Ryman Healthcare's Response to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25

About Ryman Healthcare

Ryman Healthcare is a New Zealand-based company founded in Christchurch in 1984. The company operates 38 villages in New Zealand and in 2014 expanded to Australia, where we now have eight operational villages and a further seven in our development pipeline.

All Ryman villages operate a 'continuum of care' model, whereby independent retirement living units and serviced apartments are co-located with a full suite of aged care services, including low care, high care, specialist dementia care, and home care packages provided by Ryman.

Ryman has been named New Zealand's Most Trusted Brand in the aged care and retirement industry at the Reader's Digest Most Trusted Brands Awards eight times in the past nine years.

Ryman is a member of the Aged & Community Care Providers Association (ACCPA) and the Retirement Living Council (RLC), and is an active contributor to aged care and retirement living policy discussions in both Australia and New Zealand.

Ryman welcomes the Aged Care Taskforce's review of funding arrangements for aged care and is pleased to provide this submission on the draft aged care funding principles.

Principles for activity-based funding in aged care

14. What, if any, changes do you suggest IHACPA consider for the residential aged care pricing principles?

Ryman Healthcare recommends that IHACPA considers the following changes for the residential aged care pricing principles:

1. **Pricing Models:** Current pricing does not adequately fund operating expenses, particularly for crucial hotel services that play a vital role in care provision. An increased co-contribution from consumers to fund this shortfall is recommended. This could take the form of a higher basic daily fee set by the provider based upon their value proposition, or a portion of the Refundable Accommodation Deposit (RAD) could be retained by the provider to fund the shortfall.

Lower-Income consumers should retain government support.

Currently, the cap on Refundable Accommodation Deposits (RAD) is set well below the median house price, necessitating an application to IHACPA when setting RADs for new

developments. This is a time-consuming process and approvals often exceed 60 days to secure, delaying admissions of permanent residents.

It is important for providers to make a fair return on their investment, which is currently not the case. The sector is making recurring operating losses and there is little incentive for the necessary investments to meet the growth in demand as the care needs of the Baby Boomer generation emerge. Major operators have either suspended the development of new care beds or scaled down the number of beds planned for future projects.

As the planned elimination of bed licensing and a shift to consumer-based funding approaches, consumers will ultimately select providers based on their preferred service level. It's essential to give older people the freedom to decide the extent of amenities and services they desire.

2. **Transparency in Pricing:** Transparency in pricing would be enhanced by providing detailed breakdowns of costs associated with different classifications of care. This would give providers greater insight into the appropriate levels of care required from admission date whilst awaiting an independent needs assessment. This would also help consumers and their families make informed decisions and understand what they are paying for when asked for a contribution.

3. **Co-Contribution Mechanisms:** Ryman recommends introducing co-contribution mechanisms that allow individuals with the means to contribute financially to their preferred lifestyle and amenities within an aged care facility. This would help lessen the financial burden on the government while providing choice for those who desire enhanced services. Low-income individuals should retain subsidies, so they can access a high level of care without being financially strained.

The cap on consumer contributions should be reviewed to better align with the financial capacity of the affluent elderly cohort we are caring for. Caps on annual and lifetime co-contributions, and the basic daily fee, prevent consumers from paying for the level of service they desire. A consumer survey conducted by the Aged and Community Care Providers Association (ACCPA) demonstrated consumers' willingness to make higher co-contributions to support hotel services.

4. **Guaranteed Quality for All:** All consumers should receive a consistent level of high-quality care and services regardless of financial contribution. Quality should not be compromised based on one's ability to pay.

5. **Incentives for Innovation:** Incentives for aged care providers to innovate and enhance services within the existing pricing framework should be considered. This will spur the development of creative solutions that improve the overall resident experience.

6. **Input from Stakeholders:** Funding should reflect a holistic understanding of the needs and expectations of consumers within the residential aged care sector. Direct care (provided by Registered Nurses/Personal Care Workers) is often the measurement of quality, yet a lack of overall wellbeing (loneliness/poor mental health) is evidenced to be a health risk. Programs that engage residents and improve their wellbeing are therefore just as important as direct care minutes. Funding should reflect the contribution of activities and lifestyle staff to provide a full accounting of the

amount of actual care operators are providing consumers. As it stands, operators are disincentivised from supporting this crucial aspect of every individual's overall health and wellbeing.

