

May 2019

## NATIONAL AGED CARE ALLIANCE

# SUBMISSION to Department of Health Consultation

## Proposal for a new residential aged care funding model

### About the National Aged Care Alliance

The National Aged Care Alliance comprises 53 peak national organisations in aged care, representing consumer groups, providers, unions and health professionals, working together to determine a more positive future for aged care in Australia. As a leading voice for improvements to aged care for the past decade, the Alliance strives to implement its vision for ageing in Australia, that:

*Every older Australian is able to live well, with dignity and independence, as part of their community and in a place of their choosing, with a choice of appropriate and affordable support and care services when they need them.*<sup>1</sup>

Further information about the Alliance is available at <http://www.naca.asn.au/>.

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<sup>1</sup> National Aged Care Alliance (2015) Enhancing the quality of life of older people through better support and care, NACA Blueprint Series June 2015, available from: [https://naca.asn.au/NACA\\_Blueprint\\_2015\\_Final-1.pdf](https://naca.asn.au/NACA_Blueprint_2015_Final-1.pdf)

## Introduction

The National Aged Care Alliance (the Alliance) comprises 53 peak national organisations in aged care, representing consumer groups, providers, unions and health professionals, working together to determine a more positive future for aged care in Australia. As a leading voice for improvements to aged care for the past decade, the Alliance strives to implement its vision for ageing in Australia, that:

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Further information about the Alliance is available on the [Alliance's website](#).

In general, the Alliance is cautiously supportive of the proposed new funding model. The Alliance supports the simultaneous implementation of the recommendations in the Australian National Aged Care Classification (AN-ACC) report as a package, as indicated by the authors.

Gaps remain in the proposed model that need to be further explored, and those the Alliance has identified are noted in our responses to the consultation questions below. It is expected that both this consultation and the current pilot trials of the model will reveal further improvements that can be made to the model.

## Consultation Questions

### **1. Are there any risks or benefits of the proposed funding model that have not been identified?**

The primary risk in moving to the proposed funding model relates to price. The Alliance recognises that the AN-ACC does not address price (other than proposing weighted activity units), but this remains an absolutely critical issue in relation to the potential risks and benefits of the model. Furthermore, price must reflect the care needed to meet the new Aged Care Standards.

An adequate price that accurately reflects the costs of providing high quality care will be pivotal in building an aged care system that is viable in the long term. The experience of the National Disability Insurance Scheme (NDIS) shows the serious and systemic problems that arise when a price is set that does not cover the true cost of delivering a service. In the NDIS inadequate prices have resulted in some organisations ceasing to provide services and others struggling financially to cover funding shortfalls. It is critical that this does not occur with any new funding model for aged care.

Given the NDIS experience, it will be important for the government to ensure transparency and accountability in the processes used to determine price.

There is some concern that there is no demonstration of the cost-return ratio of transitioning to the proposed model. There will be significant costs to providers and government to change funding models, but the study reports have not demonstrated that the costs can be recouped

in savings or additional benefits to residents over time. While the current funding system is far from perfect, it would be worthwhile to quantify both the costs and the benefits of changing to the new model – perhaps at various price differentials to understand system implications of different prices before decisions are made.

Another significant risk is that the costing studies have been based on current practice in what many medical, nursing and allied health professionals consider a seriously flawed system that does not always meet the needs of consumers. This raises the question of whether the results of the studies may simply replicate current flawed practice, rather than accurately reflect the cost of meeting the needs of residents in a more effective and efficient system. Any new funding model must support innovation, improve service levels, and deliver high quality of life to residents. It must also fill gaps in the current system resulting from inadequate funding levels.

The Alliance believes that the study may not have adequately represented costs for small, specialised providers that may be servicing thin markets, even in metropolitan locations. These services tend to have similar demand fluctuations as small providers in remote areas because they are providing an essential niche service to CALD and other smaller populations, but this may not be recognised in the new funding model. There is a risk that the new model may not provide sufficient funding to these critical specialised services.

