Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25

Questionnaire

Please read the following information before making your submission to this public consultation.

About your submission

Your feedback will contribute to the development of the *Pricing Framework for Australian Residential Aged Care Services 2024-25* (the Pricing Framework), which will guide the Independent Health and Aged Care Pricing Authority's (IHACPA's) approach to developing its aged care pricing advice for residential aged care and residential respite care.

Before completing the questionnaire, you should read the *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-25* (the Consultation Paper).

This survey includes all 11 questions from the Consultation Paper. You are encouraged to respond only to questions of interest or relevance to you. You do not need to respond to all questions.

IHACPA has also included some questions that seek information about you, your role and your perspective. Answers to these questions will help us understand and contextualise your response. We would also like you to provide your name and email contact details so that we may contact you if we have any questions about your feedback. **All questions are optional**, however responses that do not include answers to these questions may be given reduced weight in our analysis and the development of the Pricing Framework.

Publication of submissions

All submissions, including the respondent's name and/or organisation name, will be published on IHACPA's website unless respondents specifically identify sections that they believe should be kept confidential due to commercial or other reasons. You should not include any sensitive or private information about yourself or your organisation that you do not wish to be publicly available.

We may use your details to contact you regarding your submission but we will never share any of your contact details or make your email or phone number public, abiding by our Privacy Policy. Email addresses and phone numbers will be redacted or removed when submissions are uploaded to the IHACPA website.

Certain information in submissions may need to be withheld from publication in some circumstances, if it:

- may contain information that is commercially sensitive.
- is factually contentious - contains data, methodologies or processes that are likely to be contestable by another party on the basis of a fact.
- raises individual confidentiality concerns - contains information that, if released, may be in breach of confidentiality regulations.
- contains assumptions about likely legal or industrial determinations (for example wage increases) - information that, if released, may be used to prejudiced or influence determinations of other statutory agencies as representing an IHACPA position.

This questionnaire may take around fifteen minutes to one hour to complete, depending on the length of your responses and how many questions you choose to answer. We recommend copying your responses into a separate document in case you have any problems submitting your responses.

You are also welcome to make a submission by email to submissions.ihacpa@ihacpa.gov.au. If responding by email or mail, please attach a copy of the questionnaire to your submission.

Start your submission

1.Full name

Mark Sheldon-Stemm

2.Email address

[redacted]

3.Phone number

[redacted]

4.State or territory (please choose one option)

☒ NSW
☒ Victoria
☒ Queensland
☐ South Australia
☒ Western Australia
☐ Tasmania
☐ Northern Territory
☐ Australian Capital Territory

5.Organisation name (enter N/A if this does not apply to you)

Research Analytics and Riverview Residence Collie

6.Your role (enter N/A if this question does not apply to you)

As an aged care consultant and a part time CEO of a small rural provider in WA I operate out of WA and visit other states to connect with clients.

7.Which statement best describes your involvement with aged care? (please choose one option)

☐ I am an aged care resident or person receiving care
☐ I am a carer and/or family member of a person receiving care
☐ I am from a peak body or similar organisation
☐ I am from a professional college or association
☒ I work for a medium or small residential aged care provider
☐ I am an approved provider for residential aged care
☒ I work for a home care provider
☐ I am a health professional/clinician
☐ I work for a Commonwealth, state or territory government department or agency
☐ I work for a Primary Health Network (PHN)
☐ I work for a Local Health Network (LHN) or public hospital
☐ I work for a private hospital or private hospital association
☐ I work with a research institute, organisation, university, policy institute or consulting group
☐ I work for an information technology provider
☐ I am from the general public
☒ Other (please specify)

If other please provide details:

I also work as a consultant to aged care providers across Australia who are residential and home care providers including Aboriginal and Torres Strairt Islander peoples. Overall, I work with around 50 clients at any one time from across metro/regional/rural/remote locations. I develop models of care and conduct financially modelling for care services which I have been doing since 1996. My other role in aged care is as a CEO for a small rural proivder who operate residential and home care services.