By addressing these aspects, IHACPA can create a pricing framework that accommodates various financial capacities while maintaining a focus on quality care and equitable access for all residents.

The Australian National Aged Care Classification funding model

15.Do the current Australian National Aged Care Classification (AN-ACC) classes group 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 evidence is there to support your answer?

The current AN-ACC classes aim to group residents in a way that is relevant to both care and resource utilization. The classes are used to inform funding allocations, where higher-acuity classes receive more funding to cover the increased costs associated with providing care to residents with greater needs.

This creates a cohort of mixed acuity residents who are constantly changing, along with their mandated minutes of care, which proves difficult when managing rosters efficiently. Shifting to a more agile roster (as opposed to fixed shifts) results in a casualisation of the workforce, which can negatively impact the quality of care. Classes should have more funding weighted to the base care tariff to create a buffer that ensures sufficient staffing to manage a variable acuity resident population.

There is a lack of transparency about how AN-ACC classifications are determined, which impacts operators when scheduling services. The issue is compounded by the delay in receiving an independent needs assessment to determine a resident's classification. Effectively, operators must guess a resident's classification, which can result in a consumer not receiving adequate care.

Ongoing monitoring and evaluation of the AN-ACC system's effectiveness in accurately reflecting care needs and resource utilization are crucial. This will involve analysing whether residents within the same AN-ACC class indeed require similar resource levels and whether any adjustments are needed to better align classifications with actual care demands.

Prescribed care minutes focus on clinical resources, so do not account for other roles essential in delivering a comprehensive service, such as activities and lifestyle staff who play an essential role in supporting a resident's overall well-being.

An increased co-contribution from self-funded retirees to cover the expenses related to hotel services is needed. At present, the Basic Daily Fee is capped at 85% of the single person pension ($58.98 per day), irrespective of one's financial situation. This leaves inadequate funding to cover the costs of hotel services (including food, cleaning, laundry, etc.), especially given the current inflationary environment.

The $10.80 supplement allocated to bolster funding of hotel services falls well short of bridging the gap.

Government assistance should remain for those receiving full pensions.

For most elderly Australians, their wealth is primarily tied up in their home's value. Nonetheless, means testing only considers a fraction ($186k) of this value, while the median house price is more than $1 million in many major metropolitan areas. This means test threshold is outdated and should be updated to reflect the reality of the current Australian housing market.

16. What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?

What does the future hold for low-care services within a residential care setting?

With the end of residential care bed licensing set for mid-2024 and the clear preference of consumers to receive care within their own home, retirement villages that have co-located Residential Aged Care services are perfectly placed to meet this growing need.

Residents in lower acuity classifications can receive cost effective residential care services in their retirement living unit, with support close at hand.

The advent of technologies such as radar, GPS, and biometric sensors offers passive monitoring during times the resident is alone, meaning older people can live independently for longer These technologies are now coupled with sophisticated algorithms that offer predictive insights, allowing village staff to make preventative interventions to support their residents.

Residential Aged Care facilities are primarily structured to address the complex behaviours of dementia residents, yet they often do not adequately accommodate the needs of psychogeriatric individuals who demand more personalised attention to mitigate risks to fellow residents.

The current funding model does not accommodate extended periods of care for a single resident. Consequently, this situation discourages providers from admitting psychogeriatric patients, potentially leaving them unsupported within the community where they pose even greater risk to themselves and others. This situation may also contribute to the notable prevalence of antipsychotic medications within aged care facilities. More funding needs to be directed to the management of individuals requiring one-to-one support.

17. Are there any other legitimate or unavoidable costs associated with a permanent resident's stage of care? For example, entry into or departure from a service.

Yes, aside from the ongoing costs of care, there are additional legitimate and often unavoidable costs linked to a permanent resident's stage of care. These costs can include entry into or departure from a care service.

