31 August 2023

Submission on Residential Care Pricing 2024-25

About Bolton Clarke

Bolton Clarke is one of Australia's largest aged care providers. With a history that goes back 1985, Bolton Clarke support more than 130,000 people in home care, retirement living and residential care.

We are a charitable organisation focused on building world class services to support fuller and more independent lives for older people, in Australia and globally

Our size and sophistication let us deliver high quality services and stay financially sustainable, with any surplus that we generate invested into our research institute to improve the quality of care.

Contact

Bolton Clarke welcomes the chance to contribute to IHACPA's 2024-25 residential care pricing advice. IHACPA's 2023-24 advice was a significant step towards evidence-based pricing in aged care and we look forward to seeing IHACPA refine its approach in years to come.

Some of the comments in this submission relate to issues that should be resolved for IHACPA's 2024-25 pricing recommendations, while others relate to larger issues that will take time to resolve.

Process

Chance to comment on draft advice: Stakeholders should be given the opportunity to comment on draft pricing advice before final advice is given to government to minimise the risk of error and/or controversy surrounding the final advice.

- The consultation window can be very short provided the dates are known in advance.
- The draft does not need to contain the final data where that is not yet published just the datapoints that will be used.

Reasonable notice of final advice: Pricing advice should be published by the end of Q3 in the previous financial year to support planning and budgeting which occurs in Q4.

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- Ideally the government subsidy decision should be published at a similar time, but we recognise this not something IHACPA can control.

Earlier start to pricing advice cycle: Consistent with the above, the pricing advice cycle should start earlier in the year, with initial consultation on the framework occurring in June/July.

Reasonable notice of revisions and reweighting: To limit transition costs (e.g., agency use, overtime, reduced hours, redundancies) revisions or reweighting that mean significantly less funding or extra staffing for some services should be published one-year prior to the date of effect.

- The alternative is for government to cushion transitions through stop-loss policies for reduced funding and implementation buffers for increased staffing.

Classification and weightings

Monitoring changing practice: IHACPA's recent costing study should pick up changes in practice since RUCS, but ongoing studies will be needed to monitor the effect of increased staffing on resource utilisation.

- A particular change since the Royal Commission there has been reduced use of psychotropic drugs and more emphasis on non-pharmacological intervention for people with dementia (though many providers were already doing this prior to the Royal Commission).
- Increased staffing in response to new targets may also change resource utilisation patterns. For example, Bolton Clarke intends to direct additional rostered time towards more support for the most at risk residents. Changes in response to increased staffing should not influence the 2024-25 price, but it emphasises the need for ongoing costing studies.

Bottom-up costing study: IHACPA should undertake a bottom-up costing study to measure cost of implementing best practice guidelines for palliative care, complex health care and complex behaviour support.

- Palliative care, complex healthcare, and support for complex behaviour are underfunded by current residential care subsidies.
- This leads to people choosing to be cared for in hospitals instead, being transferred to hospitals when their care needs exceed what a residential care service is funded to provide, or having difficulty finding a service that is willing to accept them.
- Some facilities may provide higher levels of support to some residents, but it is necessarily the exception rather than the rule because the level of support that can be provided is constrained by the funding. Therefore, the cost of this support is not measured by observational costing studies that average out current practice.

Respite services: under current funding, where beds are full, providers will prefer long-term residents over respite residents. This is because respite funding does not recognise the additional cost of supporting a person for a short period of time, including admission and discharge costs, and periods of vacancy between respite residents.

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Scope of costs

Additional / extra services: IHACPA should assume that there is a margin on additional/extra services rather than netting off the full revenue against the cost base.

- Excluding extra services from the everyday living cost base is correct but since there is not extra services only cost data the only way to do this is to subtract the associated revenue from costs. However, if it is assumed that all the extra revenue relates to cost then increases in extra/additional services revenue at a sector level will just reduce the hotelling supplement rather than improving sector financial performance.
- This is a minor issue at present given the limited revenue being raised through these channels, but it is likely to become much more important in the future.

Re-examine split between accommodation, care, and everyday living: The way that IHACPA divides costs is consistent with general industry practice. However, there it can be reasonably argued that some of the everyday living and accommodation costs should really be counted towards care, while lifestyle support, which is generally counted as care is arguably better consider lifestyle component (like catering) where the level and nature of support is a matter of personal preference. This is something that should be considered for later years rather than to inform the 2024-25 price.

