UTS Ageing Research Collaborative (UARC)

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IHACPA Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025–26: UARC response

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Background

The UTS Ageing Research Collaborative (UARC) welcomes the opportunity to respond to the Independent Health and Aged Care Pricing Authority's (IHACPA) *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025–26*.[1]

UARC has identified several issues that arise in IHACPA's Consultation Paper that extend beyond the set of questions that IHACPA has posed. UARC has responded to several of these matters of particular significance and has included them at the end of this submission.

UARC notes that on the 18th of September 2024, IHACPA released *Residential Aged Care Pricing Advice 2024–25,*[2] coinciding with the Department's release of an updated AN-ACC funding guide.[3] UARC has attempted to update this submission to reflect relevant changes to residential aged care pricing, with the caveat that it will conduct a more comprehensive analysis of the updates in AN-ACC funding in due course.

[1] Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025-26 | Resources | IHACPA
[2] Residential Aged Care Pricing Advice 2024–25 | Resources | IHACPA
[3] The Australian National Aged Care Classification (AN-ACC) funding guide | Australian Government Department of Health and Aged Care

IHACPA Consultation Questions and UARC's Response

1. Do the current 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)? What factors should be taken into consideration in developing any future refinement to the AN-ACC branching structure for independently mobile residents? What evidence is there to support this?

In response to this question, UARC notes that the underlying criteria for designing the AN-ACC classification system, according to the Department of Health and Aged Care, are:

"Each class represents residents:

- with similar needs and the cost of staff time to deliver consistent care
- whose daily care costs are similar
- with similar clinical risks and safety indicators."[4]

As paraphrased by IHACPA, the AN-ACC classes should group residents in a manner relevant to both care and resource utilisation (i.e. the residents that require the same degree of resources to support their care delivery).

To assist IHACPA in developing its initial pricing advice, it commissioned Scyne Advisory to undertake a Residential Aged Care Costing Study in 2023.[5] The study was limited to data from 111 facilities, equivalent to 4.2% of the population of residential aged care services in Australia.[6] Therefore, its results must be treated as indicative at best.

Likewise, the direct care time data was collected from 4,598 residents (permanent and respite), which represents approximately 2.5% of residents on 30 June 2023 with an AN-ACC classification (see Table 1 below).

While the total independently mobile sample (Classes 1-3) represents approximately 3.9% of the national total, Class 3 (n=46 residents) comprises only 2.3% of the 2000 residents with that classification nationally.

[4] AN-ACC assessment process and classification | Australian Government Department of Health and Aged Care
[5] 2023 Residential Aged Care Costing Study Final Report | IHACPA
[6] Aged care data snapshot—2023 | AIHW Gen-Aged Care Data

Table 1: Comparison of costing study sample to national population of residents with AN-ACC classification

	National population[7]		Costing study sample[8]	
AN-ACC permanent resident classification level	**% of permanent residents 30 June 2023**	**Number of permanent residents as of 30 June 2023**	**Number of participating residents per AN-ACC class**	**Sample as a proportion of the national population**
1 - Admit for palliative care	0.1%	104	0	0.0%
2 - Independent mobility - without compounding factors	3.2%	5909	264	4.5%
3 - Independent mobility - with compounding factors	1.1%	2000	46	2.3%
Total Independent mobility	*4.3%*	*7909*	*310*	*3.9%*
4 - Assisted mobility, high cognition, without compounding factors	6.4%	11804	256	2.2%
5 - Assisted mobility, high cognition, with compounding factors	19.1%	35394	841	2.4%
6 - Assisted mobility, medium cognition, without compounding factors	8.0%	14872	375	2.5%
7 - Assisted mobility, medium cognition, with compounding factors	14.3%	26418	617	2.3%
8 - Assisted mobility, low cognition	9.1%	16902	399	2.4%
Total Assisted mobility	*57.0%*	*105390*	*2488*	*2.4%*
9 - Not mobile, higher function, without compounding factor	6.7%	12436	341	2.7%
10 - Not mobile, higher function, with compounding factors	5.1%	9487	244	2.6%
11 - Not mobile, lower function, lower pressure sore risk	13.1%	24308	625	2.6%
12 - Not mobile, lower function, higher pressure sore risk, without compounding factors	2.9%	5425	151	2.8%
13 - Not mobile, lower function, higher pressure sore risk, with compounding factor	10.4%	19269	555	2.9%
Total Not mobile	*38.4%*	*70925*	*1916*	*2.7%*
98 - Default class for residents entering for permanent care to receive palliative care	0.0%	14	0	0.0%
99 - Default class for residents entering for permanent care (not palliative care)	0.2%	459	0	0.0%
Total permanent residents with AN-ACC	**100.0%**	**184862**	**4714**	**2.6%**
AN-ACC respite resident classification level	**% of respite residents as of 30 June 2023**	**Number of respite residents on 30 June 2023**	**Number of participating residents per AN-ACC class**	**Sample as a proportion of the national population**
101 - Independent mobility	15.5%	1254	0	0.0%
102 - Assisted Mobility	69.4%	5621	17	0.3%
103 - Not Mobile	14.0%	1137	27	2.4%
100 - Default class for residents entering for respite care	1.1%	86	0	0.0%
Total respite residents with AN-ACC	**100.0%**	**8105**	**44**	**0.5%**
Total permanent and respite residents with AN-ACC	**100.0%**	**192967**	**4758**	**2.5%**

