 2021, *Final Report: Care, Dignity and Respect*, Vol. 2, p21.

of residents are broadly similar. All older people in the care of an RACF, including respite clients, are deserving of care planning, quality handover and monitoring. Without this, the risk of deconditioning and functional decline will increase. These activities should be undertaken for respite clients and should be reflected in aged care pricing for respite care. WA therefore recommends that the one-off adjustment payment currently paid for permanent admissions to residential aged care is also applied for respite admissions.

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

WA has heard from local aged care providers that indexation is a critical issue, due to the cumulative financial impact of Commonwealth indexation failing to reflect year on year cost growth.

Any indexation methodology for RACF must adequately capture annual increases in both the price of commodities and labour, particularly in a climate of increasing staff to resident ratios.

Indexation applied to regional and remote services should assess contemporary cost pressures, particularly housing costs (for example, average weekly house rental value). Adjustments need to be timely and calculated at a local government area level to account for changes in these cost pressures.

In regional and remote areas, the cost of labour has a very high premium attached – especially in jurisdictions with high-income remote workforces – that needs to be reflected in the indexation. National Disability Insurance Scheme (NDIS) pricing (for allied health, support workers etc) is the most relevant comparative pricing[4].

IHACPA will need to maintain contemporary pricing with other service systems to incentivise provision of residential aged care to areas of unmet need, including by encouraging new and emerging providers, supporting growth in service design and capacity to incorporate dementia and culturally appropriate design principles, and the delivery of appropriate virtual care.

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?

WA would strongly support adjustments to ensure the provision of culturally appropriate services and physical environments for Aboriginal and Torres Strait Islander people, a critical issue for aged care providers in regional and remote WA. An adjustment of this sort should cover the costs incurred in:

- preparing a care plan (including, for example, interpreters and translators)

[4] *NDIS Pricing Arrangements and Price Limits 2023-24*, available from https://ndis.gov.au/media/6069/download?attachment [accessed 25 August 2023]

- broader care considerations and support for individuals, for example to travel to country, undertake cultural activities and participate in gatherings
- providing appropriate facility layouts and room design, for example to enable separation of related men and women, and outdoor spaces for on-country experiences.

In addition to support for the specialised services IHACPA has already identified (including dementia/cognitive impairment, complex care, specialised equipment), other adjustments should include residents with degenerative disorders (who require maintenance therapies), mental health conditions, and complex behavioural support needs. The current AN-ACC model might not adequately reflect the clinical journey of residents with cognitive decline.

Additional costs requiring adjustment are also associated with:

- residents who need higher intensity allied health services to maintain functionality and independence, including allied health needs assessment in individual patient categories
- telehealth specialist appointments requiring onsite clinical staff to attend
- clinical notes as evidence of staff support and for family meetings
- situations requiring additional coordination between an RACF and a hospital to ensure a safe and timely discharge to residential aged care – this could include a funding contribution towards care coordination and handover
- aged care providers' clinical accreditation to provide certain sub-acute care services
- translators and maintenance of cultural connections for residents from culturally and linguistically diverse backgrounds
- incentives for providers to manage more complex cases, including older people with mental health issues and/or disabilities
- services for people with disability in the NDIS who require aged care and clinical services (noting this is a small cohort)
- potential funding to a community provider in remote locations that lack an RACF. IHACPA requires a capability to review individual cases, make allowances for location and fund accordingly.

8 What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariffs (BCT) weighting?

As a starting point, WA recommends the IHACPA implement an adjustment to Modified Monash Model (MMM) remoteness ratings for towns surrounded by remote or very remote areas that lead to a lower than expected funding outcome. For example, the town of Kalgoorlie in WA has an MMM 3 rating, while being surrounded by MMM 6 and 7 areas and 600 kilometres by road from a metropolitan centre. The MMM 3 rating reduces viability in this instance because facilities will not be appropriately compensated for the additional costs of operating in such a remote location.

MMM does not accurately reflect the complexities (and exceptions) of individual communities. The NDIS has adjusted MMM price loadings for specific locations (including Merredin, Kalgoorlie and Geraldton in WA) to better reflect the higher costs

of service delivery. WA recommends the IHACPA apply the NDIS Isolated Towns Adjustment to adjust remoteness ratings for all towns surrounded by remote or very remote areas. This adjustment has been applied to locations in WA (including Kalgoorlie), New South Wales and Queensland within the NDIS to reflect costs more appropriately.

