Submission by the Australian Nursing and Midwifery Federation

ANMF Submission to the Independent Health and Aged Care Pricing Authority Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025-26

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Introduction

1. 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 326,000 nurses, midwives and care-workers across the country.

2. 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.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides 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.

4. 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.

5. The ANMF thanks the Independent Health and Aged Care Pricing Authority (IHACPA) for the opportunity to provide feedback on the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025-26 (the Consultation Paper).

1. Do the current Australian National Aged Care Classification (AN-ACC) classes in Figure 10 group independently mobile 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)?

6. The AN-ACC has two groups for independently mobile residents: Class 2 (without compounding factors), and Class 3 (with compounding factors). Based on the AN-ACC's National Weighted Activity Units (NWAU) and subsidy amounts from 1 December 2023 Class 2 residents attract $48.23 (NWAU 0.19) while Class 3 residents correspond to a NWAU of 0.31 and attract $78.68. Class 2 residents are to receive 110 total direct care minutes including 30 minutes of registered nurse (RN) care while Class 3 residents are to receive 143 total direct care minutes including 32 minutes of registered nurse care.

7. The compounding factors in the 'independent branch' for Class 3 residents include the Resource Utilisation Groups – Activities of Daily Living (RUGADL) which covers four items (bed mobility, toileting, transfers, and eating), the Australian Modified Functional Independence Measure (AM-FIM cognition) designed to measure the care burden associated with cognitive limitations, the Australia-modified Karnofsky Performance Status (AKPS) that measures a resident's overall performance status, daily injections, and behaviour. There is limited/no published evidence that provides insight into the degree to which these Classes are appropriate in terms of care and resource utilisation highlighting that case mix systems take time to refine and that there needs to be active and ongoing research and evaluation to ensure that Classes continue to be appropriate.

8. Here, IHACPA would need to determine whether the subsidies are: i) independently sufficient for each Class, ii) appropriate between the two Classes. One issue here, is that knowing whether funding is appropriate must also consider the degree to which providers are accountably and transparently utilising existing funding to allocate and provide resources and care as well as whether that care is of sufficient quality. Part of this consideration must also include attention to i) whether the allocated direct care time for each Class is sufficient, and ii) whether the subsidy is being accountably and transparently utilised to provide that care. There is evidence that many providers are not achieving their mandated direct care time targets citing workforce shortages to be the reason why. Some of these providers are known to be offsetting financial losses from accommodation and daily activity costs through unspent money received through AN-ACC. This highlights the need for greater transparency and accountability in the use of funds on the part of providers as well as more careful oversight and consequences when providers utilise funding received for the purposes of delivering care to residents on other things especially profits. One consequence would be ensuring providers return unspent funds.

1.a. What factors should be taken into consideration in developing any future refinement to the AN-ACC branching structure for independently mobile residents?

9. The IHACPA would need to consider whether the compounding factors for Class 3 residents, either singly or in combination, result in different resource and care costs. Here, consideration would need to focus on evidence from providers to demonstrate that costs for different residents within Class 3 are different as well as wider evidence to determine whether diverse residents currently grouped together in Class 3 represent too varied a group to be reasonably combined into one. The ANMF (SA Branch) has highlighted that one recommendation for consideration

should be to include cognitive ability in the assessment of independently mobile people as this has a significant impact on the support required. For example, an independently mobile resident with severe cognitive impairment who requires significant behaviour support is likely to require more care and supervision than a fully dependent person who has no cognitive impairment.

10. As above, consideration would also need to be given to the extent to which providers are currently transparently and accountably utilising funding received for Class 3 residents and whether increased funding toward the care and resources needed to support these residents is warranted.

11. If the IHACPA is considering refinement to the branching structure for independently mobile residents, there is likely also a strong rationale for considering refinement for other Classes in the existing branching structure in a similar fashion to that which is explained above. This also highlights that variable funding determined through allocation to any AN-ACC class must also be sufficient in order to support high quality, dignified care to all residents and that providers must be held accountable for providing that care rather than using AN-ACC funding to offset losses made in other areas of the business such as accommodation and daily activities as has been reported in recent months. Further research and evaluation is likely to be needed to ensure that presentations such as chronic illness, multimorbidity, and increasing resident complexity are appropriately accounted for within each AN-ACC Class.