[7] Aged care data snapshot—2023 | AIHW Gen-Aged Care Data
[8] 2023 Residential Aged Care Costing Study Final Report | IHACPA

Bearing this caveat in mind, the costing study's analysis of direct care minutes by AN-ACC classification and staff type shows an expected increase in resource use at progressively higher levels of care (see Figure 1). However, within the permanent resident An-ACC classes there are two anomalies which warrant closer examination.

Figure 1: Average direct care minutes captured per day by AN-ACC classification and staff type

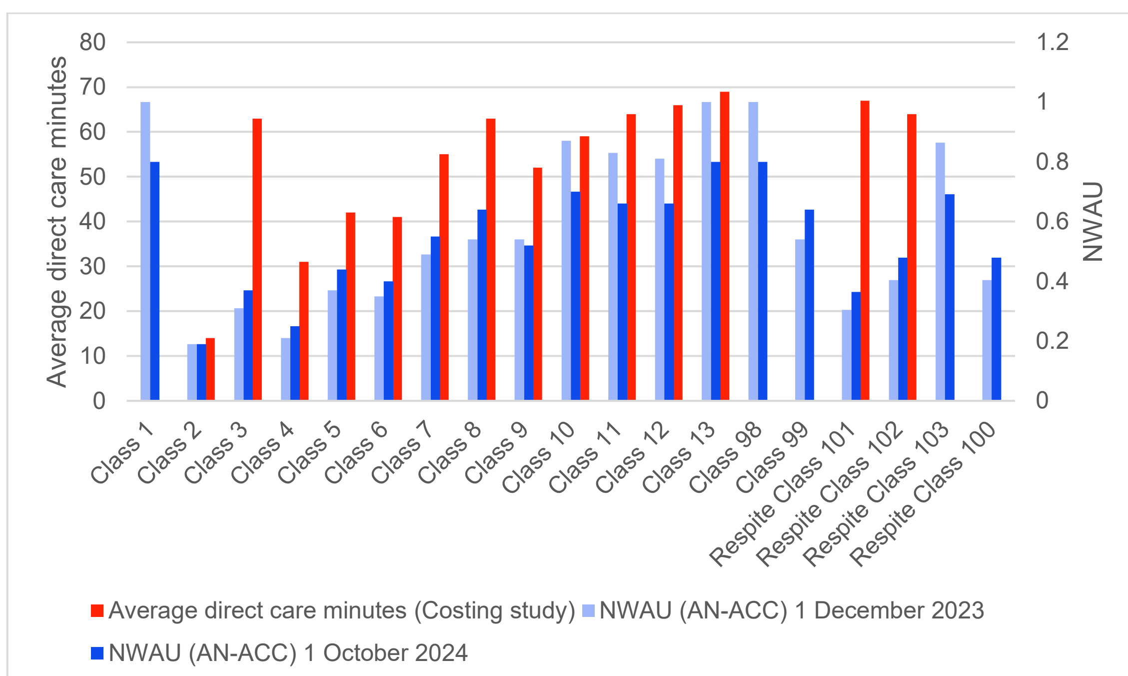
Source: IHACPA (2023), *2023 Residential Aged Care Costing Study*, Scyne Advisory, p.5

The most significant anomaly is Class 3 (Independent mobility, with compounding factors.)

