

31 August 2023

Re: Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25.

Thank you for the opportunity to submit to the consultation on the Pricing Framework for the Australian Residential Aged Care Services. This is a submission from the Wicking Dementia Research and Education Centre (Wicking Centre) based at the University of Tasmania. Briefly, the Wicking Centre is a leading organisation undertaking high quality education and research in relation to dementia, particularly with respect to the themes of the cause, care and prevention of dementia and the health and wellbeing of those with this condition. The Wicking Centre offers an ecosystem of educational opportunities ranging from free courses through to both undergraduate and postgraduate degrees. The Wicking Centre also offers short courses on aged care (Equip Aged Care Learning) as well as a new program on developing and supporting optimal respite care, both funded by the Commonwealth Department of Health and Aged Care. Collectively, these courses have reached hundreds of thousands of Australians, including aged care workers, health professionals and informal carers who support people with dementia. The author was also a board member of Glenview Community Services from 2013 to 2023, with Glenview having designed and delivered a 96-bed house-hold model in a village development ('Korongee') for people with dementia.

This submission focusses on the support of people with dementia through aged care funding instruments. There are already over 400,000 Australians living with dementia, which will rise to close to 1 million around the middle of the century with demographic shifts in our community. The majority of people living with dementia reside in the general community with up to 40% in residential care. Of all people in residential care, the majority have a significant cognitive impairment. The recognised goal of supporting people with dementia is person- and relationship-centred care that recognises dignity, choice and active inclusion in care decisions. However, issues in the care of people with dementia persist, defining people by the condition of dementia and reinforcing dependence, rather than recognising their worth as people first with remaining abilities, and the condition of dementia second. These concerns were highlighted by the Royal Commission into Aged Care Quality and Safety, and likely relate to organisational and workforce issues around competency and capacity in dementia care.

The AN-ACC funding tool provides support for older people through the application of three main components: an initial transfer payment, a Base Care Tariff and a variable component derived from an assessment of support needs. The Base Care Tariff includes financial augmentation for classifications of specialised care, including Aboriginal and Torres Strait Islander peoples, people with disabilities, and those who are homeless.

The AN-ACC tool for the assessment of support needs was developed on the basis of suitability and efficiency of use by independent clinicians/assessors, and is largely derived from existing instruments (Eager et al 2020). The tool was refined by analysing data obtained from residential facilities, with 13 classifications derived from measures related to mobility, cognitive ability and compounding factors. Notably, this approach has been developed as a clinician/carer tool based on data obtained through functional measures that involve judgement of the assessor/clinician. The orientation here is then firmly of the impact of the resident on the organisational workforce rather than a personalised assessment of the resident's needs and choices. The impression then is that funding is provided to a classification that describes the

resident's impact on the institution, the care burden, rather than what may be required to provide the best possible care for the individual based on evidence, including the active participation of each person in their care. In summary, financial support is not directed at individual needs, potentially also reablement, but rather at what physical resources are required to support their classification. By this process, care planning by an organisation is separated from the funding instruments, including that conducted by independent assessors on care burden.

Ultimately, service providers will receive funding based on this casemix of burden, and the allocation of funds will presumably align with the Aged Care Quality Standards and other regulatory expectations (eg minutes of care, access to a nurse, infection control etc). Two main issues arise from this approach. Firstly, that service providers ultimately receive funding based on the Base Care Tariff and this casemix, which may influence their willingness to accept into their service those people who are in lower funding categories. In the context of quality dementia care, there may be a disincentive for providers to invest in ensuring the best quality care and organisational funding to support people with dementia who don't have significant mobility issues or other compounding factors. Perversely, successful reablement and maintained mobility of residents could lead to lower funding. Secondly, there appears to be little incentive for providing the best quality dementia care through incentives of the funding structures, other than through the expectations of the Quality Standards. Relatedly, proscribed minutes of care may well be linked to physical support and clinical care, but are not a particular inducement for providers to ensure that people with dementia receive care that is focused on their specific cultural and personal needs. In summary, AN-ACC shares features of the previous Australian Aged Care Funding Instrument (ACFI) in financially supporting dependency rather quality-oriented care and/or reablement/restorative approaches.

