UnitingCare

UnitingCare Queensland's Submission to IHACPA

Pricing Framework for Residential Aged Care Services in 2024-25

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Executive Summary

UnitingCare Queensland is one of the largest residential aged care providers in Queensland (BlueCare) and the Northern Territory (ARRCS) with over 70 years' experience. The residential aged care sector is undergoing significant cultural and demographic change.

UnitingCare Queensland recommends that IHACPA:

1.1 Expand its remit and funding to:

- *Conduct reviews, reporting and research into trends, gaps, and needs analysis of the aged care sector and its associated funding, pricing model and framework with the reports to be freely and publicly available.*
- *Include all funding sources and federally regulated aged care prices and subsidies (including prices and subsidy levels for Commonwealth supported places in residential aged care facilities).*

2.1 Review for classes 2 to 4:

- *the funding levels of the classes;*
- *consideration of consolidation of these class; and*
- *whether pricing of these classes considers whether the Support at Home Program might be a more appropriate care pathway.*

2.2 Review for classes 8 and above:

- *A bed-based supplement for specialised beds or funding piece for patients with behavioural difficulties, such as dementia.*
- *Whether the classes accurately capture behavioural issues (e.g. dementia) and their associated costs or whether new classes are required.*

2.3 Create a reassessment supplement similar to the initial entry adjustment, the permanent care recipients' subsidy.

2.4 Look to include a capital component in its calculation of the NWAU or look to provide additional NWAU units to account for capital costs in classes 8 and above.

3.1 Encourage overnight respite care, by:

- *Introducing a basic fixed fee for respite beds to incentivise providers to facilitate respite needs; and*
- *Increasing respite variable component funding rates to account for a level of vacancy due to booking timing between clients (i.e. to account for the vacancy ratio).*

3.2 Introduce a respite funding model to include a category (or categories) for behavioural and mental health complications.

3.3 Create an initial entry adjustment for respite residents to account for the significant costs in admitting respite residents.

4.1 Be required to brief the Minister each year (as soon as practicable) for the difference between the forecast and actual rate of inflation just passed, and advise of what the appropriate adjustments would be

needed to account for any disparity (to serve as a rebalancing mechanism).

5.1 Introduce a BCT uplift for MMM2 to MMM4 facilities and review the BCT uplift for MMM5 to MMM6 facilities.

5.2 Investigate whether an ASGS classification is a better geographic classification to base the BCT uplift on.

5.3 Expanding Indigenous Specialisation to include MMM1 to MMM5 facilities with an appropriate uplift.

5.4 Review the BCT uplift for Indigenous specialisation for MMM6 facilities.

6.1 Account in its pricing model any significant reforms or regulatory changes that require significant variation to providers' systems or operations.

6.2 Account in its pricing model any increased overhead costs resulting from increasing training costs and changes to training delivery.

7.1 Ensures the following six principles be retained in transitioning NATISFACP facilities to an AN-ACC model:

1. *Ensuring that block funding and funding per registered bed is kept under the transition given the transient nature of many First Nations populations.*
2. *Expanding Indigenous Specialisation to include MMM1 to MMM5 facilities with an appropriate uplift.*
3. *Ensuring that the resource intensive nature of providing culturally appropriate services to Australians is recognised in the funding model ranging from specific training, building and accommodation design, and culturally appropriate food.*
4. *Creating a higher temporary specialised variable component (classification funding) for indigenous specialised facilities to account for the long delays in getting assessors to regional and remote areas and the cultural issues in getting First Australians due to complex trauma and history of these people.*
5. *Ensuring that a funding uplift for smaller remote facilities is provided for (similar to the 24/7 Registered Nurse supplement) as our NATISFACP facilities are much smaller than comparable mainstream facilities given the small communities they service.*
6. *Balancing the requirement between a specialised threshold and ensuring that the local community can access residential aged care.*
7. *Ensuring that AN-ACC model transition for MMM1 to MMM6 First Nations facilities are appropriately funded accounting for all funding streams.*

Introduction

Every day in the community, we engage with people from all walks of life. We deliver skilled, evidence-based interventions for those facing adversity, and utilise our reach and vision to confront injustice.

