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AMA Submission to the Department of Health – Proposal for a new residential aged care funding model

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The AMA thanks the Department of Health for the opportunity to comment on the new residential aged care funding model – the Australian National – Aged Care Classification (AN-ACC) model. AMA members, particularly general practitioners (GPs), visit patients in residential aged care facilities (RACFs) and are concerned that their patients are not receiving equal access to the same health care as the rest of the population. While doctors themselves are not funded via the Aged Care Funding Instrument (ACFI), doctors have a responsibility to advocate for their patient's care needs, including to ensure there are adequate resources available to receive appropriate care. The technical aspects behind the new funding model are not within the AMA's scope, and refers the Department of Health to the aged care peak bodies and the Aged Care Financing Authority for more specific feedback, particularly on the issue of model implementation. It is important that quality of care is maintained during the implementation process and that aged care providers are adequately supported and communicated with by the government.

The AMA supports in principle the new funding model and the rigorous research that lies behind it. In particular, the AMA is pleased that a fixed plus variable funding model, adjusted for geographic location is recommended. If designed correctly, this will hopefully address the difficulties imposed by pure activity-based funding for smaller aged care providers in different geographic locations. The new transparency associated with a case-mix classification and funding model is also a very positive development for aged care providers, government and consumers. The AMA agrees, this type of model creates the potential at some point in the future, to define staffing requirements by AN-ACC class, and develop best practice models of care for each case-mix/class. This type of transparency is very welcome and is somewhat overdue in the Australian aged care sector.

An activity-based funding system

While activity-based funding has many positives, the success of shifting to an activity-based funding model will depend on the price generated by the funding formula. The AMA notes price is out of scope in this consultation. No matter how robust a funding formula is, if the price paid per activity is too low, or not adjusted to staff wages growth or insufficiently indexed, the funding model cannot generate high quality care and positive resident outcomes. The quality of care in RACFs is already compromised by staff shortages and high staff turnover.

The AMA urges the government to consider the struggles of Australia's public hospital system[1,2] as a result of chronic underfunding when determining the National Weighted Activity Units (NWAU). Locking in a fundamentally low NWAU initially with a slow annual growth rate may result in NWAU never reflecting the actual cost of care and never meeting demand. Aged care, like hospitals, need to be efficient *and* effective.

Independent assessment

The AMA supports the recommendation that AN-ACC assessors are independent from the aged care provider. Having aged care providers assess their own residents for funding under the ACFI created a conflict of interest.

The independent assessment structure may also free up more time for aged care staff to actually care for their residents. AMA members report that ACFI compliance is an enormous administration burden to RACF staff and detracts from the quality of resident care. Staff shortages is a main cause of missed care in RACFs. Doctors require registered nurses to carry out a clinically reliable handover, however AMA members report that there is on occasion no registered nurse available to do so. Staff shortages increase the risk of neglect, ill health, and hospital transfers.

The AMA notes the recommendation that the independent assessor should assess the new resident within four weeks of them entering the RACF (recommendation 3). The Department of Health must ensure there is an adequately trained, readily available AN-ACC assessment workforce to achieve this. AMA members have reported long waiting times for aged care assessment team (ACAT) assessments, and the Department should learn from this experience when it comes to developing the AN-ACC assessment workforce. Respondents (AMA members) of the 2017 AMA Aged Care Survey reported that the highest average waiting times for an initial ACAT assessment for their patients was one to three months[3]. There are also reports that some older people have been waiting up to 12 months for an ACAT assessment[4].

The Department must also ensure that assessor training is consistent across the country to reduce the risk of funding inequality.

Reassessment

The AMA notes recommendation 6 which outlines the conditions for reassessment. Responsiveness and flexibility are important factors in reassessment. Residents can deteriorate quickly, and the new model must take this into account so as not to disadvantage a resident. This is particularly relevant to palliative care and end of life situations. The AMA suggests protocols

[1] Australian Medical Association (2019) *2019 Public Hospital Report Card* https://ama.com.au/sites/default/files/public-hospital-report-cards/AMA%20Public%20Hospital%20Report%20Card%202019.pdf

[2] Australian Medical Association (2018) *AMA submission on the Pricing Framework for Australian Public Hospital Services 2019-20*. https://ama.com.au/submission/ama-submission-pricing-framework-australian-public-hospital-services-2019-20

[3] 2017 AMA Aged Care Survey, page 24. https://ama.com.au/article/2017-ama-aged-care-survey

[4] Department of Health (2017) *Legislated Review of Aged Care 2017*. Page 139. https://agedcare.health.gov.au/sites/default/files/documents/08_2017/legislated_review_of_aged_care_2017.pdf

for fast reassessment should be explored for situations where the resident requires palliative care or has deteriorated quickly.

Care planning

It is important to recognise that care planning and funding for that care are linked. An older person may require services from an allied health professional, however funding for that service may not be acknowledged until a care planning assessment has occurred. There should be some form of communication between the two.

