

POLICY REPORT

Funding regimes and the implications for delivering quality palliative care nursing within residential aged care units in Australia

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ABSTRACT

Introduction: Background: Funding to Australian residential aged care units has undergone recent reforms. Parallel with these fiscal developments, the Australian Government commissioned the *Guidelines for a Palliative Approach in Residential Aged Care* that addressed the inequities of service associated with dying in residential aged care. Aims: This literature review describes the variances in funding between Australian residential aged care facilities (RACFs), and multi-purpose services (MPSs) and, in doing so, exposes the impact that funding variances have on the delivery of end-of-life and palliative care to residents in aged care units.

Findings: Government funding policy allowed RACFs an opportunity to adopt and implement the guidelines and standards, through funding individual resident identified healthcare needs. By comparison, MPSs are funded through an agreed (government and organisation) number of beds to provide nursing care to residents. This funding allocation forms MPSs' general consolidated revenue for service delivery. Key issues: RACFs identify nursing care needs of residents through a residential classification scale, while management of MPSs allocates funding to service provision.



Conclusions: The significant factor of funding beds (MPS) not the delivery of nursing care required by residents (RACFs) does impact on the implementation of a palliative approach for residents and, hence, the delivery of quality nursing care. Nursing management should consider funding implications when allocating resources to services in MPSs.

Key words: Australia, funding, multi-purpose service, palliative care, resident classification scale, residential aged care facilities.

Introduction

The size of Australia's aged population is expected to continue growing with the 'baby boom' generation (those persons born between 1946 and 1965), benefiting from medical and technological advances in health care, thus increasing their life expectancy¹⁻⁴. This, however, is a double-edged sword. An extended life may also mean reduced quality of life⁵, especially for those who are socially disadvantaged. Such people may spend the last years of their lives suffering from one or more co-morbidity and may require residential aged care.

Residential aged care has been the responsibility of the Australian Government since the *Aged Persons Home Act 1954*⁶. In the 1990s it became an increasing government focus due to the need for economic and residential aged care reforms to cope with an anticipated increase in demand for services. The reforms involved improved efficiencies, standards of living and safety aspects for aged care residents. The *Aged Care Act 1997* reformed residential care by providing legislated standards and outcomes required for residential aged care facilities (RACFs) to receive funding.

Multi-purpose Services (MPS) were established in 1993 when rural acute hospitals, which the government believed were not sustainable, accepted a new concept in health care servicing. The MPSs promulgated an amalgamation of funding and services from both the State and Federal Governments⁷ to meet the identified health needs of local and outlying communities. Residential aged care is an integral part of an MPS, catering for frail older people no

longer able to live independently within the immediate or extended community.

The funding relationships and variances between RACFs and MPSs are explored and the implications for delivery of high quality nursing care exposed. This article forms part of the background for a wider research study commenced in 2004 and conducted in a rural MPS, which examined the delivery of end-of-life and palliative care to residents. The findings of this article allowed the researchers to compare the resident classification scale of an RACF with the general consolidated revenue of an MPS to determine the capacity for adoption of the palliative approach consistent with the guidelines (S Allen, pers. data, 2008).

Findings

The rationale for adopting a palliative approach in residential aged care settings

Death and dying are part of life's cycle and an integral aspect of life in residential aged care units. Little research has been conducted examining the different settings in which aged people die or the quality of living they experience while dying⁵. There is little clinical research into aged care settings. This is not surprising when evidence suggests that aged care nursing has secondary status to acute sector nursing⁸.

The increasing number of older people living in residential aged care units with chronic illnesses, co-morbidities and dementia, has heralded the emergence of an interest by nurses in providing effective palliative care in aged care



settings. Evidence suggests that the transferring of residents who require palliative care to acute hospitals is inappropriate and isolates residents from their known environment, familiar carers, family and friends, thus causing unnecessary distress⁹. The provision of palliative care within residential aged care units avoids the necessity to move residents from what has become their home, to die in an unfamiliar environment¹⁰.

The extension of life through modern technology has impacted on the provision of care for older people with life-limiting illnesses. It is acknowledged that less than 15% of older persons living in residential aged care units die of a terminal disease¹ while many more die following a period of slow deterioration brought about by acute episodes of chronic illness/es. It cannot be assumed that all people who die in residential aged care units have the same requirements¹; therefore, there is a growing realisation that palliative care must be available and accessible in these settings.

O'Connor and Aranda¹¹ argue that there are three levels to palliative care: a palliative care approach; specialist interventions; and specialist palliative care units. While the latter two are synonymous with the delivery of specialised nursing care, the former is applicable to residential aged care nursing. The approach to palliative care emphasising living and acknowledging death as part of life, signifies that palliative care is a philosophy of care, rather than a specific organisation or site of care^{12,13}.