8.What perspective do you represent? (please choose one option)

☐ People receiving care/aged care residents
☐ Carers and family members
☒ Aged care providers
☐ Clinical workforce
☐ Non-clinical workforce
☐ Australian Government
☐ State or territory government
☐ General public
☒ Other aged care stakeholder (please specify)
☒ Other (please specify)

If other please provide details:

As part of my role as CEO and consultant I have a perspective across a wide range of care and service and have developed the only model of care that successfully operates in aged care. In developing a unique model of care, I am able to show how this meets the requirements of person-centred care. I also have the perspective from building cost and price models, collecting cost of care data and advising providers on a sustainable model of care. In the submission I use the word "we" as the models and data involves not only the analysis undertaken by my company but also the participants (aged care providers) that shared their data as part of the studies into the cost of care.

9.If you work for a residential aged care provider, what type of organisation do you represent? (please choose one option)

☐ Government-owned
☐ Private
☒ Not-for-profit
☐ N/A
☐ Prefer not to say

10.Are you located in a rural or remote area? (please choose one option)

☒ Yes (please specify)
☐ No (please specify)

Please provide details:

The role as a part time CEO in rural WA - Collie and my role as a consultant is across Australia

11.Are you a member of, or do you represent or provide specialist care to any of the following groups? (tick multiple)

☐ Aboriginal and Torres Strait Islander peoples
☐ Culturally and linguistically diverse communities
☐ People with dementia
☐ People experiencing or at risk of homelessness
☐ LGBTQI+ people
☐ Veterans
☒ N/A
☐ Other (please specify)

If other please provide details:

However in my role as CEO and consultant all of the above groups are represented

12.Have you heard of the Independent Health and Aged Care Pricing Authority (IHACPA) or the Independent Hospital Pricing Authority (IHPA) prior to this public consultation?

☒ Yes
☐ No

13.How did you hear about this consultation?

☐ Social media (please specify)
☐ Department of Health and Aged Care Newsletter Alert
☒ Independent Health and Aged Care Pricing Authority email or letter
☐ Peak body or similar organisation
☐ Commonwealth, state or territory government department or agency
☐ Another aged care provider
☐ Other (please specify)

If you selected social media or other or please provide details:

Click or tap here to enter details.

Consultation questions

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? (maximum: 5,000 characters)

Whilst the principles are well stated they lack the application in a pricing system that will provide long term sustainability for residential aged care. This applies to the following areas.

Promoting Person Centred Care;
Fairness;
Efficiency;
Stability;
Transparency;
Promoting value;

Promoting Person Centred Care:

The concept of person-centred care includes all aspects of a person and not only the physical tasks undertaken to support someone's mental/emotional/spiritual wellbeing. This relates directly to the aged care standards where the current funding is classified to residents based on standards two and three and ignores large parts of standard one and four. Standard four clearly states people in care should be provided with support for their psychological, emotional and spiritual needs. To date residential aged care has never been funded to provide these.

As part of the requirement to meet this standard aged care providers have staff who carry out activities/ lifestyle and allied health functions either in groups or one on one to support people in maintaining their psychological, emotional, spiritual and overall health wellbeing. These functions have been ignored in the past funding models (RCS and ACFI) and is now ignored in AN-ACC funding as the minutes per day per resident for these functions is not included the funding (even though these are required to be reported in the Quarterly Financial Report (QFR's)).

There is also no evidence the principle of choice is considered in the funding therefore providing the ability to provide genuine choice to residents.

Suggested changes to the principle of Person-Centred Care:

A holistic approach is taken to care and services which includes the physical, psychological, emotional and spiritual wellbeing of the person rather than the allocation of restricted care services which ignores the person themselves.

Fairness:

The principle of fairness fails to recognise the different geographic domains that exists across aged care. The cost of providing services in Metropolitan, Regional, Rural and

Remote areas has never been considered in terms of the costs of labour, goods, and services as these are different in each of these domains. The use of the Monash Modified Model (MMM) is seriously flawed and does not take account of where the source of labour, goods and services come from, or the cost associated with getting them there. A prime example of this currently is the use of Agency Registered Nurses in rural areas in order meet the government minimum requirements. The cost of this includes travel and accommodation which is not a cost to a metropolitan and/or a regional provider must pay.

Suggested changes to the principle of Fairness:

Fairness includes an ABF which differentiates the cost differences of providing services to the various locations around Australia and a separate ABF is applied to each of the geographic domains of – Metropolitan, Regional, Rural and Remote.

Transparency:

Currently there is no transparency in the ABF funding with many of the parameters used ignoring several costs issues and is based on information that lacks empirical evidence from actual services delivered. Proper transparency consists of consumers and providers being able to fully understand how the funding has been arrived at and how it applies to them. This will become a further issue in July 2024 when the residential aged care licenses move to the residents. Currently stakeholders are unable to determine how the funding is arrived at and how this relates to services provided.