WA is aware the Commonwealth Department of Health and Aged Care (DOHAC) has extended eligibility for its AN-ACC Transition Fund Grant to RACFs in MMM 3-4 areas experiencing higher care costs compared with other MMM 1-4 services due to their isolated location (including Kalgoorlie and Geraldton). The grants' purpose is to transition RACFs from the Aged Care Funding Instrument (ACFI) to AN-ACC with no impact on their funding, and they will only be available for 2023-2024. While this is welcome, a more sustainable model is required to shore up provider viability in these locations.

The BCT also needs to consider service models and weight accordingly. For example, local allied health services are not available to remote RACF residents, so those professionals must travel to the facility, incurring significant time and travel costs. As an example, allied health professionals flying Perth-Port Hedland return would require 6+ hours of travel time and flight costs upwards of $1,000, and there are more remote locations. Multiday visits would also incur accommodation costs.

Aged care service delivery in remote and regional WA does not fall within the "efficient price model" parameters. The consultation paper notes on page 36 that "there are significant differences between the public hospital and residential aged care systems that require specific consideration". Some characteristics to consider are hospitals' short term and episodic stays compared with aged care services, where: length of stay cannot be determined; residents' needs increase as length of stay increases; and residents have varied needs, including cultural, health, and mental health.

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?

Over the longer term, the Aged Care Quality and Safety Commission's evidence base could be used to link classification and pricing to consumer outcomes over time. This would provide, for example, assurance that facilities are providing optimal allied health services to aged care residents.

Quarterly provider reporting provides an opportunity to develop benchmarks for high quality care, including in allied health services. Alternative arrangements to the mandatory 24/7 registered nurse and minimum care minutes currently being investigated by DOHAC for services where it is not feasible to meet those staffing requirements – such as enabling other staff and/or technology to deliver mandated care minutes, strengthening staffing profiles etc – will also inform how quality consumer outcomes can best be achieved.

WACHS's financial modelling indicates the benefit of the increased revenue from AN-ACC is outweighed by the cost of meeting the new minimum care minute requirements and other compliance costs. It is anticipated that this adverse net financial impact will become unsustainable over time.

Some WA residential aged care providers have raised similar concerns regarding the financial impact of the new care minute requirements, when comparing the outcomes from the previous ACFI to the AN-ACC and associated reforms. This is of concern in the wake of cumulative financial challenges for the aged care sector, driven in part by Commonwealth funding that has not kept pace with cost growth over time.[5]

IHACPA's pricing framework must ensure that the aged care sector does not face an adverse net financial impact from reforms, while continuing to drive the quality of care envisaged by the Royal Commission in its Final Report.[6] This will require the pragmatic implementation of the care minute requirements to support residential aged care providers with the significant amount of reform transition required, with due regard to the realities of the current labour market.

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

Application of the AN-ACC model to MPSs

WA does not support the current AN-ACC model being applied in full to MPSs because their service delivery requirements differ from stand-alone RACFs. MPSs have been financially disadvantaged over time because Commonwealth contributions have not kept pace with inflation and cost growth.

WA does recognise there are elements of the AN-ACC which might be relevant for MPSs, for example measures of resident complexity and fixed fee / entry payments to account for higher one-off costs. However, application of elements of the AN-ACC needs to be carefully considered due to the inherent differences between residential aged care facilities and MPS sites. Any future IHACPA pricing of MPS services must recognise the unique context in which they operate, maintain the current flexibility in their operating model and lead to Commonwealth funding outcomes that support ongoing MPS viability.

The MPS model includes acute, residential and community-based services in a flexible service delivery model with staff and resources shared across the site. A holistic approach should be taken to pricing, where the impact of each component on the

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[5] See Royal Commission into Aged Care Quality and Safety, 2021, *Final Report: Care, Dignity and Respect*, Vol. 1, p154; StewartBrown, 2023, *Aged Care Financial Performance Survey Report March 2023,* available from: https://www.stewartbrown.com.au/images/documents/StewartBrown_-_Aged_Care_Financial_Performance_Survey_Report_March_2023.pdf [accessed 25 August 2023]; Department of Health and Aged Care, 2023, *Financial Report on the Australian Aged Care Sector 2021-22,* available from: https://www.health.gov.au/resources/publications/financial-report-on-the-australian-aged-care-sector-2021-22 [accessed 18 August 2023]

[6] Royal Commission into Aged Care Quality and Safety, 2021, *Final Report: Care, Dignity and Respect*, Vol. 1-5.

overall MPS operation is considered. This would ensure that the combination of funding streams provides financial viability for smaller sites, thin markets and remote locations.