At 63 minutes per day, the average level of direct care staffing for residents in Class 3 is twice that of the next higher class (Class 4, Assisted mobility, higher cognitive ability, without compounding factors, 31 minutes) and is not equalled until Class 8 (Assisted mobility, low cognitive ability, 63 minutes), which itself is an outrider (see below). It is not until Class 11 (Not mobile, lower function, lower pressure sore risk) that care staffing levels exceed those of Class 3, and then only by 1 minute per day.

Further, the staffing profiles of the care minutes show that residents in Class 3 receive significantly more care from higher cost Registered Nurse and Enrolled Nurses compared to Classes 8 and 11, where lower cost carers deliver a much higher proportion of care.

Figure 2: Comparing the direct care minutes per day with NWAU values



Source: IHACPA (2023), *2023 Residential Aged Care Costing Study*, Scyne Advisory, p.5; DOHAC (2023), Aged Care Supplements and Subsidies, 20 September 2024.

Figure 2 indicates the relative *actual* resource requirements of residents by AN-ACC class as measured by the average direct care minutes in the costing study (in red), alongside the relative *expected* resource requirement, as measured by the National Weighted Activity Unit (NWAU) values for the different classes (in blue). Note that the Figure has been updated to reflect the existing NWAU values for 2023-24 (light blue), as well as the recently announced NWAU values from 1 October 2024 (dark blue).[9]

Focusing on Class 3, Figure 2 indicates that while there has been a modest positive change in the resourcing (i.e., an increase in NWAU value for 1 October 2024), the relatively high level of direct care staffing of Class 3 is not reflected in its relative NWAU value. As a result, the funding available to meet the care needs of residents in Class 3 is significantly below that available to providers for Class 8 and Class 11 residents (see Table 2).

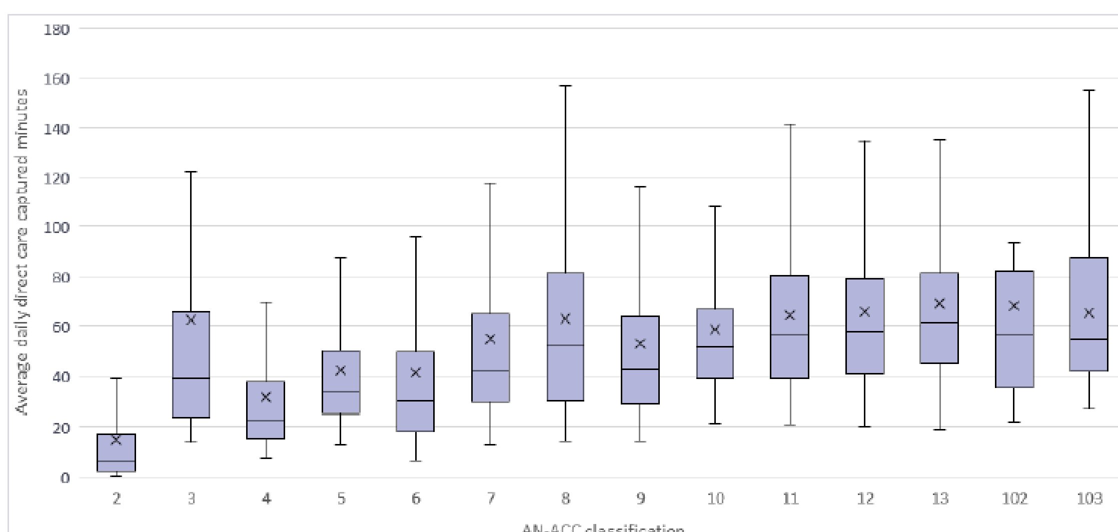
[9] The Australian National Aged Care Classification (AN-ACC) funding guide | Australian Government Department of Health and Aged Care

Table 2: Comparing direct care staffing with NWAU values and AN-ACC pricing

	Direct care minutes delivered[10]	% of minutes delivered by carers[11]	NWAU value (1 Dec 2023)[12]	Funding per resident per day (as of 1 Dec 2023)[13]	NWAU value (1 Oct 2024[14]	Funding per resident per day (1 Oct 2024)[15]
Class 3	63	61	0.31	$78.68	0.37	$103.60
Class 8	63	77	0.54	$137.06	0.64	$179.21
Class 11	64	79	0.83	$210.67	0.66	$184.81

In addition, evidence from the costing study about the variation in direct care staffing requirements for Class 3, indicate a separate issue, specifically the diversity of care resourcing needs of older persons within this class. This is evident in Figure 3 below, which shows that the range of individual total daily minutes for Class 3 residents in their sample is materially wider than for all other Classes up until Class 7, and is exceeded by the range for Class 8.