Suggested Changes to Transparency:

Details in the development of ABF and the resulting funding should be made available to all stakeholders so those involved are fully aware of what is being funded.

Promoting value:

The current pricing lacks any association to the model of care used by aged care providers. There is an array of models currently being used and without firstly defining a model of care the ABF is unable to provide the stability and efficiency required. Therefore, the following change is required to the principle of promoting value. This goes further to the point pricing on the allocation of minutes required per resident per day which is currently inaccurate and does not relate to the models of care provided. Value can only be determined when there is a full understanding of the care model and how it is applied.

Suggested Changes to Promoting value:

Pricing should support value based on the model of care used and the allocation of resources for the model. Details on this are provided further in this consultation submission.

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? (maximum: 5,000 characters)

The Australian National Aged Care Classification funding is tied to minutes per day per residential

aged care. There are several problems with the current model.

1 The allocation of the minutes per class

2 The absence of activities/lifestyle/allied health in funding

3 Those living with dementia and the resources required to manage certain types of behaviors

4 The requirement for funding to be allocated on the basis geographic domains.

Having modelled aged care services for over 25 years and conducted cost of care studies over the past seven years from hundreds of residents across Australia on their direct care needs this data does not match the minutes currently allocated to the different classes in AN-ACC.

Therefore, we consider the current minutes allocated are incorrect. With further changes in October 2023 the minutes are even further away from the evidence collected through the above studies under MyCDC.

Our model has been operating for several years and it shows AN-ACC's minutes for registered nurses is too high in the lower classes and insufficient in the higher classes. Therefore, the care minutes are skewed in the wrong direction. The care minutes also do not correlate to our data.

For example, someone who is a class 2 has been allocated 32 minutes of registered nurse time per day (30 minutes from October 23). This is someone who is mobile, has high cognition and no compounding factors. Whereas someone who is a class 13 has been allocated 53 minutes of registered nurse time per day to cover a non-mobile, low functioning with a high risk of pressure sores and compounding factors.

In the case of a class 2 resident, our research shows that 15 minutes of a registered nurse's time per day is the right allocation of time and with a class 13 resident, the time averages out at 72 minutes of registered nurses time per day. The care minutes are also skewed in the wrong direction.

Therefore, our modelling shows the current allocation of minutes for ANACC is not in step with the costs of delivering care. To address this, the minutes need to be revised across all classes for both registered nurse and care requirements.

Overall, our research shows a more even distribution that reflects the real care needs and ensures there is no advantage or disadvantage for an aged care provider to take on a lower or a higher-class resident.

Our conclusion is, there appears to be no real basis for the allocation of minutes per class nor any long-term empirical evidence behind this allocation. Please refer to our initial study provided to the Minister of Aged Care at the time (Ken Wyatt) on the allocation of costs. "CDC Report - How Consumer Directed Care will work in Residential Care - Report for Minister – 2018". This was under a funding agreement - 4-7ST7JCF - CDC in residential care report provided to the Department of Health at the time.

The second point is the minutes for Activities/Lifestyle & Allied Health staff also need to be included as part of the ABF. Details on this will be provided later in this submission.

The third point is the lack of a class for some people living with dementia. This is particularly evident for those who have developed Lewy Body dementia. Under the current classification these people are listed as class 3 as they are mobile. Yet they require constant supervision and monitoring due to outbursts of aggression and/or hallucinations which are unpredictable. These outbursts often lead to serious incidents occurring.

Often aged care providers will not take these people into care because of the risk involved and the lack of funding to provide the support and supervision required. They are considered a high risk.

Fourthly, funding should be broken up that relates to the different geographic domains of Metropolitan, Regional, Rural and Remote. Each of these should have different cost structures and therefore should have a different ABF. The current "one size fits all" does not recognize the cost differences. Information on this is also covered in the next question.

To adjust AN-ACC and have it represent a true picture of care and services then the following would need to occur.

Firstly, the minutes allocated to each class of residents should be based on long term empirical data to reflect the allocation of minutes. This should then relate to an agreed model of care which meets the quality standards (both current and future). The table below shows our empirical evidence on the requirements for each class of resident.