"Live life in all its fullness"

We are leaders in providing care and support to older Australians. We meet people where they are and walk alongside them to achieve positive change and growth. Right across Queensland and the Northern Territory, UnitingCare Queensland supports our older Australians redefining what's possible in their lives.

UnitingCare Queensland provides health, aged care, disability and community services to over 430,000 Australians a year as the largest Queensland based not-for-profit employer with 16,500 staff and 6,500 volunteers. UnitingCare Queensland has 70 years' experience in providing in-home care to our older Australians, residential care in our 57 aged care facilities and four private hospitals. A summary of our operations can be found in Appendix 1.

Pricing Framework for Australian Residential Aged Care Services 2024–25

UnitingCare Queensland welcomes the opportunity to provide feedback on the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25. This is our second submission to the Independent Health and Aged Care Pricing Authority's consultation on the Pricing Framework for Residential Aged Care Services.

Since the last consultation, there has been formal sector wide analysis of the Residential Aged Care Sector. The University of Technology Sydney's *Aged Care Sector Mid-Year Report 2022–23* found that the residential aged care sector is under increasing pressure, with operating losses per resident per day of $17.47 in December 2022 compared with $11.34 in December 2021.[1] The department's financial report on the Australian aged care sector also recently found that the financial performance of residential care has an average per resident per day loss of $32.97.[2]

[1] Australia's Aged Care Sector: Mid-Year Report 2022-23, https://opus.lib.uts.edu.au/handle/10453/170529
[2] Financial Report on the Australian Aged Care Sector, https://www.health.gov.au/sites/default/files/2023-08/financial-report-on-the-australian-aged-care-sector-2021-22_0.pdf

1. Pricing Principles and Holistic Care

Addresses the following question:

Q1. What, if any, changes do you suggest the Independent Health and Aged Care Pricing Authority (IHACPA) consider for the residential aged care pricing principles?

While we broadly support the proposed residential aged care pricing principles, IHACPA will have to balance what may be, at times, competing priorities. For example, principles of efficiency and sustainability, which are customer centred care approaches may compete with principles of innovating and investment, which are currently a response to pricing decisions.

The pricing framework must consider residential aged care pricing principles. Currently, there is no margin in the pricing framework for innovation and investment, only funding to cover the cost of delivering care. In practice, the principles will provide IHACPA the opportunity to provide appropriate funding for innovation and investment, by considering both the economic costs of care and other contributing costs. The principle of fairness must also consider other funding issues such hoteling, accommodation, subsidies and supplements. IHACPA could consider all funding available to providers, not just AN-ACC, with federal government support.

The proposed residential aged care pricing principles could go further in recognising that residents will have differing personal preferences. For example, some residents may prefer living closer to their families over quality, which is not currently considered as part of the principles.

Additionally, the pricing principles do not consider the importance of capital investment in equipment and infrastructure to provide high quality and safe environments as well as investment in hiring, training and developing staff and organisation processes.

Holistic Care

Delivering high quality, individualised and holistic care is at the heart of all we do. The pricing model should enable older Australians to receive an individualised approach to holistic care, rather than a one-size-fits-all approach, based on:

- A deep relationship between providers and older Australians
- Delivering holistic, high quality and individualised care that meets consumer needs
- Mutually understood and measurable goals
- The provision of safe and consistent care that is in line with best practice with a continuous improvement culture
- Filling the service gap and providing consumer support
- Community integration

From our perspective, holistic care aims to:

- Understand and respect a person's values, past experiences, preferences and expressed needs

- Coordinate and integrate care
- Communicate information and educate
- Maintain physical comfort
- Offer spiritual and emotional support
- Alleviate fear and anxiety
- Involve family and friends
- Transition well with continuity of care
- Provide access to care
- Ensure older Australians are connected with the communities where people work and live

This means recruiting multidisciplinary teams with strong person-centred cultures and who bring together psychosocial and clinical care. A simplified diagram is outlined below in Diagram 1.

Diagram 1: Holistic Care

IHACPA's remit

In order for the sector to deliver high-quality and person-centred care for all Australians, IHACPA must be able to consider all funding necessary to deliver this care (i.e. accommodation costs, hoteling costs, and other subsidies that the government provides operators).