1.b. What evidence is there to support this?

12. Evidence would need to be sought from providers to confirm whether costs for residents currently grouped into Class 3 are substantially different. Published research evidence might also offer insight into whether residents with compounding factors in Class 3 require substantially different care which would mean the costs of providing that care might be different.

2. What, if any, factors should the Independent Health and Aged Care Pricing Authority (IHACPA) consider when looking at specialised base care tariff (BCT) rates for Aboriginal and Torres Strait Islander peoples?

13. Considerable health disparities and a higher burden of chronic diseases are faced by Aboriginal and Torres Strait Islander peoples. This might require adjusting tariffs to reflect the additional resources needed to manage and treat these conditions effectively. Engaging with Aboriginal and Torres

Strait Islander communities and health professionals though genuine consultation and co-creation is crucial to understand their specific needs and preferences. This can help tailor tariffs to better reflect the actual costs and requirements of care in these communities.

14. The IHACPA must consider data regarding the provision and costs of care for Aboriginal and Torres Strait Islander Peoples and determine whether BCTs are configured correctly to provide appropriate care. As above, provider transparency and accountability regarding the use of funds must be considered.

15. Several factors can be suggested for consideration including but not limited to the costs associated with providing culturally safe and competent care (including training for staff) and accessibility factors regarding the geographic distribution of Aboriginal and Torres Strait Islander Peoples and the differences in terms of costs and resources based on differing geographic locations. Social and cultural determinants of health might also be valuably considered as these complex and interrelated factors might be influential in terms of determining the cost of care as these have substantial impact on healthcare outcomes for older Aboriginal and Torres Strait Islander Peoples.

16. Consideration should also be given to how tariffs align with broader government health strategies and initiatives aimed at closing the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and the general population. Here, higher tariffs might be required to ensure that the tariffs are sufficient to support adequate funding for services that are tailored to the needs of Aboriginal and Torres Strait Islander peoples, including preventative care, early intervention, and chronic disease management.

3. What, if any, additional cost variations and eligibility requirements are associated with the provision of care for Aboriginal and Torres Strait Islander residents?

17. Location (i.e., metropolitan, regional, rural, remote) across a range of areas and the increased costs of providing care to Aboriginal and Torres Strait Islander Peoples in homes were less than 50% of residents are First Nations must be considered. Any deliberations around changes to costs and eligibility requirements associated with the provision of care must be developed in consultation with relevant Aboriginal and Torres Strait Islander stakeholders.

4. What, if any, factors should IHACPA consider when looking at specialised BCT rates for specialised homeless status?

18. The impact on workers who provide care for homeless individuals should also be considered. Here, BCT rates should account for the additional training, resources, and required by staff. Ensuring that rates are sustainable for providers, are transparently and accountably used, while adequately compensating for the increased complexity and cost of care is essential for maintaining quality care. Continuous feedback and review processes can help adjust rates and ensure they remain effective in addressing the needs of this population.

19. The IHACPA must consider several important factors when determining BCT rates for individuals with specialised homeless status. People in this vulnerable population have a higher rate of specialised needs and which adds to the complexity of care they require. Individuals who are homeless or experienced homelessness often have complex health needs, including chronic diseases, mental health issues, and substance abuse problems. The care required for these conditions can be more intensive and specialised. Additional case management and coordination of care might also be necessary to address the diverse and complex needs of this population effectively. BCT rates should reflect the need for enhanced accessibility to services for people with specialised homeless status and sufficient coordination with social services must also be considered to account for the additional effort and resources required to integrate health care with social support systems.

20. Ensuring culturally appropriate care is essential, especially for culturally and linguistically diverse and marginalised groups within the homeless population. Specialised training and resources for staff might be needed to provide culturally safe care. Further, addressing social barriers such as lack of identification and healthcare record can impact care delivery and should be considered.