A key to successful regional and remote service provision is affording funding flexibility for providers to develop local solutions and draw on existing community strengths. Historically, MPS funding has been characterised by pooling place-based funding to provide flexibility because these services are in areas that cannot support an aged care facility and a hospital.

A rigid application of the AN-ACC would stifle the flexibility necessary for small and regional/remote services to remain viable. Aged care services in these areas might be better supported through block funding, a necessary option well recognised in IHACPA's public hospital pricing approach. Further, any proposed pricing model must adequately cover fixed costs to ensure the service's financial viability regardless of occupancy.

Costing matters

WACHS is currently undertaking a desktop costing analysis into the cost of aged care service delivery. Initial findings demonstrate that the current MPS unit price is substantially lower than the unit cost for all 38 WA MPS sites. This indicates that introducing the AN-ACC in full would result in a deficit for aged care services at small regional and remote MPS sites. When coupled with Commonwealth funding not keeping pace with cost growth for MPS sites over time, there is potential for a significant funding and service delivery challenge for the State in an area of Commonwealth Government responsibility.

WA supports IHACPA's independent annual review of costs and pricing, to ensure funding keeps pace with the cost of delivering care, noting MPS funding is currently not determined by the cost of care and lacks mechanisms to deliver funding increases apart from annual indexation.

Significant work is required to determine the true cost of service delivery and build on the 2019 MPS Review of the funding model's effectiveness to better understand key cost drivers and inputs. Data on cost drivers is currently limited and fragmented and requires further development before it can reliably inform future policy. Data could be strengthened on the number of beds, location, length of stay, morbidities, First Nations status, service needs dependent on community requirements, impact of other hospital services delivered by the site, resident needs/complexity/acuity including mobility and cognitive impairment).

Further, the MMM classification should not be the sole indicator of location cost differences as sites within the same MMM classification can have very different locations, service requirements and costs. For example, Exmouth and Meekatharra are both classified as MMM7 and have very similar capacity and service profiles. However, Meekatharra demonstrates a unit cost almost three times that of Exmouth largely due to its isolated location and lack of community infrastructure, compared to Exmouth which has more supporting infrastructure and is in a higher traffic location. It

is noted that while the MMM is used extensively in Commonwealth programs, it is primarily a workforce planning tool and not a funding instrument.

Other pricing factors for consideration

WA MPSs face significant additional staffing costs that Commonwealth funding does not adequately cover. For example:

- higher wages necessary to attract and retain staff
- difficulty recruiting permanent staff, resulting in high agency and locum use at increased cost
- lack of consistent staffing increasing patients' care needs
- the lack of appropriately trained staff for AN-ACC's increased care requirements. For example, WACHS continues to experience an ongoing cycle of dementia-trained staff being unavailable, which requires agency/short-term staff to be trained who then invariably leave shortly thereafter, requiring new staff to be trained.

Pricing must recognise that infrastructure influences the operating costs and service design. For example, an MPS residential component in the hospital has different operational requirements (for example minimum staffing profiles to maintain acute services) to a facility where the RACF is a co-located or separate building to the hospital (for example where staffing can be flexed up or down to suit resident occupancy and needs).

Further, WA would encourage the IHACPA in its future pricing work on MPSs to:

- take a wide sample of services to better understand jurisdictional, regional and site-based variations
- work to an adequate timeframe to implement a new pricing model (indicatively two to three years) to agree on data requirements, validate data and undertake shadow pricing
- remain cognisant of developments with the new Support at Home Program, as in-home care is delivered by WA MPSs
- consider mechanisms for the MPS service to address unmet needs. For example, the ability of an MPS to respond flexibly to accommodate changing community needs including supporting additional residents, and providing respite and community services, which is a key goal of the MPS program.

11 How could, or should the AN-ACC model be modified to be used for 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?

WA does not support using the AN-ACC model for NATSIFACP if it does not provide certainty or constrains flexibility, in which case retention of block funding would be preferred.

The advantage of the original NATSIFACP program is it has the flexibility to meet the needs of older Aboriginal people by integrating community and residential services in small populations. Like the MPS model, the flexibility of the service model is integral

to meeting the demonstrated needs of the community. Applying an activity-based funding framework to such a complex service delivery model would be challenging. A rigid application of ABF will stifle the flexibility necessary for remote services to remain viable.

As with MPS aged care service provision, the NATSIFACP pricing model should encourage and de-risk market entry by community providers by ensuring service viability with a funding source not dependent on size or occupancy.