1.1 UnitingCare Queensland recommends that IHACPA's remit and funding be expanded to include:

- ***To conduct reviews, reporting and research into trends, gaps, and needs analysis of the aged care sector and its associated funding, pricing model and framework with the reports to be freely and publicly available.***
- ***To include all funding sources and federally regulated aged care prices and subsidies (including prices and subsidy levels for Commonwealth supported places in residential aged care facilities).***

2. AN-ACC Classes Feedback

Addresses the following questions:

Q2. 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?

Q3. What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?

Q4. 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.

Q7. 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?

Under the current AN-ACC classification arrangements, an aged care resident is assigned to one of 13 classes of care funding depending on several factors, such as mobility, cognitive ability, and function. We believe further investigation is required by IHACPA as to whether the assessment uplifts align to the cost of care being delivered, as providers spend more on direct care than what AN-ACC covers.

Classes 2 to 4

Based on our own data, the number of residents in classes 2 to 4 are low in mainstream facilities, likely due to the associated regulatory burdens and costs. More broadly, consideration must be given to whether residents on lower classes of care should be in residential care at all.

We suspect we are not alone amongst providers as seeing these classes as no longer financially viable given care funding levels and the complex regulatory environment of residential aged care. This is likely resulting in fewer residents on lower classes of care entering facilities as a proportion of residential numbers.

Given these trends, examination should also be given to whether other programs (such as Support at Home) might be more suitable. As noted in our previous paper, insufficient funding bias means providers are more likely to select residents based on their class.

2.1 UnitingCare Queensland recommends that IHACPA review for classes 2 to 4:

- ***the funding levels of the classes;***
- ***consideration of consolidation of these class; and***
- ***whether pricing of these classes consider whether the Support at Home Program might be a more appropriate care pathway.***

Class 8 and above

All classes (up to class 8) are based on mobility. Classes 8 and above do consider behavioural issues (e.g. dementia) as a contributing factor, however further research is required. BlueCare has several dedicated services to provide care to individuals with behavioural issues. However, consistent funding is required to ensure investment to support care for challenging residents. We believe there should be a bed-based 'behaviour price' to reflect this complexity.

The biggest impact on care minutes and a significant drain on resources is the increasing number of residents with behavioural difficulties in those in Class 8 or above. This particularly impacts residents with dementia, in services with limited ability to provide diversional therapy.

Dementia requires investment in skills and capital to deliver care that is resource intensive. This also includes regulatory requirements, maintaining linkages with external agencies (such as the NDIS and Dementia Support Australia), costs associated to assessments, case management, ongoing reviews and capital-intensive redesign of environments.

Caring for residents with dementia is capital intensive. Providers are increasingly required to invest more into dementia care as the previous funding mechanisms were not designed to accommodate the number of dementia residents providers currently care for.

Current subsidies and funding model for dementia care is insufficient to incentivise providers to invest in appropriate facilities and capital works for dementia residents. Previously, providers would receive a supplement for dementia residents, which may have ended due to the scale of dementia residents being admitted but has not been replaced. As a result of these factors, providers must be selective in the way dementia residents and others with behavioural difficulties and mental health issues are brought into facilities. Consideration is given to issues like the adequacy and appropriateness of facilities, the unpredictability of a resident's response to the environment, the associated workforce impacts of having that resident and the impact of other residents.

We believe IHACPA should consider the adoption of new classes for behavioural issues specifically, particularly given increases in care requirements and reporting. Furthermore, residents may suffer from rarer cognitive issues that are difficult to provide care for, which is not currently considered in the funding model.

It should also be noted that hospitals are referring dementia patients onto providers who cannot adequately support them, which has the potential to damage the atmosphere of the facility for other residents and staff.

It should also be noted, for providers the capital intensive nature and resourcing requirements for those with behavioural issues means that a higher bed rate should be provided. For example, if a class 10 resident leaves, a provider might face a significant funding shortfall if they take on a class 3 resident and put them in a specialised dementia area.

The current model of taking aggregates and targeted monitoring does not accurately reflect the cost.

2.2 UnitingCare Queensland recommends that IHACPA's review for classes 8 and above:

- ***A bed-based supplement for specialised beds or funding for patients with behavioural difficulties, such as dementia.***
- ***Whether the classes accurately capture behavioural issues (e.g. dementia) and their associated***

costs or whether new classes are required.