There is serious potential risk in the model around funding for reablement and restorative care. There is a level of incentive built into the model for providers to invest in reablement and restorative services by not requiring reassessment for funding if a resident's needs decrease as a result of reablement and restorative care. However, there is no evidence cited that demonstrates that the costs of reablement and restorative services or preventive care will be covered by this built in incentive. It is also important that small improvements in function are supported as these are often most useful and helpful to residents while not significantly affecting the cost of providing care.

In fact, the reassessment study provides some stark information about the current availability of reablement or restorative care. Of the 775 residents who were reassessed after 4-6 months, only 6 (0.8 percent) had participated in a structured reablement or restorative care program during that time period. This raises a question about the current availability of these services in residential aged care, and why access to these services is so limited.

In effect, the model removes the current disincentive to undertake effective reablement and restorative care under ACFI. But there is no evidence that the recommendation around not requiring reassessment is sufficiently proactive to remedy the current lack of access to these services experienced in residential care.

Reablement services include general health services and disability services, and the new funding model should not exclude access to reablement services that are available to the general population.

One element of the new model that may need consideration relates to how the one-off adjustment payment is used. Recommendation 19 of the Resource Utilisation Classification

Study specifies that the adjustment payment should not be “contracted out to third party providers”. Existing best practice care planning and care delivery for new residents in many instances includes contracted allied health professionals. This needs to continue as a very appropriate use of the adjustment payment.

The Alliance also perceives some risks in the adjustment payment only being available once to each consumer. This may disadvantage consumers from exercising their choice if they would like to move from one residential facility to another. In addition, not all services are able to provide comprehensive ageing in place, which means that residents may need to be moved to another facility that caters for their changing care needs. All new residents need to be assessed and care plans developed, regardless of whether they are entering a residential facility for the first, second or third time.

## **2. Are the proposed resident assessment and classification processes appropriate? If not, why not?**

Overall, the assessment and classification processes seem robust. However, there seem to be some gaps in the assessment regime.

The assessment focuses on functional and physical capabilities as the drivers of costs but does not address other resident requirements such as needs for meaningful activity, emotional or social support. These services may not significantly drive care costs, but the reports do not set that out in any detail.

In relation to meaningful activity, presumably the fixed costs component of the model would include some of these costs as expressed in the facilities studied. There is a question whether in a consumer-directed care environment, these are more appropriately individual rather than fixed costs.

Emotional and social supports are individually-focussed needs. Most care staff experience a pressing need for more time to individually care for residents – to provide emotional support and give more time and attention to improve residents’ quality of life. It is not clear whether these individual supports were sufficiently incorporated into the research.

The Alliance supports the recommended qualifications of the assessment workforce – registered nurse, physiotherapist or occupational therapist with experience in aged care, who have completed approved AN-ACC assessment training and comply with continuing professional development requirements.

The Alliance recommends that assessors are also required to have specified training or experience in both palliative care and dementia care. Modules on palliative and dementia care should also be included in the AN-ACC assessment training requirements.

Some refinements to the assessment process in relation to palliative care are recommended.

With respect to the assessment tool:

- the question ‘is the person entering the facility for residential palliative care?’ should be rephrased ‘is the person entering with palliative care needs?’ because residential

aged care facilities are not hospitals or hospices and people are not and should not be admitted 'for' palliative care. People living with a life-limiting illness enter residential aged care, therefore many residents have a need for palliative care.

- the question 'is there an existing palliative care plan (primary care or palliative care team)' should read 'is there an existing palliative care plan (primary care or *specialist* palliative care team)'.
- it is not clear why the question around malignancy does not include other life-limiting illnesses or chronic conditions. Others that are relevant to palliative care include dementia, chronic heart failure, end stage kidney or lung disease or neurodegenerative diseases.