Figure 3: Box-and-whisker plot of average daily direct care minutes by AN-ACC classification



Source: IHACPA (2023), *2023 Residential Aged Care Costing Study*, Scyne Advisory, p.54

This variation in direct care staffing (within Class 3 and between Class 3 and other AN-ACC classifications) may reflect differences in residents' care needs. For instance, residents who are independently mobile with compounding factors which include a diagnosis of dementia can have very different needs and can exhibit equally different behavioural and psychological symptoms. More intensive care may be required to assist some residents with communication, nutrition, continence and other needs and to support residents who have symptoms such as agitation, aggression, loss of inhibition and being up at night. In other cases, people may need specialised care through the Specialist Dementia Care Program.

[10] IHACPA (2023), *2023 Residential Aged Care Costing Study*, Scyne Advisory, p.5
[11] Ibid, p.63
[12] Schedule of Subsidies and Supplements for Aged Care (health.gov.au)
[13] ibid
[14] The Australian National Aged Care Classification (AN-ACC) funding guide | Australian Government Department of Health and Aged Care
[15] ibid

When taken together, these considerations argue that it would be contrary to the principles of AN-ACC to simply increase the NWAU value for all residents in Class 3 as it is currently structured. The latest changes would appear to be an insufficient response.

Instead, and to be consistent with the criterion that each class represents residents who require the same degree of resources to support their care delivery, there may be an argument to undertake refinements that would improve the classification structure's soundness, involving both Class 2 and Class 3. Based on further analysis of a much larger sample of relevant residents, it may be necessary to distinguish between independently mobile residents who have:

- high cognitive ability and no compounding factors
- low cognitive ability and no compounding factors
- and low cognitive ability with compounding factors

Classes 4-8 (Assisted mobility) also appear to diverge from NWAU

Figure 2 indicates that further attention may also be warranted regarding the relative expected resource requirements of residents with assisted mobility (Classes 4 – 8). It would appear that, based on the direct care staffing levels in the costing study, these classes may require more resources than what is indicated by their relative NWAU. UARC notes that the latest IHACPA release goes some way to addressing this concern.

This was particularly the case for Class 8 (Assisted mobility, low cognition). At 63 minutes of direct care staffing per day, the level of care delivered to residents in Class 8 is materially greater than for residents in classifications on either side. Class 8 also has the widest range of individual total daily minutes of all classes, making a strong case for further analysis of the range of needs of residents in this class. The evidence may prove that it would be appropriate to undertake refinements of this class as well to distinguish between assisted mobility residents with low cognitive ability who have no compounding factors and those who do have compounding factors.

Stability of the AN-ACC classification system

As a concluding observation for this question, UARC recognises that any refinements to AN-ACC classes must be soundly justified and cautiously adopted so as to optimise the longer-term stability of the classification system.

As noted in UARC's 2023 submission to IHACPA's consultation paper on the 2024-25 residential care pricing framework, AN-ACC classes should not aim to reflect the ongoing variations in the types and intensity of delivery of care that respond to the needs of people living in aged care homes, other than on a more macro-scale. It is a matter of achieving an effective and efficient balance.[16]

However, the current wording of IHAPA's residential aged care pricing process principle which addresses 'Stability' says "The payment relativities for ABF should be consistent over time", and this wording (other than replacing ABF) is carried over to the proposed wording.

[16] UARC Response to IHACPA Consultation August 2023.pdf (uts.edu.au)

UARC's issue is with the use of the term 'consistent'. That term does not allow for any soundly justified changes to classes of the nature discussed under Question 1. It is proposed that replacing 'consistent' with 'stable' would better reflect the ability to conduct occasional reviews of the structure of the classes.

5. 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?