Assessments and reassessment costs

There is a trend of higher needs residents requiring shorter periods of care, as they deteriorate faster due to changes in their condition. As a result, there is a cost increase with assessments and reassessments for these residents. While the funding arrangements factor in the initial assessment costs, it does not factor in the costs, such as new or updated care plans, care coordination activities, briefings to staff, and linkages and engagement with families. The costs to implement these reassessments in our experience closely match the initial entry adjustment permanent care recipients' subsidy.

There are also issues and costs associated with linkages and engagement with families of residents. The sensitivities around care documentation, confidentiality and privacy should be noted. Visits by family and friends to residents should be considered as part of legitimate or unavoidable costs, in addition to the reassessment costs mentioned.

2.3 UnitingCare Queensland recommends that IHACPA create a reassessment supplement similar to the initial entry adjustment – permanent care recipients' subsidy.

Capital costs

The unavoidable costs of factors like behavioural difficulties also includes significant capital costs. The current funding arrangements are insufficient for providers to justify further investment in facilities, given the NWAU does not have a capital component. This is quite significant for providers managing behavioural issues, we note the boom of specialised (and capital intensive) dementia wings being created in residential aged care services.

Given the lack of data collection on these specialised facilities, IHACPA will have to conducts its own studies in conjunction with the sector to work the additional capitals of these items. Some examples of costs include: additional security systems, additional door placements and designs of walls and the built environment to facilitate dementia residents to live as independently as possible.

2.4 UnitingCare Queensland recommends that IHACPA look to include a capital component in its calculation of the NWAU or look to provide additional NWAU units to account for capital costs in classes 8 and above.

3. Respite

Addresses the following question:

Q5. 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?

Residential aged care services predominately provide overnight respite services following the deregulation of the overnight respite sector. One of the key trends we see is our facilities are prioritising long-term residents over providing short-term temporary overnight respite care.

The funding model of respite does not provide a sufficient level of funding to incentivise the provision of overnight respite care. Facilities are under pressure to maintain high occupancy, so an empty respite bed comes at a cost to a facilities performance. As a result, there is a large disincentive to keep a respite bed available, which is essential given the inconsistent nature of respite bookings and need in the community. While there is a large demand for respite, it is not priced to reflect the inconsistent occupancy for beds to be left open regardless of occupancy by a respite client.

To address this issue, there should be a basic holding fee for respite beds (similar to the TPIC charge), rather than activity-based funding which, based on our experience, does not work. This will ensure providers are incentivised to create permanent respite beds, with increased funding for respite to account for variable occupancy.

3.1 UnitingCare Queensland recommends that IHACPA encourage overnight respite care, by:

- ***Introducing a basic fixed fee for respite beds to incentivise providers to facilitate respite needs; and***
- ***Increasing respite variable component funding rates to account for a level of vacancy due to booking timing between clients (i.e. to account for the vacancy ratio).***

The parameters of the respite funding classification are based on mobility and ignore the significant costs of managing people with behavioural and mental health issues. The AN-ACC class system recognises this but the respite funding model does not.

Additionally, short stays often require greater care demands than a permanent resident as you have an increase in anti-social behaviours due to a change in environment for the resident.

3.2 UnitingCare Queensland recommends that IHACPA introduce a respite funding model to include a category (or categories) for behavioural and mental health complications.

Providers must then also provide the services and care for them as if they are permanent residents. This causes increased costs and complexity of care and is not factored in the respite funding unlike a permanent resident who receives an

initial entry adjustment payment to pay for the development of care plans and other associated costs in transitioning the person into residential age care.

3.3 UnitingCare Queensland recommends that IHACPA create an initial entry adjustment for respite residents to account for the significant costs in admitting respite residents.

4. Indexation

Addresses the following question:

Q6. What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

IHACPA bases the future financial year's price on a forecasted rate of inflation. We applaud IHACPA for publishing the calculations of its pricing model and the forecasted values used for indexation.

Where indexation forecasts are incorrect, this can have significant implications in the sector. For example, in the most recent financial year 2022-23, IHACPA forecasted inflation to be 2.82 per cent, not the actual rate of 5.96 per cent. As a result, providers lost the difference, a total underfunding of $213.19m.