Report 2 sets out that 'residents entering a facility for palliative reasons are a distinct group with a predictable care trajectory and costs'. In fact, an illness trajectory may be short with evident decline, long-term with intermittent serious episodes, or prolonged and dwindling depending on a person's diagnosis, comorbidities and a range of other factors. For example:

- some people will have straightforward and predictable needs that are generally able to be managed with the provision of palliative care by existing health care providers including GPs and aged care staff.
- others may have intermediate and fluctuating needs, with intermittent onset of worsening symptoms (such as unmanaged pain, psychological distress and reduced functional independence) resulting in unplanned and emergency use of hospital and other health services. These people may require access to specialist palliative care services for consultation and advice but are able to receive care from their existing health and care providers.
- others might have complex and persistent needs in relation to physical, psychological, social and/or spiritual health that are not able to be effectively managed through established protocols of care. While people in this group will require more ongoing direct care by specialist palliative care providers, this should occur through partnerships and shared care models with existing health and care providers.

In Version 1.0 of the AN-ACC, people in class one are defined as having a palliative care plan developed by a palliative care team nurse or physician and/or appropriate medical practitioner on admission to the care home; a life expectancy of three months or less; and, a score of 40 or less on the Australia-modified Karnofsky Performance Status (AKPS).

A person with a life expectancy of 3 months or less, with a palliative care plan in place may not need to be in bed for 50 percent of the time but may still require ongoing clinical assessment, complex symptom management and significant support. Including this AKPS measure (score of 40 or less) as a requirement for assignment to Class 1 will exclude people who require the additional funding to support their palliative care needs. The inclusion perpetuates the inaccurate view that people nearing the end of their life tend to be in bed rather than focussing on measures that enhance their quality of life and funding those interventions appropriately.

A resident is only able to be assigned to class one on admission. “Residents who ‘become palliative’ while in residential care are reassessed as per any other change in care requirements”. This would more accurately be expressed as “residents whose palliative care needs increase significantly”. A resident does not become palliative, just like they don’t ‘become aged’. The Australian Government describes ‘palliative care’ as *person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life*. The majority of people entering residential aged care will have an active or progressive or advanced disease.

It is not completely clear how the assessment protocol deals with a resident being assessed on the borderline between classes. If the resident is assigned to the lower class, there may be a negative impact on the level of care able to be provided. The Alliance understands that the AN-ACC is a work in progress and further refinement is likely to be undertaken through the pilot trial as the model is tested on larger cohorts. Additional potential problems may declare themselves during implementation.

**3. Are the proposed reassessment triggers appropriate? If not, why not?**

**4. Are there other factors that should be considered for inclusion as reassessment triggers?**

The current pilot trials may provide an opportunity to identify any additional triggers. Significant clinical decline over a short period of time could be an additional trigger for reassessment.

**5. Should the Commonwealth consider the introduction of reassessment charges for services that trigger unnecessary reassessments?**

This may be appropriate once the new system is well established, but the Commonwealth should be cautious about introducing charges during the transition period. A number of residential aged care facilities are experiencing marginal financial viability, and the transition to a new funding model will in itself require additional expenditure by facilities during the transition. Adding additional cost burdens on providers may have negative effects in that environment.

**6. Should there be a requirement for reassessment in the proposed funding model?**

No. The Alliance strongly supports the concept of allowing providers to be funded at higher levels if investment in reablement and restorative services results in higher functioning for residents. We would urge future governments not to attempt to claw back this funding after implementation of the model.

However, as outlined in the answer to question 1, there is no evidence that this funding stream will either cover the average costs of reablement and restorative care programs or be adequate to provide enough of an incentive to significantly increase residents’ access to these services.

With the change to external assessment for funding, it will be important that providers have timely access to reassessments when a resident's condition deteriorates in a short period of time. It will also be necessary to develop a suitable process for providers to disagree with the external assessment – potentially seeking reassessment if certain criteria are met.