Class 2 – Nursing 15 minutes – Care 120 minutes

Class 3 – Nursing 21 minutes – Care 138 minutes

Class 4 – Nursing 25 minutes – Care 114 minutes

Class 5 – Nursing 33 minutes – Care 138 minutes

Class 6 – Nursing 35 minutes – Care 132 minutes

Class 7 – Nursing 37 minutes – Care 158 minutes

Class 8 – Nursing 38 minutes – Care 167 minutes

Class 9 – Nursing 48 minutes – Care 156 minutes

Class 10 – Nursing 58 minutes – Care 212 minutes

Class 11 – Nursing 47 minutes – Care 215 minutes

Class 12 – Nursing 48 minutes – Care 210 minutes

Class 13/1 – Nursing 72 minutes – Care 225 minutes

These then need to be adjusted to include the activity/lifestyle & allied health staff and be funded accordingly. Information on these minutes is outlined in the following question.

Then a separate class should be created for those living with dementia, such as Lewy Body which takes account of the cost of supervision and resources, or they simply will not gain entry to an aged care facility.

Finally, the amount funded for these minutes should recognize the different geographic domains cost structures. Again, this is detailed later in this submission.

16.What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes? (maximum: 5,000 characters)

In line with the previous comments there are the following factors to be considered:

1 The inclusion of Activity/Lifestyle & Allied Health services.

2 ABF based on the various cost structures faced by residential providers in the different geographic domains outlined in earlier answers – Metropolitan, Regional, Rural and Remote.

3 The inclusion of a class for those living with dementia that require a greater level of resources in managing behaviours.

4 The allocation of resources required to provide a sustainable aged care sector across all geographic domains.

5 The discontinuance of the notion of fixed costs versus variable costs as this does not apply to the operation of residential care.

Evidence for the changes:

The inclusion of Activity/Lifestyle & Allied Health services to meet standard four of the Aged Care standards:

Our studies show that on average residents receive between 12-20 minutes per day of activities in either a group or as individuals and a further 5-10 minutes per day for Allied Health. At an average cost of $40 per hour for an Activity Officer (wage rate plus oncost) and Allied Health professional is in the order of $125 per hour. Therefore, providers are currently spending $12-$15 per resident per day which is not funded under the ABF.

Including the above the minutes per class would have 20 minutes added to Care (this is our adjusted minutes):

Class 2 – Nursing 15 minutes – Care 140 minutes

Class 3 – Nursing 21 minutes – Care 158 minutes

Class 4 – Nursing 25 minutes – Care 134 minutes

Class 5 – Nursing 33 minutes – Care 158 minutes

Class 6 – Nursing 35 minutes – Care 152 minutes

Class 7 – Nursing 37 minutes – Care 178 minutes

Class 8 – Nursing 38 minutes – Care 187 minutes

Class 9 – Nursing 48 minutes – Care 176 minutes

Class 10 – Nursing 58 minutes – Care 232 minutes

Class 11 – Nursing 47 minutes – Care 235 minutes

Class 12 – Nursing 48 minutes – Care 230 minutes

Class 13/1 – Nursing 72 minutes – Care 245 minutes

ABF based on the various cost structures faced by residential providers in the different geographic domains outlined in earlier answers – Metropolitan, Regional, Rural and Remote.

Our studies show the cost of providing care in the various geographic domains is different for the following reasons.

The cost of labour is different in terms of trying to attract staff to work in areas outside of the Metropolitan areas. Most Regional/Rural/Remote providers pay above the award to attract qualified staff such as Registered and Enrolled Nurses.

They also face unfair competition from state-based hospitals located in the non-metropolitan areas.

In the case where providers from a non-metropolitan area are required to use agency nurses, they pay the extra costs of travel and accommodation, which metropolitan providers do not have to. This often equates to around a 20% additional cost.

The cost of goods is also more expensive in Regional/Rural/Remote areas due to the cost of freight.

Other services, such as maintaining the infrastructure (call bells, IT systems, maintenance of specialised equipment) include additional costs due to these specialists travelling from metropolitan areas.

The recommendation is to have these additional costs included in developing the ABF. A proposal as to how this could be applied is outlined later in this submission.

The inclusion of a class for those living with dementia that require a greater level of resources in managing their behaviours.

The requirement to manage people living with various forms of dementia is not recognised in the ABF and there should be a sperate class for these people.