The AMA understands that a nationally standardised care planning assessment toolkit is proposed and that care planning is a recommended condition of receiving government subsidies. There should be a requirement that the RACF must consult the resident's usual doctor in the care planning stage to ensure their medical needs are met. A patient's usual doctor may already have important medical information, such as an advanced care plan or current medicines that the RACF needs to deliver a quality service. Usual doctors are not consulted well in the ACAT assessment and this issue has been raised in the AMA's submission to the Streamlined Consumer Assessment consultation[5]. Further, precautions need to be taken to ensure the standardised assessment does not become a 'tick-box' exercise – in consultation with the patient's usual doctor, there should be opportunity for the aged care provider to adapt care to the individual's needs, provided it is practical and safe.

Supplements under the new AN-ACC funding model

The AMA notes that the homeless supplement and adjusted subsidy reduction would discontinue under the new model, with further studies to occur on whether other supplements should be continued (recommendation 20). There certainly will be circumstances where an older person may require specific medical equipment or support that is not covered by the AN-ACC assessment and there should be funding support and mechanisms to recognise this. This is an important example of why care planning and AN-ACC funding assessments should be communicated. Studies into the respite care supplement are extremely important because, in addition to impacts on the older person, it impacts the wellbeing of their families and carers who may take time from their jobs to care for the older person.

Incentives for good practice

The new model provides incentives for aged care providers to improve their resident's care and the AMA is supportive of this. Specifically, where the provider receives the same high level of funding even if the resident improves and therefore requires less resources.

[5] Australian Medical Association (2019) *AMA submission to the Department of Health – Streamlined Consumer Assessment for Aged Care* https://ama.com.au/submission/ama-submission-department-health-%E2%80%93-streamlined-consumer-assessment-aged-care

Will the funding actually go to resident care?

Recommendation 19 outlines that the Commonwealth introduce accountability systems to ensure the adjustment payment is used for its intended purpose. There is community concern that how aged care providers spend government funding is not transparent and a senate inquiry could not conclude that for-profit providers are not engaging in improper tax or financial practices[6]. The AMA agrees aged care providers should be accountable to ensure all funding is used for its intended purpose.

Recommendation 19 also states that the adjustment payment should 'not be contracted out to third party providers'. On some occasions (for example, if the new resident has come from hospital), temporary rehabilitation might be required from, for example, a physiotherapist. Since many physiotherapists are hired externally, the AMA is concerned the resident may not receive these much-needed services. The AMA suggests that clinical and allied health care be exempt from this rule.

Ensuring access to allied health care

Many allied health services are provided by external professionals but are funded under the Aged Care Funding Instrument (ACFI), not Medicare. AMA members report that it is difficult for their RACF patients to receive allied health support, and this has been attributed to inadequate funding under ACFI. From the consultation paper provided, the AMA assumes allied health funding would come under the variable component. Government must ensure that RACF residents have equal opportunity to access allied health services as the rest of the population. For example, RACF residents are not eligible for the Medicare *Better Access Initiative* because psychologist services are supposed to be covered under ACFI. However, access to psychologists is limited in RACFs.

Research and development agenda

The AMA supports the use of AN-ACC data to conduct research to continuously improve the AN-ACC model and the wider aged care system. Research into the care of older people in Australia is severely lacking and therefore data transparency and research on quality and outcome measures is welcome.

The AMA notes the intention to use the AN-ACC to inform the ongoing debate on staffing ratios. The AMA believes that advocacy for a staff ratio has been misrepresented – the AMA does not support what has been termed a 'crude staff ratio'. A minimum staffing ratio model would need to align with the level of care need of each resident in the RACF and ensure 24 hour on-site registered nurse availability. This recognises that there is not one single staffing ratio that will act as a silver bullet for care quality and safety issues.

The AMA supports the AN-ACC data to be used as a method of determining existing levels of care need and hours of care for each staff level. However, the AMA cautions that best practice models should be based on what care *should* occur, not what care is *currently* occurring. There have been

[6] The Senate Economics References Committee (2018) *Financial and tax practices of for-profit aged care providers*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Taxpractices-agedcare/Report

too many examples of poor-quality care as a result of staff shortages and/or unqualified staff to base best practice models on staffing mix averages currently occurring across the aged care sector.

Conclusion

The AMA acknowledges that this significant reform will need to be improved over time as unknown risks emerge. For this reason, the AMA regards the AN-ACC model as a positive first step to improving the funding of the aged care sector to improve the quality of care older people receive. The AMA cautions that NWAU prices must be adequate, sufficiently indexed, and adjusted for staff wages growth so quality care is not compromised by a lack of funding. The AMA urges the Department to consider the existing issues under the hospital NWAU system under the AN-ACC model context. In addition, to consider the issues of ACAT assessments and its workforce. While AN-ACC assessment should be independent, it is important that care planning assessment is communicated with the AN-ACC workforce in case there are unforeseen care costs that are not picked up in the assessment. The AMA supports further studies into which aged care supplements should be retained to determine which unforeseen care costs should be funded for by the government. The AMA also supports using the AN-ACC data to continuously improve the model and the wider aged care system.

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