Australian Nursing and Midwifery Federation

SUBMISSION TO THE INDEPENDENT HEALTH AND AGED CARE PRICING AUTHORITY (IHACPA) CONSULTATION: TOWARDS AN AGED CARE PRICING FRAMEWORK CONSULTATION PAPER

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 320,000 nurses, midwives, and carers across the country.

Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals, and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

The ANMF welcomes the opportunity to provide feedback to the Independent Health and Aged Care Pricing Authority's (IHACPA) consultation on the 'Towards an Aged Care Pricing Framework Consultation Paper'. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities. With regard to the care of older people, ANMF members work across all settings in which aged care is delivered, including over 45,000 members who are currently employed directly in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors (acute, residential, primary health care, in-home care), depending on their health needs. Being at the forefront of aged care and caring for older people around the clock, seven days per week in acute care, nursing homes, and within the community, our members are optimally positioned to make clear recommendations to improve funding policies and processes that seek to enhance the quality and safety of Australia's aged care system.

A NEW FUNDING APPROACH FOR AGED CARE

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?

1.1. A challenge that might arise when using the AN-ACC to support ABF in residential aged care is if there is a misalignment between a resident's actual care needs, the classification the individual resident is assigned to, the cost of delivering the care that the resident needs, and the pricing of services as reflected in the national weighed activity units (NWAU). If there is a misalignment, for example where a resident's actual needs are not suitably reflected in the classification they have been assigned to, then their care needs might not be appropriately addressed. Likewise, if there is a misalignment between the real cost of delivering care and the NWAU, then a resident might not receive the care they need because of insufficient funding. This highlights the need for ongoing work to review and update the new funding system to ensure fitness for purpose as the new system matures and to ensure that timely mechanisms are implemented to correct care/payment misalignment.

1.2. The ANMF recommends that future costing studies should show how nationally consistent individual groups/sites are for comparative purposes and will need to take into account economies of scale. Size of facilities (e.g., number of beds), geographical layout (e.g., multi-story sites), and residents with complex care needs may also impact on costings and especially workflows.

1.3. Some further potential challenges identified by the ANMF include; lack of maturity of the AN-ACC and familiarity with its use, possible failures regarding the implementation of the AN-ACC as per the recommendations of the project team (i.e. a phased approach), and the need for an efficient price that reflects the real cost of care for each casemix classification including a need to ensure that starting price (post 1 Oct 2022) reflects this and that the price is appropriate for future application as the sector evolves.

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?

2.1. The ANMF is supportive of the implementation of the AN-ACC as a more suitable replacement for the outgoing Aged Care Funding Instrument (ACFI) within the raft of reforms to Australia's aged care sector currently underway (e.g., improved staffing and skills mix, improved code of conduct, quality standards and workforce strategy, enhanced nutrition, multidisciplinary in-reach teams from hospitals, availability of nurse practitioners, and sufficient funds to pay higher wages). Based on the information available, AN-ACC appears to be a promising tool that has the potential, if implemented and monitored correctly and carefully, to support sustainable improvements in the delivery of efficient, safe, and dignified care for residential aged care recipients. It will be important that the AN-ACC be fit for purpose in terms of supporting best practice care for recipients of residential aged care services in both public and privately owned facilities and that the true cost of providing care be accounted for and met. Here, it should also be highlighted that there is a difference between care that is of an 'acceptable' standard and 'best practice' care. The funding of care delivery should also ensure that where possible, care that is restorative and reenabling be provided. Ongoing review and evaluation of AN-ACC must consider developments in the ways care is delivered including technology and models of care to ensure alignment with best practices, emerging evidence, and the delivery of effective, appropriate, safe, and dignified care. Given that the AN-ACC will change the way care planning is undertaken, i.e., under ACFI providers often used an ACFI assessment as a basis for a resident's care planning. The independent process of AN-ACC assessment will require a change to care planning assessment. It is important that funding be sufficient to support best practice care and best practice care planning being implemented sector wide (post ACFI) for nursing homes. An issue will be to ensure that best practice care planning processes are implemented and sustained as part of the AN-ACC roll-out.