#### **7. What are your views on an annual costing study to inform price?**

The Alliance strongly supports annual costing studies to inform price. These studies must be conducted by an independent agency, and the process must be transparent. Having a price that accurately reflects the cost of delivering service is an essential component of the funding model. Costing studies must include key components such as workforce costs. The government should undertake consultation with the sector to ensure the aspects studied include all the key elements of cost to deliver quality care.

It is important that these studies are annual. This will ensure they build an evidence base for changes in costs over time especially given these studies are new to aged care. The studies also need to actively include the costs of small, specialised services across all locations not just in rural and remote areas.

The Alliance also strongly supports the additional research recommended by the reports – including studying the costs of respite care.

There are potential lessons to be learned from the process developed to set the National Efficient Price in healthcare. The Alliance supports a similar dynamic, robust and ongoing stakeholder consultation process being adopted within aged care. This would ensure the impacts of any new measures are fully understood and any unintended consequences identified, especially where incentives and penalties are introduced.

#### **8. What are the risks and benefits of rolling viability supplements into the fixed payment NWAUs?**

#### **9. What are the risks and benefits of rolling homeless supplements into the fixed payment NWAUs?**

Both these initiatives should reduce paperwork for providers and the Department. This is a very clear benefit.

Attention needs to be taken that residents and providers are not financially disadvantaged during the transition period. For example, Study 5 (page 16) outlines that the current viability supplement covers increased costs for hotel services, which are out of scope in the AN-ACC model, and that this potential funding shortfall still needs to be addressed.

The use of external assessors needs to be well structured and moderated to ensure that the assessors are appropriately skilled and understand the particular environmental and cultural contexts, histories and challenges of homeless people.

The Alliance supports the observation in the report that states “this is a matter that would require careful consideration to ensure additional costs and challenges these providers face are fully addressed. For example, the former homeless do not have a family or traditional



external support network who would be engaged in activities such as outings or specialist visits and in that absence the provider takes on the responsibility and any cost of this.”

**10. Which transition option do you prefer? Why?**

**11. Are there any other approaches that should be considered?**

The largest issue around the transition to a new funding model is whether government payment systems are adequate. There have been ongoing problems with the current system and adding further complexity may have negative consequences. It will be absolutely essential for all government systems to manage a new funding model that is thoroughly trialled and tested before systemwide implementation is attempted.

Should the two-year transition approach be taken, some further modelling should be made of the study recommendation that ACFI payments are frozen for existing residents during the transition period. This measure may adversely affect provider viability at a crucial time in the transition period for the sector.

The key principle for decisions around the transition to the new model must be that services are able to continue and not be compromised.

To determine the best option, the Alliance would like to see further detailed information and planning around what the transition would involve.

**12. What are the implications of ceasing ACFI assessments in relation to care planning activities?**

In principle, ACFI assessment resources could be applied to providing care, care planning and supporting the adjustment of new residents to the home. This initiative should strengthen care planning, facilitating greater leadership and a more multidisciplinary approach to care planning.

Current best practice approaches to care planning use a multidisciplinary approach, often using staff expertise, nursing, allied health and medical expertise. This approach should be further encouraged.

**13. Do you support the development of a best practice needs identification and care planning assessment tool for use by residential facilities?**

Yes, the Alliance supports providing a best practice tool for care planning as long as its use is not mandatory. Residents have diverse needs, and true consumer-directed care requires a high level of flexibility in service provision. A best practice tool could be used as the basis for needs identification and care planning tailored to individuals and communities. This tool would need to be co-designed with consumers, nursing, allied health and medical professionals to ensure a comprehensive multidisciplinary approach.

Care planning needs to be an essential element of the funding reform package, implemented at the same time as the external AN-ACC assessment and, therefore work on the care planning



tool should commence immediately. Additionally, a mechanism to check implementation of best practice within care planning also needs to be considered.

**14. Do you support a requirement for care planning assessments to be undertaken at least once a year for all residents, with outcomes discussed with residents and carers?**

The Alliance strongly supports this approach.

# NACA

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