The underfunding result from 2022-23 due to the incorrect inflation forecast at a sector level can be calculated using the Residential Aged Care Pricing Advice 2023-24 Technical specifications.[3] Using, the ACFR funding total ($6,789.m) by the adjustment rate (in Table 4 on page 14) (3.14%) we get an underfunding rate of $213.19m.

4.1 UnitingCare Queensland recommends that IHACPA be required to brief the Minister each year (as soon as practicable) for the difference between the forecast and actual rate of inflation just passed, and advise of what the appropriate adjustments would be needed to account for the discrepancy.

[3] Residential Aged Care Pricing Advice 2023-24 Technical Specifications, https://www.ihacpa.gov.au/sites/default/files/2023-06/residential_aged_care_pricing_advice_2023-24_technical_specifications_0.pdf

5. Base Care Tariff Uplifts

Addresses the following question:

Q8.What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariffs (BCT) weighting?

The BCT weightings are important to ensuring aged care providers can operate in regional and remote areas as well as for the care of marginalised and disadvantaged groups. The current BCT weighting gives uplifts for MMM5 to MMM7 regions and for specialised homelessness services and specialised indigenous services with specialisation requiring over 50% of residents.

Based on two recent reports, the UTS report using StewartBrown survey data '*Aged Care Sector Mid-Year Report 2022–23',* the residential aged care sector in MMM2 to MMM4 facilities are struggling badly when compared to MMM1 and MMM5 to MMM7 region facilities.[4] Additionally, the Department's financial report on the Australian aged care sector identified a similar trend.[5]

Based on UnitingCare Queensland's experience, MMM2 to MMM4 regions need an uplift to better represent the increased costs of providing care particularly as the economic environment has changed since the original RUCS study in 2019. Additionally, our costing experience is that MMM5 to MMM6 regions also need an increase to the BCT weighting uplift for similar reasons as the MMM2 to MMM4 regions. Due to commercial confidence, we are unable to fully elaborate on these costs, however based on both the StewartBrown and departmental paper and data provided by providers through the ACFR and QFR process, we expect the costs issues outlined below to come through in financial figures.

Agency Cost

MMM2 to MMM7 regions are more reliant on agency staff than an MMM1 region. For MMM7 we find the BCT uplift to be sufficient. Our experience is that whilst agency staff are around 6pc of total hours, they account for around 17pc of total cost (i.e. around three times greater cost).

Accommodation and Travel

While providers support and employ staff, they should not need to enter the residential property market to supply housing for staff, which is becoming a standard requirement in regions that are not MMM1. It is another layer of administration that is outside of the core business of residential aged care and significantly increases costs of delivering care. Adding to these pressures are agency staff costs and their associated travel and accommodation costs, which have increased dramatically in the sector, making

[4] Australia's Aged Care Sector: Mid-Year Report 2022-23, https://opus.lib.uts.edu.au/handle/10453/170529
[5] Financial Report on the Australian Aged Care Sector, https://www.health.gov.au/sites/default/files/2023-08/financial-report-on-the-australian-aged-care-sector-2021-22_0.pdf

it no longer viable to only pay award or above award wages. Additionally, increased flight costs and low vacancy rates are increasing the costs of bringing staff to these areas. Indeed, for a MMM2 site, the travel costs (e.g. flights and accommodation) exceeded the agency cost of staff.

Allied health and specialist services

There are challenges accessing allied health and specialist services across the aged care sector, particularly in rural and regional locations. This includes support for mental health, palliative care, external agency costs, dietitians, and telehealth services.

For example, a physio in Mackay can cost up to $200 an hour, significantly higher than the costs in South East Queensland. Additionally, the cost to fly-in sought after allied health and specialised can double and triple the cost typical in an MMM1 region.

The StewartBrown Aged Care Financial Performance Survey Report found other direct care labour costs, such as allied health, averaged $26.30 per bed per day in the six months ending calendar year 2022.[6]

There is also a focus on mental health and isolation in aged care, including in the new Aged Care Act and Standards around trauma informed care and the resident impact of this. Issues around mental health, which may include depression, behavioural changes (non-dementia related), isolation and trauma and require individualised case management, should be considered in assessments.

Furthermore, there should be a palliative care uplift at certain points in time to account for medicine costs. Additional costs to cover linkages with external agencies and other stakeholders for case management and assessment resources should also be considered.