2.2. As stated in the Residential Care for the Aged; An overview of Government policy from 1962 to 1993,[1(p.4)] over-servicing and exploitation of aged care residents and government subsidies remain a concern which was echoed again late in.[2] Transparent and up to date reporting and audits are a key component in the creation of an efficient, sustainable, and safe residential aged care system. It will be vital that this be applied over the course of the implementation and maturation of the new AN-ACC system.

[1] Le Guen R and the Parliamentary Research Service. Background Paper No 32. 1993. Residential care for the aged: An overview of Government Policy from 1962-1993. Online: Department of the Parliamentary Library, Commonwealth of Australia. 1993. Available: https://www.aph.gov.au/binaries/library/pubs/bp/1993/93bp32.pdf

[2] O'Keefe D. Government clamps down on ACFI claims. Online: Australian Aging Agenda. 2015. Available: https://www.australianageingagenda.com.au/executive/government-clamps-down-on-acfi-claims/

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

3.1. Given that best practice care is complex, it must support not only direct care activities but also indirect care (those actions that support the overall effectiveness of direct care interventions). Costing and funding of aged care should include consideration that staff must be able to spend sufficient time with residents to deliver safe, dignified, appropriate care. Further, staff also need time with family/loved ones including to respond to family's questions and to engage in other professional interactions that don't necessarily fall within an itemised 'care activity' for individual or groups of residents. If these types of things are not accounted for, then it is likely that the provision of safe, dignified care will suffer as staff would need to rush or minimise time with residents and families, particularly if staffing levels are low. There are often problems with itemised lists of care activities. Care involves a range of complex and inter-related activities and is more nuanced than lists of activities or actions. Looking at the entirety of care (direct and indirect) in a more holistic fashion rather than a list of things is likely to be more reflective of care requirements and upholds the ambition of the provision of dignified, person-centred, whole of person care. Now that funding has been decoupled from care planning, it is imperative that standards are applied to ensure that individual care plans reflect individual needs rather than cost.

3.2. The ANMF highlights that assessment and evaluation of resident outcomes beyond financial benchmarking terms (as outlined in the Stewart Brown Reports) should occur to ensure that the NWAU weightings are appropriate and support the delivery of safe, effective care. Metrics such as hospital admissions from residential aged care, medication errors and falls should all add to the assessment of the funding model. Understanding whether or not there is any change in terms of resident outcomes will be vital to ensuring that the new approach is effective and performing successfully.

3.3. Compliance and regulation tasks, which are frequently assigned to nurses – especially registered nurses, should also be considered. How these tasks are impacted by the implementation and maturation of AN-ACC and the broader aged care reforms should be considered, particularly as often, nurses are assigned non-clinical roles and tasks that might take them away from direct resident care.

3.4. The ANMF highlights that increasingly, the complex care residents require demand high-cost consumable items such as wound care/management and nutritional supplements. If these costs are not addressed appropriately in the AN-ACC, this care might not be well supported and drive otherwise avoidable hospital transfers which can be associated with poorer resident outcomes, and experiences, and cost-shifting to the public sector. Further, with the increasing acuity and comorbidity of older people, there is a greater requirement for nursing staff to coordinate interdisciplinary teams. These costs should be considered given the lack of funding for allied health professionals within AN-ACC.

3.5. The ANMF also highlights that future costing studies should take into account that the current bucket of money was retrofitted from ACFI, and is now being distributed to AN-ACC. Any future funding should be based on the evidence established through future cost of care studies completed, with very minimal consideration of previous funding that was retrofitted to AN-ACC. As with any change that is introduced quickly rather than via a phased approach, evaluation under operational conditions from the outset is essential so that critical corrections and adjustments can be made in a timely manner. The ANMF argues that the AN-ACC must reflect the true cost of best-practice care, be maintained by an independent authority, free from political and policy interference, and that there be a bi-partisan commitment by government and opposition that aged care funding will not be subject to the vagaries of political expediency in the budget allocation cycle.