1. **Entry Costs:**
   - **Admission supplement:** The current supplement is crucial to cover administrative and onboarding expenses when a new resident enters a facility.
   - **Initial Assessments:** Intensive assessments conducted during the initial period of residency (3 months) to determine a resident's care needs and preferences incur associated costs. The admission process alone requires six hours of nursing time.
   - **Room Setup:** Costs associated with setting up a resident's living space can be part of the entry expenses (specialist equipment, e.g. extra long or wide bed/bariatric equipment).
2. **Departure Costs:**
   - **Exit Fees:** When a resident leaves a care facility, there are additional administrative tasks related to departure.
   - **Room Restoration:** If a resident's room requires refurbishment or restoration after their departure, the associated costs are borne by the provider.
   - **Legal and Administrative Costs:** The legal and administrative processes linked to vacating a room and refunding deposits leads to additional expenses.
3. **End-of-Life Care:**
   - **Palliative Care Costs:** A resident entering their final stage of life requires specialized palliative care, for which there are added costs associated with clinical support, comfort measures, and support services. Often staff also spend considerable time supporting family members.
   - **Funding for Palliative Care:** To receive palliative funding a resident must be independently assessed. There is generally a delay in completion of the assessment, which can result in providers not being funded for this additional effort if the resident passes away before being assessed (?? Check accurate)

4. **Dementia Care:**

   - **Challenging Behaviours:** Dealing with challenging behaviours often necessitates extensive one-to-one staff support that is not adequately funded.
   - **Staffing:** Staff ratios need to be higher in a dementia care environment due to the nature of dementia behaviour, which is less structured demanding more staff time spent in the moment to support individual residents. Activities and Lifestyle staff spend more time supporting these residents. This is an additional cost.

5. **Regulatory Compliance:**

There is a regulatory burden, and associated cost, to meet new monitoring and reporting obligations that has not been compensated for: calculating minutes, increased quality indicators, compiling prudential reporting. These have dramatically increased the administrative costs of operating a village and costs of systems that can handle this type of information.

6. **Consultations and Collaborations:**

Providing specialized care involves consultations or collaborations with external specialists, resulting in professional fees or service charges

18.Are there any other legitimate or unavoidable costs associated with a respite resident's stage of care? What evidence is there to support your answer?

Every resident entering residential care follows a uniform admission process, which can be time-consuming during the initial three months. This demands a considerable allocation of resources, often for a relatively brief stay.

The additional accommodation supplement has been beneficial.

Developing aged care pricing advice

19. What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

IHACPA should review several considerations in its indexation methodology for residential aged care pricing advice to ensure accuracy and fairness in reflecting the evolving landscape of care provision:

1. **Labour Costs and Wage Inflation:** Given that labour is a significant component of care expenses, IHACPA should incorporate the wage price index and labour cost inflation into its methodology. This ensures that pricing adequately accounts for the changing costs associated with employing trained and skilled staff.
2. **Staffing Shortages and Workforce Dynamics:** IHACPA should consider the ongoing challenges related to staffing shortages in the aged care sector. The indexation methodology should factor in the potential need for contracted staff, who often come at a higher cost due to their limited availability.
3. **Quality of Care Metrics:** The indexation methodology could integrate the star rating quality of care metrics to incentivize providers to maintain or improve the quality of services.
4. **Aged Care Workforce Training:** Consideration should be given to the training and professional development of aged care workers. A more skilled and well-trained workforce will impact care quality and operational costs.
5. **Consumer Needs and Preferences:** The methodology should account for the diverse needs and preferences of consumers. This might involve providing options for different care packages and amenities that align with a broader range of preferences. This would require a greater consumer co-contribution.
6. **Long-Term Sustainability:** IHACPA should ensure that the indexation methodology promotes the long-term sustainability of aged care services. It should aim to prevent underfunding that could compromise the quality and availability of care in the future.
7. **Transparency:** IHACPA should maintain transparency, including a better understanding of the metrics that make up the funding calculation used to determine classifications.

By taking these considerations into account, IHACPA can refine its indexation methodology to better reflect the complexities of the aged care sector and contribute to fair and accurate pricing recommendations.

Adjustments to the recommended price

20.What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this?