5.1 UnitingCare Queensland recommends that IHACPA introduce a BCT uplift for MMM2 to MMM4 facilities and review the BCT uplift for MMM5 to MMM6 facilities

Australian Statistical Geography Standard (ASGS) Regions

UnitingCare Queensland's experience is that the Australian Statistical Geography Standard (ASGS) Edition 3 – Remoteness Area Category 0-4 is the better predictor than the Modified Monash Model (MMM) in determining both operating and capital costs of regional, rural and remote residential aged care facilities and support at home services.[7]

Under the MMM, in regional areas, the particular care costs for nursing are tied to whether or not there is a hospital located nearby. Having a hospital nearby does not actually reduce costs but significantly adds to staff wages, agency loading, travel and accommodation benefits as we directly compete with the Queensland Government for staff in these areas.

This actually disadvantages MMM2 to MMM5 regions in Queensland where the government has adopted a more decentralised hospital model with smaller regional hospitals significantly impacting these regional designations and requiring an uplift that would otherwise be granted under the ASGS model.

For us, the difference in costs in both facilities and corporate operations are

[6] https://www.stewartbrown.com.au/images/documents/StewartBrown_-_Aged_Care_Financial_Performance_Survey_Report_December_2022.pdf

[7] Australian Statistical Geography Standard (ASGS) Edition 3, Remoteness Areas, https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas

better reflected by the ASGS model than the MMM model. Challenges we face daily and our ability to resolve them in a cost-effective manner decrease more accurately in line with the ASGS regional and remoteness level than the MMM level.

General staffing and housing costs are generally predicated at ASGS level rather an MMM level as are freight and travel costs because the ASGS level inputs these very real indicators. These costs make up the majority of our facilities' costs and hence the ASGS may be a better classification system given that nursing and other clinical costs whilst significant are not the primary drivers of cost.

***5.2 UnitingCare Queensland recommends that IHACPA* investigate whether an ASGS classification is a better geographic classification to base the BCT uplift on.**

Specialised First Australian Care

In both Queensland and the Northern Territory, ARRCS First Australian focus facilities and Blue Care Pinangba facilities are classed as specialised homeless services as there is no Indigenous specialisation available for MMM1 to MMM5 regions.

It is difficult to maintain specialist indigenous services in mixed communities given the specific community need for trauma informed cultural awareness training required to provide high quality care.

UnitingCare Queensland places a premium on our culturally valued service to Indigenous Australians and believe the specialised work necessary to provide this service should be more clearly identified in any classification system.

Expanding indigenous specialisation to MMM1 to MMM5 regions will assist in providing high quality culturally appropriate care for all First Australians across the sector.

There is also a significant disparity between MMM 6 and 7 with the specialised indigenous MMM 7 being similar to NATSIFACP but MMM6 not being a sufficient uplift.

ARRCS specifically provides services to First Australians in an MMM6 region as the only provider in the region running multiple facilities. ARRCS' experience with costings shows its costs as similar to MMM7 designated facilities.

Due to the commercial nature of this work, we appreciate being contacted directly to discuss this further.

The issues boil down not only to access, but the very distinct operating challenges we experience in smaller communities, such as:

- Smaller labour markets and difficulty getting suitably qualified labour, requiring increased remuneration in order to secure employees
- Increased attraction, recruitment, and retention costs, including travel and accommodation
- Ongoing urgency in retention driven by difficulties in replacing staff
- Increased cost and challenges to leverage training and other centrally delivered services
- Premium costs for agency and contract staff when required
- Increased travel time, distances and cost for service delivery
- Increased workforce investment where there is a lack of community infrastructure, including complementary social and health care services
- Challenges achieving critical mass volumes in some service types to

support engagement of requisite skills (e.g. allied health and nursing services)

- Increased operational costs resulting from logistics and transport implications
- Reduced economies of scale for operating costs (e.g. reduced vehicle utilisation, property costs and administration)
- Thin care recipient markets resulting in reduced volumes and service efficiency and increased business impact of care recipient choices and market changes
- Difficulties achieving critical mass volume for required service streams to support viable engagement of requisite skills
- Delays in access to and delivery of operating supplies impacting service efficiency and delivery
- Increased investment and cost in community connection and engagement to appropriately suit local community

5.3 UnitingCare Queensland recommends that IHACPA expanding Indigenous Specialisation to include MMM1 to MMM5 facilities with an appropriate uplift.