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

4.1. The ANMF suggests that the direct and indirect care costs per AN-ACC classification by staff type, e.g., RN, EN, care worker should be considered. Such research would then provide a mechanism to compare care supply and demand at the facility level at least. It is assumed that the care minutes arrived at is based on 200 minutes average as a relative weight of AN-ACC for all populations. This may not reflect good alignment of nursing inputs based on the cost of each of those groups. Also research into complex care and the impact this may have on the costing model should also occur. Further, as care should be reenabling and restorative where possible, it will be important that residents care needs be assessed in terms of keeping residents healthy, avoiding ill health, and actually improving health and wellbeing. Understanding how these aims can be prioritised and supported through the provision of sufficient funding will be a key consideration in developing future refinements to the AN-ACC assessment and funding model. As the AN-ACC model matures, there will be a need to ensure timely reassessment of residents especially if there is a significant change in the older person to ensure correct funding. Here, the demand and the cost to meet demand must drive the price not an artificial constraint of budget allocation.

4.2. The ANMF highlights that issues around mental health/psycho-geriatric specific facilities and care could be considered in developing future refinements to the AN-ACC assessment and funding model. Currently, there is a widespread lack of suitable facilities and services catering to residents with complex mental health care needs, particularly in the private aged care sector. There needs to be specific recognition of psycho-geriatric needs and additional funding, above and beyond cognitive decline. While there is much discussion around providing ‘care’, in the context of psycho-geriatric care/mental health care for older adults, the main issue is about having enough staff to appropriately and safely monitor and manage behavioural issues. At present, within the AN-AAC there appears to be a real underestimation of both ‘normal’ cognitive impairment and psycho-geriatric needs. Nor is the issue of ‘time to care’ mentioned to improve mental health and stimulation.

4.3. The ANMF highlights that there is little mention of other special needs and costs associated with meeting needs of particular cohorts beyond people who have experienced homelessness and First Nations residents. Future refinements might usefully examine whether there are additional costs in catering for different cultural and language groups especially in recruiting suitable staff.

4.4. The ANMF also highlights that unlike a hospital, an aged care facility is the resident's home. There is a real intersection between quality of care and time delivered outside the more task-oriented care requirements (dressing wounds, administering medication, washing, showering, turning residents in bed). Time taken to make it feel like a home, to ensure there are daily interactions with each resident (that are recorded), getting them to walk slowly to the dining room etc. are as much about the care as the nursing tasks listed above. In hospital, most patients are there for short stays. There isn't as much focus on their social well-being and mental health, they eat in their bed, they are more mobile when they start to recover, there usually have multiple visitors etc. To a degree the AN-AAC classifications represent a medical/hospital model and is based on functional tasks. While that is part of the story of aged care, it isn't the whole story. These 'time to care' elements need to be valued in the elements that are included in the classifications and funding which could be valuably considered in terms of future refinements to AN-ACC.

PRINCIPLES FOR ACTIVITY BASED FUNDING IN AGED CARE

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?

5.1. The ANMF highlights that there is a pressing need to maintain wage capacity with other markets sectors and to ensure that the pricing framework supports wages that will effectively attract and support the retention of high-quality staff in the aged care sector. Here, the ANMF is concerned that a national average wage might not represent the most appropriate way of calculating wage costs due to the differences between average wages between states and territories, regions, and providers. If a national average wage was too low, then providers in particular regions might not be able to compete for staff with providers in other regions. Pushing to an average cost might disenfranchise e.g., specialist providers. The ANMF recommends looking to the results of the costing studies to see if there are differences. Costing studies can then be used to see how costs can be determined across settings to ensure that appropriate wages and wage growth can be sustained across disparate settings.

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

6.1. Linked to several of the principles articulated in the consultation paper, such as 'transparency', 'quality care', and 'promoting value' is the need for accountability in the use and reporting of the use of funds received. It must be an obligation on the provider that the use of any funds received for the delivery of care be transparently and accountably used for the purposes it was provided, and if not for the surplus to be returned to the government. It is also important that issues of "commercial in confidence" are not allowed to get in the way of appropriate transparency and accountability regarding the use of funds.

6.2 The ANMF highlights that in activity based costing methods, there is a hierarchy of costs which allows for non-linear cost accumulation, i.e. costs not caused by providing care such as education/ training, marketing and research. These non-linear costs should be clearly identified and reported.