UARC has consistently argued that the objective of residential care is to provide a home, care and support for older people that responds to their varying needs. People should not be considered to have been admitted to a facility to receive episodes of care but to have a home where they can live fulfilling lives and receive care and support appropriate to their changing circumstances.

In our submission to IHACPA's consultation paper on the 2024-25 residential care pricing framework 2023-24 UARC stated: "Funding for a resident's life course in an aged care home does not readily align with the activity-based funding approach for types of care delivered to patients in hospitals". [17]

Further, UARC is not aware of any reference to activity-based funding in Schedule 8, Part 1 of the Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022 which amends the National Health Reform Act 2011.

Accordingly, UARC fully supports the proposed revised terminology for the residential aged care pricing principles which replaces the terms' activity based funding' and 'ABF' with variants of 'the AN-ACC funding model'.

[17] UARC Response to IHACPA Consultation August 2023.pdf (uts.edu.au)

Additional matters arising from the Consultation Paper

Safety and quality adjustments

IHACPA's Consultation Paper has identified three priorities for future developments (Section 7). Under Section 7.1, IHACPA advises that it considers safety and quality adjustments a long-term objective and intends to consider such adjustments once the funding model is further established. In general, UARC supports the inclusion of safety and quality adjustments, provided these do not create further unintended consequences. These could include perverse incentives to prioritise lower-cost quality improvements (over more costly quality improvements) or exacerbate existing disparities of care quality by allocating additional resources to services of already high quality.[18]

UARC requests IHACPA to include a likely timeframe, which may change under different circumstances, and for that timeframe to be included in its annual Work Program and Corporate Plan.

Efficiency

Also, UARC notes that one of IHACPA's Overarching residential aged care pricing principles states: "Efficiency: ABF (to be reworded as “The funding model”) should facilitate the sustainability of the aged care system over time and optimise the value of the public investment in aged care." This principle aligns with the Minister's Expectations Setting Paper, which requires, in part, that the Pricing Framework include how IHACPA will "drive efficient, effective and transparent use of resources in the aged care sector."[19]

We, therefore, consider that, as with safety and quality, this Consultation Paper could have included a separate sub-section on efficiency, with a similar commitment by IHACPA to engage with relevant parties to develop a plan for incorporating efficiency objectives into its pricing advice.

IHACPA may wish to address this matter in next year's consultation paper. For example, one issue that likely warrants further consideration is the extent to which pricing advice translates into the efficient use of resources regarding direct care staffing. In the most recent edition of Australia's Aged Care Sector Report, UARC demonstrated in a series of analyses that some providers are falling well short of their mandatory care minute requirements and are making considerable unearned surpluses on primarily taxpayer-funded direct care.[20]

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[18] Konetzka RT, Skira MM, Werner RM. Incentive Design and Quality Improvements: Evidence from State Medicaid Nursing Home Pay-for-Performance Programs. Am J Health Econ. 2018 Winter;4(1):105-130; Alshamsan R, Majeed A, Ashworth M, Car J, Millett C. Impact of pay for performance on inequalities in health care: systematic review. Journal of Health Services Research & Policy. 2010;15(3):178-184.

[19] Expectations setting paper | Minister for Health

[20] UARC_Australias Aged Care Sector Mid Year Report 2023-24.pdf (uts.edu.au)

Thin Markets

Finally, in Section 7.3 of IHACPA's Consultation Paper, IHACPA noted that the Aged Care Taskforce indicated that specialist funding arrangements may be required for services operating in thin markets, such as those in certain rural or remote regions. UARC agrees that this is a priority area for IHACPA and the Government, as the financial viability of services in thin markets is an important pre-condition to ensuring equitable access to quality care for all older Australians.

UARC notes that the most recent update to the AN-ACC funding model includes, as per IHACPA's pricing advice, a more granular approach to pricing the Base Care Tariff (BCT). Specifically, additional BCT categories have been added, enabling differentiated BCT pricing for homes in regions designated MMM1, MMM2-3 and MMM4-5. UARC welcomes this change, noting that it aligns with our previous calls to better align the BCT with the costs of residential care, particularly for homes in MMM4 areas (rural towns), which appeared to suffer the highest rates of financial distress in 2022-23.[21]

[21] Australia's Aged Care Sector: Full-Year Report (2022-23).pdf (uts.edu.au)