5.4 UnitingCare Queensland recommends that IHACPA review the BCT uplift for Indigenous specialisation for MMM6 facilities.

6. Safety and quality

Addresses the following question:

Q9. What, if any, evidence or considerations will support IHACPA's longer term development path for safety and quality of AN-ACC and its associated adjustments?

The long development path to incorporate safety and quality into the funding model is a complex one for IHACPA and all aged care stakeholders. Unlike the clinical outcomes of the Hospital system, residential aged care deals with people's home life and the holistic nature wrapped around it.

The AN-ACC pricing model uses the RUCS pricing assumptions from 2019 and is currently undergoing an update to better reflect the pressures of running a contemporary aged care facility.

Whilst we support the pricing model update to reflect modern-day impacts, we note the residential aged care sector is still undergoing significant reform that is impacting the cost to deliver care, costs of regulatory reform. and associated training costs before even considering care and quality outcomes.

This is particularly pertinent as a new Aged Care Act starts from 1 July 2024 that incorporates many regulatory changes that will improve quality and safety but also significantly increase the ongoing costs of delivering safe and quality care.

Regulatory reform costs

Providers face costs to implement regulatory reform through training, data collection and other costs not currently accounted for because AN-ACC is based on a walk through and time tracking model that assumes a fixed overhead model at a certain point in time.

Ideally the pricing framework should account for new and imposed regulatory reforms costs. For instance, in facilities where there are NDIS patients, all staff may be required to meet certain regulatory costs, such as Blue Card registration (at a cost of $138 per staff member), which is not considered under the pricing framework.

There are also change costs associated with changes to reporting, such as systems and implementation costs, training and support costs, and reorganisation and service costs, amongst others that are imposed by Federal and State Governments. These all increase the ongoing cost of delivering care, and in often unpredictable ways.

Additionally, the governments 'carrot and stick' approach does not work under the current funding structure. Providers are only financially incentivised to be compliant, not incentivised towards better care outcomes. Indeed, government must ensure compliance requirements, such as compulsory care minutes, do not lead to perverse outcomes (for instance, a Tasmanian provider publicly made their enrolled nurse workforce redundant as it was cheaper to hire personal carers to meet their care minute target).

6.1 UnitingCare Queensland recommends that IHACPA needs to account in its pricing model any significant reforms or regulatory changes that require significant variation to providers' systems or operations.

Training

During the COVID pandemic, costs associated with training were reduced due to restricted face-to-face and on-site training activities. While the introduction of online training has provided some new opportunities and flexibility, it is not a substitute for face-to-face training. Thus, costs of training and on-site delivery are likely to increase back to pre-COVID levels, requiring additional investment in training and development resulting in a higher overhead cost. Combined with the regulatory reform agenda, these costs will inevitably result in higher overheads.

6.2 UnitingCare Queensland recommends that IHACPA needs to account in its pricing model any increased overhead costs resulting from increasing training costs and changes to training delivery.

7. NATSIFACP

Addresses the following question:

Q11. 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?

Transitioning NATSIFACP to the AN-ACC model is an important step in ensuring funding programs for our First Nations people are equitably maintained and at the front of policy-making minds. Indeed, during the transition to AN-ACC from the Aged Care Financing Instrument (ACFI), NATSIFACP was overlooked and an uplift to equalise the funding uplift only occurred recently. We know of at least one NATSIFACP provider that contemplated transitioning their facilities to AN-ACC.

UnitingCare Queensland through the Australian and Regional and Remote Community Services (ARRCS) is Australia's largest NATSIFACP provider. ARRCS and BlueCare Pinangba both run First Australian specialised facilities under the AN-ACC model. As such, we are well placed to provide feedback on transitioning NATSIFACP facilities to AN-ACC.

NATSIFACP funding facilities in MMM7 regions operate on a similar funding model to our MMM7 funded specialised indigenous AN-ACC facilities.

Both ARRCS and Blue Care Pinangba facilities are classed as specialised homeless as there is no Indigenous specialisation available for MMM1 to MMM5 regions.

It is difficult to maintain specialist indigenous services in mixed communities given the quota requirements to receive the uplift whilst still be required to provide as trauma informed cultural awareness training in order to provide high quality care.