6.3. It is noted in the consultation paper that some costs are excluded such as capital costs, depreciation, and leasing costs which are funded by Refundable Accommodation Deposits (RADs) and Daily Accommodation Payments (DAPs). This leaves Additional/Extra services as the main revenue stream to generate profits which may force providers to increase their focus on additional services. As noted elsewhere, providers will have varying capacities to provide additional/extra services with smaller providers and providers in 'thin markets' being less likely to have the capacity to provide the same level of additional/extra services in comparison to larger, wealthier providers. This could detrimentally impact the equitable provision of safe, effective, dignified care of residents. The ANMF also highlights that there have been several occasions where providers have charged for additional/extra services (e.g., internet access) by bundling unwanted or even inaccessible services. With the introduction of ABF and the reduction in provider discrepancy on staff expenditure, principles on these offerings should be included and monitored for predatory provider behaviour such as price gouging.

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

7.1. One potential issue that might arise in defining the overarching, process, and system design principles is that within each principle, certain concepts are articulated which could be ambiguous and result in confusion or lack of agreement in terms of precisely what the principle in question refers to. For example, the overarching principle of 'Access to care'. Here, the principle proposes that funding should support 'appropriate' access that is not 'unduly delayed'. It is unclear and up for interpretation what would constitute 'appropriate access' and an 'undue delay'. This might have implications for determining whether or not or the extent to which the principles have been contravened or are themselves fit for purpose. The main problem is that often, stated principles remain too high level, are poorly defined, and suffer from a lack of clarity on how they will be operationalised. Clear definition of what these concepts mean, and evaluation of provider operationalisation of these principles via the accreditation process is essential to discourage non-compliance amongst providers.

7.2. Issues of accuracy, time, cost, and complexity are all features of calculating Activity Based Funding. Due to the complexity of activity based funding, the costs of implementing and maintaining the system may outweigh the benefits and which will direct resources away from other areas within aged care.

DEVELOPING AGED CARE PRICING ADVICE

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

8.1. Providing that the residential aged care price is reviewed as planned and revised as necessary to sustainably support the delivery of best-practice, safe, high-quality, and appropriate care that aligns to the needs and preferences of aged care recipients as the profile of care recipients and the cost of care changes, the ANMF has no concerns about the definition based on the information provided.

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

9.1. The ANMF does not propose any additional aspects to be covered by the residential aged care price at this time. However, regular review of the model must be undertaken to ensure that it remains fit for purpose.

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

10.1. The ANMF agrees that the residential aged care price should be reflective of the actual cost of care delivery and that, as explained, additional factors should also be accounted for in order to ensure that a residential aged care price supports the delivery of best practice care for all aged care recipients. Best practice care will need to be individualised for each resident and adapt in relation to a resident's changing needs and preferences for care. Likewise, best practice care must be aligned to the delivery of care that supports not only the best possible achievable health and wellbeing outcomes for every resident, but also the delivery (where possible) of restorative/ reenabling care and care that is designed to prevent, minimise, or palliate ill or declining health, ability, and wellbeing. The funding model will need to ensure that there are incentives to ensure residents remain as well as possible for as long as possible.

10.2. Bargaining in the aged care sector has been consistently constrained by a lack of transparency about the level of Commonwealth funding allocated to wages and the sufficiency of that funding. This has resulted in poor bargaining outcomes, which contribute to the problem of low wages in the aged care sector that do not adequately value the work performed. Wage prices must be set at a level that is sufficient to attract and retain appropriately trained and experienced staff. If the AN-ACC model does not provide sufficient funds to ensure that wages for staff are competitive and attractive, the ongoing challenges around the attraction and retention of high-quality staff in the aged care sector will persist.

10.3. The wages component of funding must ensure not only that minimum wages as set by the Fair Work Commission through annual wage reviews and any award specific adjustments are met, but that there is capacity for meaningful bargaining outcomes that allow parties to negotiate wages that exceed award minimums. Wage prices must reflect actual wage cost and movement in bargaining outcomes, rather than award minimums. In addition, it is crucial that there is transparency about the level of funding provided to ensure that funding allocated to wages is directed to wages in the bargaining process.

10.4. The ANMF also highlights that funding for wages needs to ensure wage growth that achieves parity with other sectors, such as the disability sector and public health. Improving wage outcomes through bargaining is a key means of ensuring the aged care sector can attract and retain high quality staff and address the workforce challenges experienced throughout the sector. The principle of continuous improvement must apply to wages and conditions in the sector to ensure an increasingly qualified, specialised, and growing workforce is supported into the future.