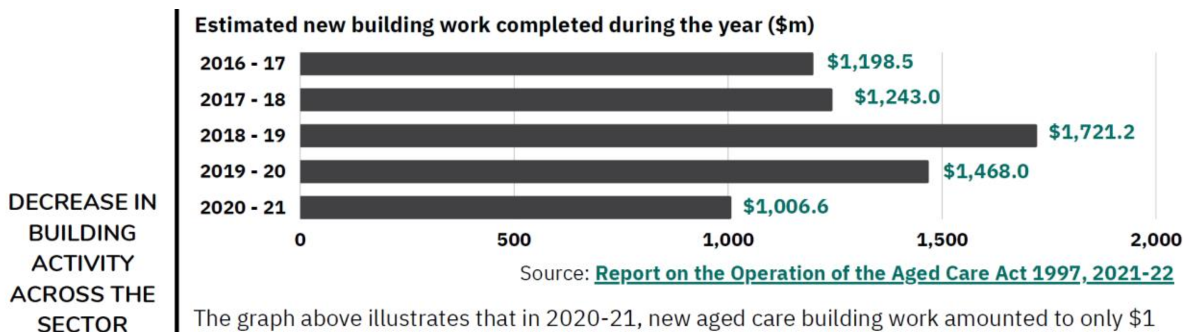
The provision of care to residents requiring specialized services can entail additional cost due to the specific nature of their needs and the resources required to address those needs effectively:

1. **Skilled Staff:** Specialized services often necessitate the expertise of skilled professionals, such as specialized nurses, therapists (particularly physiotherapists), or clinicians. These professionals typically command higher wages, contributing to increased labour costs.
2. **Training and Education:** Staff members providing specialized care require additional training and certifications (e.g. catheter management) to effectively address residents' specific needs. This incurs costs associated with ongoing education and skill development.
3. **Equipment and Technology:** Specialized care frequently requires specialized equipment, tools, and technology to meet residents' unique needs. Procuring and maintaining such equipment contributes to higher operational costs.
4. **Enhanced Staff-to-Resident Ratios:** Certain specialized care situations (e.g. challenging behaviours) necessitate a higher staff-to-resident ratio to ensure safety and quality of care. This leads to increased staffing costs.
5. **Regulatory Compliance:** Additional administrative and compliance costs associated with care delivery and monitoring.
6. **Consultations and Collaborations:** Providing specialized care might involve consultations or collaborations with external specialists, resulting in professional fees or service charges.

21.What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariff (BCT) weighting?

Service location can impact several care-related costs that are not currently addressed in the Base Care Tariff (BCT) weighting. These costs include:

1. **Labour Costs:** The MMM ranking is weighted towards increasing funding to rural and remote locations who understandably struggle to attract staff and fill beds, but consideration should be given to the higher cost of living in metropolitan areas, often requiring higher wages to attract and retain staff, which is not fully accounted for in the BCT weighting.
2. **Operating Expenses:** Service locations with higher real estate costs, utility expenses, and other operational overheads can result in increased costs for care provision.
3. **Return on Investment:** With most of the sector reporting operating losses, there is little incentive to develop new services in metropolitan locations where demand is greatest. Cost analysis needs to be completed to ensure an adequate return on investment to encourage new developments to meet the growing demand of the Baby Boomer generation. The graph below illustrates a decline in construction activity across the sector. The establishment of new facilities may take up to two years to reach a breakeven point where occupancy attains a level that generates returns. It's worth considering the implementation of a supplement to aid new enterprises during this initial establishment phase.



The graph above illustrates that in 2020-21, new aged care building work amounted to only $1 billion, and only 1.4% of homes indicated plans for new building work. The decline reflects uncertainty in the sector, viability issues (exacerbated by COVID-19) and rising construction costs which makes new development less feasible. The lack of new developments and redevelopments suggest that the quality of RAC stock will continue to decline, which raises concerns about the potential for a shortage of quality aged care homes and beds in the coming years.

22. What, if any, evidence, or considerations will support IHACPA's longer term development path for safety and quality of AN-ACC and its associated adjustments?

The indexation methodology could integrate the star rating quality of care metrics to incentivize providers to maintain or improve the quality of services.

The funding allocated for hotel services is inadequate to fulfil service requirements, which no doubt contributed to the catalogue of sub-standard care uncovered during the Royal Commission. Uncapping co-contribution limits would address this concern.

It is crucial to consider the lasting consequences of global and local events that strain the secure and equitable provision of high-quality service.

The aftermath of events like COVID-19 highlights a significant discrepancy between funding and the actual costs of ensuring resident safety.

As an example, immigration ground to a halt during COVID-19, shifting reliance to bureau staff to fill shifts at a considerably higher cost, and additional IPC measures demanded more labour and provisions.

The global impact underscores that the aged care sector is poised to encounter financial challenges for years to come, just as substantial investment is needed to support the demands of a rapidly ageing population.