Ensuring as part of the NATSIFACP change, expanding indigenous specialisation to MMM1 to MMM5 regions will assist in providing care for all First Australians. There is also a significant difference between MMM 6 and 7, the specialised indigenous MMM 7 being similar to NATSIFACP.

The issues boil down not only to access, but the very different operating models that (particularly smaller) communities experience, such as:

- Smaller labour markets and difficulty getting suitably qualified labour, requiring increased remuneration in order to secure employees
- Increased attraction and recruitment costs, including travel and accommodation
- Increased investment in retention driven by difficulties in replacing staff
- Increased cost and challenges in leveraging training and other centrally delivered services
- Premium costs for agency and contract staff when required

- Increased travel time, distances and cost for service delivery
- Increased workforce investment where there is a lack of community infrastructure, including complementary social and health care services
- Challenges achieving critical mass volumes in some service types to support engagement of requisite skills (e.g. allied health and nursing services)
- Increased operational costs resulting from logistics and transport implications
- Reduced economies of scale for operating costs (e.g. reduced vehicle utilisation, property costs and administration).
- Thin care markets resulting in reduced volumes and service efficiency and increased sensitivity to care recipient and market changes
- Difficulties achieving critical mass volume for some service types to support viable engagement of required skills
- Delays in access to and delivery of operating supplies impacting service efficiency and delivery
- Increased investment and cost in community connection and engagement to appropriately suit local community

7.1 UnitingCare Queensland recommends that IHACPA ensures the following six principles be retained in transitioning NATISFACP facilities to an AN-ACC model:

1. ***Ensuring that block funding and funding per registered bed is kept under the transition given the highly mobile nature of many First Nations populations.***

Our experience is that many residents often do not have the 'required' formal documentation and often no support network when they arrive at the facility (often they are just 'dropped' off) and often come and go at will.

2. ***Expanding Indigenous Specialisation to include MMM1 to MMM5 facilities with an appropriate uplift.***
3. ***Ensuring the resource intensive nature of providing culturally appropriate services to Australians is recognised in the funding model ranging from specific training, building and accommodation design, and culturally appropriate food.***
4. ***Creating a higher temporary specialised variable component (classification funding) for indigenous specialised facilities to account for the long delays in getting assessors to regional and remote areas and the cultural issues in getting First Australians due to complex trauma and history of these people.***

We note that whilst many First Nations people enter Aged Care at a younger age, they are on average more complex than residents entering mainstream services (i.e. higher average AN-ACC classifications).

5. ***Ensuring a funding uplift for smaller remote facilities is provided for (similar to the 24/7 Registered Nurse supplement) as our NATISFACP facilities are much smaller than comparable mainstream facilities given the small communities they service.***

This is particularly problematic considering almost all residents would be Commonwealth supported under AN-ACC and the accommodation supplements do not factor in the higher capital and maintenance costs of regional facilities.

6. ***Balancing the requirement between a specialised threshold and ensuring that the local community can access residential aged care.***

Our Tennant Creek facility is a case study of this where there is additional demand for both indigenous and non-indigenous places, however as it is NATSIFAC funded there is no ability to expand our services to non-First Australians. The cost to provide specialised services to First Nations people does not stop when there are less than 50 per cent First Nations people at the facility.

7. ***Ensuring that AN-ACC model transition for MMM1 to MMM6 First Nations facilities are appropriately funded accounting for all funding streams***

A common problem amongst First Nation facilities that are not NATSIFAC funded is that AN-ACC specialised indigenous only covers the care part of the funding whereas NATSIFAC includes Basic Daily Living and other services. NATSIFAC facilities also have had their capital funded through Federal Capital Grants.

Our experience has been frequently, the Centrepay arrangements for Basic Daily Living fees can be changed too easily by relatives resulting in significant unrecoverable debts and presumes the paperwork and resident were registered with Services Australia in the first place. As such, the BCT uplift needs to consider these other factors to ensure First Nations people receive the same care in the transition.

Next steps

UnitingCare Queensland appreciates IHACPA's consideration of our submission. We are always keen to engage and participate in roundtables, committees, forums, discussions and one-on-one meetings.

Please contact our [redacted] if you have any queries or wish to discuss our submission further.

Appendix 1: Summary of UnitingCare Queensland's Operation