Cost of capital: costs need to also include a providers' cost of capital. See also, 'defining an efficient price' below.

Indexation

Cost base: Two-year-old annual financial report data is too out of data to use as the cost base. At minimum IHACPA should use data from the previous year's aged care financial report. IHACPA should also consider using quarterly financial report (QFR) data as the cost base, so long as there are no issues with seasonality, volatility or inconsistency compared with full-year data.

Adjustment to cost base for direct care minutes: If 2022-23 data is used as the cost base it will need to be adjusted upwards to account for that fact that services are still building towards the October 2023 requirements for direct minutes. Even if later QFR data is used, many providers will not yet have achieved the staffing targets. If this is only a small number, they can be excluded from the cost base. However, if there is a large number, it may just be better to inflate the average cost base. Additional adjustments to reflect increase staff requirements in October 2024 will also need to be made.

Internal versus external growth factor: costs should be indexed using the trend change in in-scope costs per NWAU after backing out policy driven step changes such as the wage case or increased direct care minutes.

- This is preferred over external benchmarks as industry cost indexes will reflect increases in acuity within classes that are not captured by changes in input prices and other changes in the operating environment that may drive costs up or down – for example use of agency staff.
- We acknowledge that this trend may be difficult to identify given COVID and recent changes in funding models, staffing and wages. Given these difficulties it may be necessary to use an external

benchmark again for 2024-25. However, these benchmarks need to be at least compared to historical industry trends to test whether they are appropriate.

- Using sector trends can become recursive (e.g., low indexation may beget low-cost increase which may in turn beget low indexation). However, any external trend will almost inevitably be either higher or lower on average than actual sector trends introducing either structural under or overfunding, which seems to be a larger problem.

Annual Wage Review: Rather than trying to predict the cost of the Annual Wage Review, IHACPA should just account for it retrospectively through measuring trends from the previous year.

- This will mean that changes in indexation lag changes in cost increases, but this is not systematically negative for the sector. In some years it will mean indexation is less than cost increases but in other years it will mean that indexation is higher than cost increase.
- Waiting for the Annual Wage Review determination in June and then trying to predict how it will affect costs in the following year creates too much uncertainty about budgets in exchange for debatable gains in overall accuracy.
- While everything should even out over time under a retrospective approach, providers still need a reasonable margin so that they can carry negative years without operational impacts.

Efficient price

Defining an efficient price: IHACPA should undertake additional research on the theoretical and/or empirical case for setting prices based on average costs with no margin in a health sector that is dominated by non-government providers.

- The benefit of having a single price to promote yardstick competition is obvious. And having the bar pegged to industry costs so that it moves higher over time also makes sense and is consistent with the expectation for ongoing productivity improvements in the market sector.
- What is not clear is why the benchmark should be average costs with no margin. Pricing based on average costs means half the sector will always lose money. And even those with average efficiency will not be operating with a sustainable margin.
- There are substantial inefficiencies within the sector and encouraging inefficient providers to become more efficient or leave is a good thing. But even if all providers are operating at the efficiency frontier there will not be a single unit cost for aged care, with many cost drivers beyond the control of management, including many that will be impossible to measure and adjust for in a costing model. The starting economic assumption is that industry cost curves are upwards sloping, and notwithstanding economies of scale, aged care seems unlikely to violate this rule.
- Quality is also measured imperfectly in aged care, so strong incentives to cut costs can easily lead to decisions that compromise quality to maintain viability where this is easier to achieve than genuine improvements in efficiency.
- Residential care has also had an extended period where most services have experienced losses, so providers have already been motivated to achieve any easy efficiency improvements available to them.
- It makes sense to us that the price reflects the average cost, plus a reasonable margin. This should support capital costs, and cushion unexpected financial impacts such as temporary mismatches between indexation and cost increases. Providers with slightly above average costs will still face

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pressure to improve, but it will be a modest pressure to improve efficiency rather than an existential pressure to cut costs to survive.

- We are prepared to revise this view if there are theoretical or empirical arguments to the contrary, but the case does not seem to have been established, with average costs instead just being the obvious default.
- Better explaining the theory and the evidence will also help inform any debate about what the margin on top of overage costs should be.