21. Specialised care for homeless individuals can often incur additional costs including that which can be associated with emergency care, preventive healthcare, the need for higher staffing ratios, and the provision of additional support services to meet the unique needs of this vulnerable population. Consideration of these costs should be reflected in the BCT rates.

22. The rates should be informed by data and evidence on the specific needs and costs associated with providing aged care to homeless individuals. This includes analysing patterns in service

utilisation, health outcomes, and costs. Comparing rates and practices with other regions or and providers can help ensure that the rates are fair and adequate.

5. What, if any, additional cost variations and eligibility requirements are associated with the provision of care for these residents?

23. Specialised services designed to support homeless individuals in nursing homes are integral to effective, person-centred care. Individuals experiencing homelessness often present with a complex array of health issues, including chronic conditions and mental ill health. The management of these multifaceted health needs in the context of residential aged care necessitates an increase in resources and funding that must be used by providers in an accountable and transparent manner.

24. The staffing and training required to meet the needs of this population impacts financial considerations around the cost and funding of care. Due to the intensive and often more frequent nature of care required by individuals with complex conditions, providers may need to adjust staffing ratios and hire additional personnel. Furthermore, the specialised training needed to address the unique challenges faced by homeless individuals adds to operational costs.

25. Preventive care and supportive services for people who have experienced homelessness can also result in increased costs. Investing in preventive measures, screening, and health education is crucial for managing health issues before they escalate. Support services, including mental health care, substance abuse treatment, and social supports are vital for comprehensive care but can contribute to overall costs. Specialised care for people who have experienced homelessness should include a thorough assessment to determine an individual’s unique needs and appropriate levels of care. This assessment must address both health and social factors, ensuring that individuals receive the necessary support. Case management services are also crucial in coordinating care.

6. What should be considered in any future refinement to the residential respite classes and AN-ACC funding model?

26. Refining the residential respite classes and AN-ACC funding model requires a comprehensive approach that considers the diverse needs of residents, ensures adequate and flexible funding, integrates with the broader aged care system, and maintains high standards of quality and safety.

When refining the residential respite classes, it will be essential to consider several key factors to enhance effectiveness, fairness, and sustainability. It will be crucial to ensure that a detailed and nuanced assessment of the care needs of individuals utilising residential respite services (i.e., a demand model) underpins any future refinements as well as ensuring that providers are using received funds in a transparent and accountable manner.

27. The funding model must ensure that adequate resources are allocated to meet the diverse needs of respite residents. This involves adjusting funding to reflect the complexity of care required, with higher rates for those needing more costly intensive or specialised care. Refinements should promote better integration with other components of the aged care system including Allied Health care. This includes ensuring that respite care is funded to be well-integrated with home care and permanent residential care to provide a seamless care experience. A holistic approach that aligns respite services with broader care plans and support systems, including health care, social services, and community support, is essential.

28. Ensuring that nursing home staff have the capacity and skills to deliver quality respite care is another important consideration. This includes providing ongoing training for staff to address the unique needs of respite care residents and ensure compliance with best practices. Evaluating and adjusting staffing levels to provide adequate support for residents is also important. Financial sustainability is a key factor in refining the funding model. Regularly conducting cost analyses to evaluate the costs associated with respite care and the effectiveness of funding allocations is essential. Ensuring that the funding model is sustainable over the long term, given demographic trends and the growing demand for aged care services, is also crucial and must be considered by IHACPA.

29. Encouraging the adoption of innovative approaches and best practices can enhance the quality and efficiency of respite services. Supporting the implementation of evidence-based practices and innovative models of care, as well as leveraging technology to improve service delivery and care coordination, can lead to significant improvements but brings cost implications that IHACPA should be mindful of.

30. Ongoing development of the model to reflect the increasing acuity (from a healthcare perspective not just an activity of daily living perspective) of residents must also occur to ensure that aged care

is health care, not just personal care.

6a. Is the funding model approach across each respite classification adequate to incentivise services to provide a residential respite model of care?