In terms of potential solutions, the national state of dementia care in residential facilities may be improved by a greater weighting of funding related to dementia care, particularly if it is tied to a reportable outcome, such as the development of a dementia care plan, and/or evidence of organisational employment of aged care workers and health professionals with specialist dementia qualifications that include understanding of culturally respectful and safe care. With respect to specialist dementia qualifications, not all staff might require these, but there could potentially be a proscribed ratio of skilled staff to the numbers of residents with dementia.

Likewise, funding for respite care is fairly flat, essentially reflecting the mobility status of those being care for, and again, an indicator of service burden rather than a focus on quality of individualised care, or any success or not that respite has on subsequent risk of moving into residential care permanently. In his regard, it is recognised that quality respite care may be an important factor in preventing or delaying entry to permanent residential care. A greater focus on financially supporting organisations to provide high-quality respite services for people with dementia may help to support a greater proportion of this segment of the community to stay at home, and on Country, resulting in lower costs to the Commonwealth. Organisations may be incentivised by a higher payment for dementia care, to be aligned with evidence that the provider instigates evidence-based care frameworks that support a successful transition back into care in the community. An outcome related to avoidance of future transition to permanent residential outcome (eg % conversion and time to conversion) may help guide effectiveness of funding.

It is noted that the Process Principles that guide activity-based funding as outlined in the Consultation Paper is a need to innovate in service provision. In this regard, there should be consideration of how funding may be adapted to support innovation. As an example, with respect to dementia, it is now widely recognised that domestic scale housing, the 'small-house' model is an improved approach to support people with dementia, particularly in mitigating the impacts of large scale residential living on the choices and behaviours of people with dementia. Domestic-scale models of care have been shown to be a better way of meeting the needs of residents, and to also result in improved health and wellbeing outcomes (Dyer et al 2018; Gnanamanickam et al 2019). A systematic review on behalf of the Royal Commission into Aged Care Safety and Quality has indicated that small-scale living designs may provide a range of benefits, such as in social engagement, reduced physical restraint, reduced psychotropic drug use and improvements in quality of care (Dyer et al 2019).

The physical model of clustered houses of familiar construction and facilities, such as occurred with the Korongee development in Tasmania, have been designed to improve on the impacts of the transition to residential care, potentially reducing resident stress and behaviours of concern. We would recommend a consideration of how innovation in dementia care design may be incentivised in the funding instruments. This may include further support for group home style of residences in community settings. Funding outcomes could be assessed through clinical quality measures, such as rates of psychotropic drug use/deprescribing, falls, aggressive behaviours, restrictive practices and unplanned transfers to hospital, with such clinical quality measures also reflecting the input of people with dementia.

In summary, we suggest that current funding models are insufficient to support a meaningful positive change in the quality of dementia care in residential settings. Support for people with dementia and those who provide care, whether formal or informal, is provided by a relatively fragmented funding system that does not encourage the highest levels of person-centred care for people with dementia. There is potential for amelioration if funding instruments can be tied to providers accounting for the quality of dementia care, which may most easily be done by evaluation of measures that are currently collected, the perspective of people with dementia about these measures, as well as obligations on providers to employ a proportion of staff with skills and capacity in evidence-based, person-centred, and culturally respectful and safe dementia care. Conversely, consideration may be given to increasing the Base Care Tariff for facilities that are designated for a specialty in providing dementia care, subject to evidence related to the proportion of residents with dementia, the employment of skilled staff and purposeful design of the facility to support people with dementia. This may require a consideration of rebalancing of the components of the funding instrument between the Base Care Tariff and the variable component related to supporting care burden.

Sincerely



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References

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