As part of the Australian government's National Palliative Care Program¹⁴ the *Guidelines for a Palliative Approach in Residential Aged Care*^{15,16} were developed with the aim of improving the quality of life for people with a life limiting illness (besides those with a diagnosis of cancer) and their families. There is an expectation by the Australian Government that this approach will be implemented in both RACFs and MPSs^{17,18}. The aim of a palliative approach is to provide a multidisciplinary team approach to care in residential aged care settings. In Australia, the multidisciplinary approach, levels of required service,

guidelines and standards for the delivery of palliative care have developed over the last 30 years¹⁹.

The government expectation of implementing the standards and guidelines for a palliative approach within RACF and MPS is commendable, although the funding arrangements for these two settings are different. RACFs adopt a Residential Classification Scale (*Aged care Act 1997*) based on the level of care required by a resident. However, an MPS is allocated funding on the number of beds provided for the care of residential aged people, plus a flexible bed subsidy rate¹⁸.

Funding the delivery of nursing care: utilising the Residential Classification Scale

The *Aged Care Act 1997* included provision for funding to cover the delivery of nursing care required by residents in an RACF. A resident's level of dependency is determined by the Aged Care Assessment Services (ACAS) who, as delegates of the government, act as gatekeepers for entry into an RACF¹⁹. The ACAS therefore determines the level of entry for residents by their initial assessment. This classification may be either high (formerly nursing home classification) or low (hostel classification) level residential care. The dependence on nursing care of residents in RACFs is related to a Residential Classification Scale (RCS). The RCS is an eight-point scale which provides the basis for the differential daily payments scale, ranging numerically from 8 to 1 (1 being the highest level)²⁰. Residents who are assessed as a rating 8 receive no government funding for the delivery of nursing care^{4,21}

While acknowledging that assessment for residents' dependency occurs over a period of days in both high and low level RACFs²¹, the focus of this article is on the funding of nursing care for residents requiring high level care. End-of-life and palliative care occurs when residents' levels of dependency for nursing care align with the higher categories, ranging from 4 to 1. The RCS for category funding levels (4-1) consists of a set of 20 items (questions) relating to a resident's dependency on nursing care. Each item is given a



weighted score depending on the cost of providing the levels of care required^{19,20}. To determine the funding level of each resident, an assessment of the level of dependency is scored to the RCS item, with higher scores representing higher dependency and, therefore, greater funding²⁰. The need for assessment, reassessment and clear documentation is paramount for funding purposes within RACFs.

For the provision of nursing care within RACFs, registered nurses (RN; or Division 1 in Victoria, Australia), enrolled nurses (EN; or Division 2 in Victoria) and trained personal care attendant (PCA, Cert 111 or 1V) may form the 'skillmix' delivering care to residents (unlike an acute hospital, where staffing ratios of registered nurses to patient care prevail). Ratios are not applicable in RACFs. Management alone determines the staffing levels for the provision of nursing care for residents of RACFs, based on the principle of a duty of care²² and on the demonstrated competencies of the nurses²³. The RNs are paramount in the skillmix of an RACF because they are accountable for the continual assessment and reassessment of residents to determine the level of residents' dependency on nursing staff - and hence the daily funding allocation from the government.

Residents whose health status is deteriorating and therefore require increased nursing or specialist nursing interventions, may have their RCS assessment changed to reflect the extra provision of care. The residents' increased dependency level must be evidenced by a change in two or more RCS categories¹⁹. Documentation substantiating residents' health deterioration requires verification by the ACAS who examine and authenticate the file notations, assess residents by personal observation while confirming the necessity for an increased level of nursing care or specialist intervention - and increased funding. Once the change is confirmed, the relevant form is completed, signed by each resident (or ACAS when the resident cannot sign) and forwarded to the Department of Health and Ageing. Remuneration is paid by the Australian government from the date the ACAS and the resident signs the document²¹.

Funding and provision of end-of-life and palliative care to residents within an MPS

In a similar fashion to entry to RACFs, MPSs also have ACAS determine levels of entry by an initial assessment. In contrast, however, MPSs do not receive individual resident funding based on the provision of care provided to residents (no RCS instrument is used). Rather, MPSs are funded by the Australian government on the agreed allocation of a number of residential aged care beds, plus a flexible bed subsidy rate. Funding is allocated yearly, although paid monthly, and paid whether the beds are occupied or not¹⁸. There are no increases in funding allocations associated with a residents' increasing dependency on nursing staff. These monthly payments are not quarantined for the provision of residential care but form general consolidated revenue. When the needs of the residents in the aged care unit are met within the funding allocation, then excess funds may be spent elsewhere in the MPS^{7,18}. Thus management, rather than the government, determines when residents' needs have been met.

Management relocates the excess funds to program priorities identified in their Service Plan. Surplus funds may be spent on specialist consultative services, such as palliative care, or to support a service for the local or extended community. Such services may include physiotherapy or occupational or speech therapy, which could be delivered to the community as a whole, as well as to residents of the aged care unit.