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 (IHACPA)'s residential aged care pricing advice?

11.1. The ANMF agrees that this combination of 'cost-based' and 'best practice' pricing must be able to evolve and change reflecting the changing nature and landscape of the provision of safe, appropriate, dignified, residential aged care. These two concepts are not necessarily mutually exclusive. Best practice based on research often has outcomes that improve efficiency/ effectiveness in terms of resource utilisation or cost. This is why it's important that the IHACPA have a research capacity.

11.2. The ANMF believes 'best practice' should be the leading principal in determining residential aged care pricing advice over the short term due to the long-standing issues and variances within the provision of aged care that have been clearly documented in many aged care sector reviews, enquiries and reports. This will allow providers to improve their services to an acceptable level with cost-based pricing to be transitioned to a greater proportion, once an acceptable level of care is recorded.

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

12.1. As discussed at above regarding the ANMF's concerns about the proposed pricing approach and level of the residential aged care price, the ANMF is concerned that utilising Fair Work Commission wage movements alone, to adjust the cost component of Residential Aged Care Price will impede bargaining by not reflecting actual wage movements and impacting on wage negotiations within the sector. This has been a significant issue in the previous indexation method where previous government-imposed efficiency dividends which supressed aged care wages.

12.2. The ANMF is concerned with the unknown methodology of indexation and the weighting given to wage and non-wage costs. Previous residential aged care funding indexation incorporated a cost-of-living component, Consumer Price Index (CPI). The weighting was set to 75% wage component and 25% non-wage component. Under the new indexation method, no such information is provided to date. Given the COVID-19 pandemic, there has been significant downward pressure on wages and significant increases in non-wage costs. Under the previous indexation method, the set weighting method created unintended circumstances where aged care workers paid for the increased non-wage costs of providers through lower wage increases. If this situation is perpetuated, ongoing challenges with attracting and retaining high quality staff across the sector will persist.

12.3. Further, the ANMF considers it neither efficient or acceptable that "... any adjustments to wages made by the Fair Work Commission could take multiple years to be reflected in the cost data utilised by the IHACPA in calculating prices" given that wages are the major component of aged care costs and that the pricing model must reflect the actual cost of care (at a best practice level).

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

13.1. The ANMF is concerned about the potential implications of a national price covering all residential aged care in terms of its ability to effectively account for the diversity of individuals and cohorts and their varying needs across different settings. The ANMF raises the question of whether there could be the potential for the development of specified categories of price for particular client groups. The costing studies should look to see which of the two approaches, either a single national price or multiple national prices, would be most effective.

13.2. The ANMF also highlights that a recommended residential aged care price needs to consider not just the costs and best practice but also other government priorities such as reducing aged care turnover by providing decent wages and careers and attracting much needed to staff into the sector.

ADJUSTMENTS TO THE RECOMMENDED PRICE

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

14.1. The ANMF suggests that changes to the approach of adjustments must incorporate aspects for improvement to quality and safety which are often more difficult and costly to quantify. As ABF relies on historical data to determine costs, adjustments should also reflect future considerations such as quality of care and safety to both residents and staff.

14.2. The ANMF understands that processes that support adjustments to the recommended price will become more mature over time, so the model also needs to be sensitive to those areas where there are thin markets and market failure risks, e.g., rural and remote locations.

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

15.1. The ANMF highlights the need for further research, evaluation, and consideration of costing complex care which is needed by many aged care residents who have multiple complex, and evolving care needs. It will also be vital that sufficient funding be provided to ensure that care is, where possible, restorative/re enabling and supports residents to both be healthier for longer and to regain health and wellbeing.

15.2. The ANMF notes that there were several former resident payments/subsidies outlined within “The Resource Utilisation and Classification Study: Report 5” which were either not included in the study or not enough evidence was available to be assessed. Daily residential respite subsidies will need to be further assessed, to determine if the current 2 tier payment system meets resident needs. The current Oxygen Supplement subsidy is to be grandfathered while a costing study is undertaken with the goal of this supplement to be included in the NWAU which would then be incorporated into the AN-ACC variable payments. Enteral Feeding Supplement which has two separate subsidy rates (for bolus and non-bolus delivery) are to be grandfathered while a similar process to Oxygen Supplement is carried out. Veterans’ Supplement is a daily supplement paid for the increased costs of mental health associated to their service in the defence force.