31. Establishing whether the funding allocated to each respite classification is sufficient to incentivise services to provide respite models of care would need to be established based on information from providers to determine whether current funding is sufficient and being transparently and accountably utilised for care. Any further funding aimed at incentivising providers to deliver respite models should also be required to be transparently accounted for to avoid situations where providers might draw upon funding but not use it for care delivery costs.

6b. What evidence is there to support this?

32. Recent reports focussing on the aged care sector highlight that some providers are utilising funds received through AN-ACC to offset financial losses from other areas of the business including accommodation and daily activities.

7. What, if any, changes should IHACPA consider for the proposed updated residential aged care pricing principles, which take into consideration a move toward revised funding model terminology?

33. As per ANMF's previous submissions to the IHAPCA, the ANMF highlights the need for the inclusion of additional principles around accountability on the part of providers in the use of funds. While the principles articulated in the consultation paper, such as 'transparency', account for a proportion of this in the way funding is distributed, greater focus should be placed on the way the funding is used by providers and the methods of how this will be reported. Here also, the model must reflect labour costs in a timely manner as increases to wages occur.

34. The NSW Nurses and Midwives' Association (NSWNMA) has highlighted that there is evidence that providers have used aged care funding received via the AN-ACC to fund administration of medications by aged care workers who are not nurses. In some circumstances, we understand that this could be non-compliant with NSW State Poisons and Therapeutic Goods Regulations and could represent an attempt by providers to deliver care more cheaply rather than utilising care funding to employ additional nurses to meet legislative requirements designed to increase public safety. We are concerned that if this practice remains unchecked by both the Aged Care Quality

and Safety Commission and the NSW Ministry of Health, this could represent a lack of governance to verify the true costs of delivering safe care, and in turn, inform the funding required to meet legislative requirements and reflect best practice.

35. 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 or paying aged care participants. It is of importance that issues of "commercial in confidence" are not allowed to get in the way of appropriate transparency and accountability regarding the use of funds particularly when government funds are sourced from tax payers. Funds should be used to provide evidence-based, safe, effective, and dignified care that where possible, is restorative and aims to bring about better outcomes to residents. Over-servicing and exploitation of aged care residents and government subsidies remain a concern. 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.

36. As noted in ANMF's previous submission the use of AN-ACC funding to provide additional/extra services as a means of profit generation by providers remains a concern. 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. The use of ABF should bring about a reduction in provider discrepancy on staff expenditure. Principles on these offerings should be included and monitored for predatory provider behaviour such as price gouging.

37. As the ANMF has previously submitted, 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.

38. While the ANMF recognises that the principles do include 'promoting value' and promoting the use of 'ABF where practicable and appropriate', further efforts should occur to where possible

adopt an outcome/value-based approach to funding and provision of care. This would help to incentivise better outcomes for residents where activity-based funding might not.

39. The ANMF highlights that overall, the principles do not account well for the aged care workforce that provides care. The cost of wages for the provision of direct care activities is the largest outlay of funding in the aged care sector. Here, more accurately, it is the staff that deliver aged care as opposed to the provider as an organisation or business entity. The ANMF strongly recommends that the principles should be revisited to include a clearer and more apparent focus on the aged care workforce.

40. The ANMF also highlights that the currently legislated care minutes are inadequate for providing best practice care to residents. This, in turn, means that the funding allocated to each class is also inadequate. While direct RN care time will rise to 44 minutes per resident per day from 1 October 2024 including 10 percent that could be filled by enrolled nurses, this is inadequate to fund best practice care for many residents with higher needs. The number of care minutes will need to rise significantly. The NSWNMA have highlighted that they have received reports from members that providers are choosing to admit residents with the highest health needs, manipulating AN-ACC to receive the maximum funding whilst simultaneously cutting hours and redesigning jobs to amalgamate indirect care roles to capture them under direct care roles (for example, asking care workers to hand out meals, do laundry duties and reclassification as “homemakers’ to legitimise this approach and create role confusion). While the costs related to delivery of hotel services are out of scope for IHACPA’s AN-ACC pricing advice, this lack of transparency around use of funding as detailed above should be considered relative to the true costs of care.