The nursing skillmix in an MPS is similar to an RACF, being based on a duty of care²² and the demonstrated competencies of the nurses working in the aged care unit²³. The skillmix in MPSs is at variance with that of RACFs because there is no requirement for RNs to be employed to manage the complex care needs of MPS residents. Supervision and delegation of staff is often classified 'remote' in those settings with an RN not physically situated in the residential aged care unit. This arrangement is deemed acceptable practice by the Nurses Board of Victoria²⁴. The nursing skillmix in an MPS is predominantly ENs and PCAs; therefore, the assessment and reassessment of residents'



declining health status is not the same as that of the RACFs because ENs do not have the expertise (training) to recognise the complex care needs of chronic or life-limiting illnesses, thus the delivery of care is reactive rather than proactive. In the context of providing staff who could deliver quality nursing care through a palliative approach to residents of MPSs, the nursing skillmix limitations pose additional problems for funding allocation.

The MPSs do not experience funding retribution for non-compliance with the legislation (*Aged Care Act 1997*). Funding retribution for RACFs are contained in the sanctions imposed for non-compliance with the standards and outcomes²¹. This fundamental funding variance of legislative compliance and the delivery of care provided to residents of RACFs distinguish the potential for RACFs to adopt a palliative approach for residents, while other residents of MPSs are potentially disadvantaged. Monitoring adherence to this legislation (and by implication the delivery of a palliative approach) is largely the responsibility of accreditation agencies, and funding changes may occur if RACFs are found to be non-compliant. However, MPSs are not accountable to aged care legislation, thus accreditation is based on criteria set for acute care establishments, rather than being aged care specific.

A multidisciplinary approach to residents' health status

Because most people receiving palliative care are over 60 years of age²⁵, the demographics of an increasing ageing population in Australia²⁶ support the need for palliative care services to be available for people diagnosed with illnesses other than cancer. The government, through the National Palliative Care Program, recognised that people suffering from chronic or life-limiting illnesses would benefit from the multidisciplinary team approach associated with the delivery of palliative care. The Australian Government commissioned the *Guidelines for a Palliative Approach in Residential Aged Care*^{15,16} following concerns with the inequity of palliative care services. It is an expectation that these guidelines and standards be implemented in all residential aged care units,

inclusive of RACFs and MPSs^{15,16}. The guidelines promote a positive and open attitude towards death and dying, through communication with the aged care team, residents and family members^{15,16}. Using a multidisciplinary team method the palliative care approach provides a flexible plan of care and identifies the wishes of the resident, family and significant others within the context of end-of-life care and the quality care framework of Palliative Care Australia.

Multidisciplinary team meetings (case conferences) are usually coordinated by the RN of the RACF or MPS, supported by the staff who provide the care to each resident. These meetings are convened with the specific intention of setting goals and discussing the appropriate care for each resident. Case conferencing may be three or six monthly or annual, depending on a resident's changing health status; it establishes and acknowledges (in the case of RACFs) the funding for the resident. It allows for planning required services when needs change. While case conferencing is better established in RACFs, it is limited within the aged care units of MPSs. Factors impacting on MPSs conducting case conferencing are the restrictions associated with the skillmix, the non-availability of allied health services, time constraints and funding not being directly related to resident's care.

The focus of the multidisciplinary approach is care rather than cure. It embraces a social model of health²⁷. Multidisciplinary teams by their very title include professionals that provide services that could improve the quality of life of residents. As well as coping with life-limiting illnesses these multidisciplinary teams can also address provision of 'a good death' for residents²⁸. The *Guidelines for a Palliative Approach in Residential Aged Care*^{15, p.3} proffer that a palliative approach accomplishes this by aiming to:

...improve the quality of life for people with a life limiting illness and their families by reducing their suffering through early identification, assessment and treatment of pain, physical, cultural, psychological, social and spiritual needs.



This team approach will more likely bring to fruition the aims and goals found in the guidelines. However, the multidisciplinary approach alone cannot realise these goals. Adequate funding arrangements are mandatory for such policy to be successful and effective.

Conclusions

The funding of residential aged care beds in MPSs by the Australian government has impacted on the level and quality of care that is provided. It is argued that RACFs are able to provide higher quality care because funding is proportional to individual resident's health status throughout the trajectory of residency. Conversely, MPSs funding is provided on an agreed bed allocation that does not alter, irrespective of resident health status changes. This inflexibility creates a tension for MPSs who must meet the nursing care needs of deteriorating residents without additional fiscal resources. However they are also expected by government to adopt practices to support end-of-life and palliative care using an advocated contemporary approach. Supporting nursing staff to develop the skills necessary for compliance with the recommended guidelines is restricted by this funding inconsistency. These anomalies require further research and subsequent policy development that addresses rural inequities.

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