This subsidy is to be grandfathered while a study on mental health services targeting veterans is undertaken. RCS payments for grandfathered residents involve residents in aged care prior to the introduction of ACFI in 2008 who received subsidies under the previous subsidy system. These residents will transition to the new system and be assessed using the AN-ACC assessment tool. Resident-specific subsidy reductions relating to compensable status and means testing are to be retained while a costing study is undertaken.

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

16.1. The ANMF highlights that provision of mental health care might be an important additional adjustment to be considered for older people receiving residential aged care. Mental health care is a pillar of the publicly-funded health system in Australia, and low use of these services among aged care residents indicates a need for organisational and policy changes to improve access, including for residents with chronic and complex mental health diagnoses and care needs. Currently about half of aged-care residents need urgent mental health support. As the final report from the Royal Commission into Aged Care Quality and Safety acknowledges, around 10 percent of older Australians have symptoms of anxiety and depression but in residential aged care facilities this figure increases to up to 50 percent of residents. The AIHW reports that over 2015-16 and 2019-20, per capita spending on older person services decreased by an average of 1.0% per year, which reflects the fact that older persons services have not increased to the same extent as the increases in the size of the older persons population.[3] For example, while the real spending on older person services had an annual average increase of 2.3% to $630 million between 2015–16 and 2019–20, the older person population (65 years and over) increased by 14.1% to 4.1 million people over the same period. Fewer than 3% of people with mental health conditions living in Australian residential aged care facilities accessed government-subsidised mental health services, a new analysis from Flinders University and the South Australian Health and Medical Research Institute (SAHMRI) has found.[4]

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

17.1. The RUCS findings highlighted unavoidable facility factors that have a significant impact on the cost of delivering care. In addition to remoteness, low and variable levels of occupancy have significant impacts on the cost of care per bed day. Two adjustments have been included in the AN-ACC model BCT categories to support more stable funding of these facilities. The ANMF suggests that model also needs to incorporate adjustments based on resident cohort characteristics as well for example; First Nations, culture/ethnicity, homelessness, mental illness. This might be appropriately incorporated through consideration as to whether some form of block funding approach could be used for providers operating in particular areas (e.g., remote, low occupancy sites) and for particular resident cohorts.

[3] Australian Institute of Health and Welfare. Mental Health Services in Australia. Online: Australian Government. 2022. Available: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services

[4] Cations M, Collier LR, Caughey G, Bartholomaeus J, et al. Government-subsidised mental health services are underused in Australian residential aged care facilities. *Aust Health Rev*. 2022;46(4):432-41.

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

18.1 The ANMF agrees that under the principles of ABF, IHACPA should maintain its commitment to the principles of fairness and transparency in terms of managing the diverse range of providers delivering services across the residential aged care system nationally. Here, the ANMF highlights that the ABF model must ensure that approved providers are funded equitably regardless of their business and financial structures and size (e.g., State/Territory operators, non-profit/not-for-profit, and for-profit). Ensuring public-private neutrality in this way is important as this helps to avoid potential discrepancies between the funding of e.g., government versus privately owned facilities. The ANMF highlights that in Victoria there are instances where the State Government has provided 'top-up' funding to support delivery of care to residents in government-operated homes particularly where residents have on average greater physical and psychological care needs in comparison to residents in privately owned facilities as those homes were not being equitably funded by the Federal Government.

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?

19.1 The findings of the Royal Commission into Aged Care Quality and Safety highlighted a lack of transparency and accountability with profound consequences for the safety and quality of care for residents. Adjustments for safety and quality through ABF can encourage good quality care, where payment captures not only the cost and complexity of care, but also the safety and quality of care delivered. The ANMF highlights the need to take into account vulnerable populations that frequently require more expensive care due to their more complex needs. For example, people born in non-English speaking countries, people who have experienced homelessness, and people with mental illnesses. Further, the model must also be sensitive to regulatory requirements (including standards and accreditation), including in the safety and quality space. The ANMF agrees that adjustments for quality and safety issues would need to complement and support the role and work of the Aged Care Quality and Safety Commission and avoid duplication or undue impact on aged care providers. Furthermore, any pricing adjustments for safety and quality would need to consider a wide range of data, information, and perspectives, including clinicians, residents, carers and providers, along with considerations regarding occupational/workplace health and safety requirements and costs. As the AN-ACC system matures, it will be vital to monitor and evaluate its operation and impact on relevant stakeholder outcomes to ensure that safe, high quality care is being appropriately funded and delivered.

PRIORITIES FOR FUTURE DEVELOPMENTS

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

20.1. The ANMF does not consider it to be appropriate that hotel costs be incorporated into the AN-ACC funding model as this was not the purpose or intention of developing a funding tool that would be based on independent resident needs assessments. Aged care providers are diverse and offer a range of facilities and services to residents which in turn are based on many external and internal factors that might not be comparable between contexts. Some providers have the ability to provide a greater range of 'hotel' services to residents or more 'premium' offerings than others. The ANMF recommends that hotel costs should be kept separate from IHACPA's residential aged care costing and pricing advice.

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

21.1. The ANMF highlights future refinements should also ensure that costing studies adequately support re-ablement of older people with a focus on effectively and safely transitioning recipients back to home/the community rather than into long term residential aged care. The future refinements should also ensure that the impact of changing resident demographics in terms of acuity and likely increasing complex care requirements be considered.

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

22.1. Older people are entering permanent residential aged care with higher acuity needs and more complex care needs. This is likely to result in greater costs and need for staff when a new permanent resident enters a facility for the first time. When a new resident enters a facility, they will need timely assessment for both funding and care planning which are separate in the new AN-ACC system. Further, assessment of new residents should also include assessment of resident needs in terms of advanced care needs such as dementia, mental health, and allied health.

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

23.1. The ANMF suggests that in light of the numerous workforce issues in aged care that have been ongoing for some time and amplified in relation to COVID-19 and the outcomes of the Royal Commission, pricing cannot be considered in isolation from broader considerations regarding the current and future aged care workforce. As the Royal Commission heard in Research Paper 9,[5] focusing on quality improvement may have wider benefit than simply better care outcomes for residents. Shifting the focus from cost-minimisation to resident-centred to achieve best possible outcomes to residents may lead to process improvements in the facility and a better workplace culture. The cost to move facilities to a better quality may be offset in other government spending in healthcare and other aged care services. For example, better care for residents may reduce the need for hospitalisations, especially for preventable issues (e.g., pressure injury or falls) that could be addressed safely with a sufficient number of the right kinds of staff and an appropriate level of accountably and transparently used funding. Stronger focus on resident outcomes, both health and quality of life, may also reduce spending on high-risk medicines, as well as reducing workplace injuries and accidents.

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

24.1. The principle component of IHACPA's five year vision should be to ensure that the pricing system effectively, efficiently, and transparently support the delivery of safe, dignified, quality care that provides the best achievable outcomes for aged care residents and that ensures that aged care staff are properly remunerated for their work.

24.2. The ANMF highlights that occupational health and safety should also be considered in the proposed five-year vision for IHACPA's aged care pricing advice particularly in terms of infection prevention and control and other workplace safety risks that impact both residents, staff, volunteers, and visitors.

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

25.1. Primary marker of the success of IHACPA's aged care costing and pricing work would be demonstrated improvements in the outcomes and experiences of residents, clearer and more accountable use of funds for care, evidence of enhanced provision of care in residential aged care, and appropriate and competitive wages for staff working in the aged care sector resulting in improved attraction and retention of staff. Other markers of performance/success that could be considered are the number of providers leaving the sector, facility closures, growth/reduction of facilities in areas of need or thin markets, and any change in provider demographics, e.g., number of for-profits, not-for-profits etc to see if the AN-ACC contributes to unintended consequences or advantages to particular provider categories.

[5] University of Queensland. Royal Commission into Aged Care Quality and Safety Research Paper 9: The cost of residential aged care. Online: The Royal Commission into Aged Care Quality and Safety, Commonwealth of Australia. 2020. Available: https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/01_research_paper_9_-_cost_of_residential_aged_care.pdf