This class should include funding for the resources required to provide proper supervision. Our information shows that on average an additional 2-3 hours per day of a carer is required when someone like this is living in a residential aged care facility. This is not recognised in the ABF and there needs to be another class for these residents.

This would move their minutes per day from the current rate for this class 3 to a new class (which we call 3A) with Nursing 21 minutes – Care 278 minutes per resident per day. This will provide the resources required to meet the needs of the resident and to keep others safe.

The allocation of resources required to provide a sustainable aged care sector across all geographic domains.

The current Monash Modified Model (MMM) is an invalid measurement and is flawed in classifying locations for aged care.

An example of this is at Valleyview in Collie WA. This location is classified as an MMM4. Yet Collie Burn is classified as an MMM5. Collie Burn is 6.7klm outside of Collie (with no population). This results in the ludicrous situation where Valleyview in its current location is an MMM4 and not eligible for exemption or an additional funding as an MMM5 (at $14.59 per resident per day or $330k per annum). If Valleyview was located at Collie Burn (which it could without changing any access to care and services for the Collie community), then this additional funding would be available to cover the costs of care and services. This example is duplicated across many other Regional/Rural/Remote locations around Australia.

The discontinuance of the notion of fixed costs versus variable costs as this does not apply to the operation of residential care.

The application of fixed costs in residential aged care is a flawed concept. Given the cost of complying to the required minutes of care and other operational costs the majority of costs are considered fixed (around 93%). We have modelling which demonstrates how these fixed costs should be applied across all classes which would provide a more equitable and sustainable funding for aged care.

Further details on this are provided later in this submission.

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. (maximum: 5,000 characters)

Following on from the previous question the current fixed costs in residential aged care include:

1 The costs of administering the business of aged care (payroll, accounts, regulations, compliance)

2 The cost of clinical care oversight (clinical managers, systems, processes, policies, procedures, model of care and compliance).

3 The cost of nursing 24/7.

4 The cost of care is based on the model of care.

5 The costs of hotel services.

6 The costs of activities/lifestyle & allied health.

7 The costs of onboarding new residents.

8 The costs of repairs and maintenance/utilities.

9 The costs of insurance and oncosts for wages.

The only variable cost in residential aged care are the supplies for resident care and food. These will vary based on the number of residents living at the facility. However, these costs make up a very small percentage of overall costs of the operation (around 7%).

There is a false belief that rosters for nursing, care, activity/lifestyle and allied health staff can be varied based on the number of residents living at a facility at any point in time. This is simply not the case with the number of staff in these areas being based on the model of care with fixed rosters where staff are not able to lose hours based on level of occupancy. Given that occupancy rates for residential care vary from 85-98%, most providers set their rosters to accommodate their average occupancy. This is so staff have certainty in hours, and they are retained.

Due to industrial relations issues and the use of on-call casuals (given uncertainty of their availability) providers are not able to simply "adjust their costs". Therefore, most costs in residential aged care are fixed and this needs to be accounted for in any ABF model.

The costs can also be broken down into the different parts of the operation as per the following model of care. Below is an example of the model of care used:

Building the Relationship (Management)

- The initial Inquiry
- The Interview and Compatibility test
- Clinical Assessment
- Goals and Life Wishes
- Clinical Care Services
- Funding and Cost of Services
- Service Environment
- Provision of Information

When a new person Moves in (Management)

- Codesign of Clinical Services
- Codesign of CDC Services
- Introductions and Settling in Period

Building on the Relationship through service and open Communication (Management & All staff)

- Service Environment
- Review of Services
- Communication/Feedback and Adjustments
- Systems Development
- Providing the Services that meet their goals and needs (Clinical & Care Staff)
- Clinical Assessment
- Clinical Care Services
- CDC Services
- Review of Services
- Systems Development
- Service Alignment – CDC and Clinical

Growing the Organisation Based on Service & Transparency (Management)

- Business Operations, Systems and Governance

Making the Money Count (Finance & Admin)

Funding and Cost of Services

Development of Services costs and charges

Publishing Service Charges and Information

The above is an example of how a model of care can be broken up between the different parts of care and services and can be used to build ABF. Providers will apply the model in different ways, but funding can be standardized.

The use of information from the QFR's can then be used to cost these and have them included in the ABF model. We outline how this could be done later in this submission.

Modelling for this is available for the above information but there is no provision for this to be included in this submission.

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? (maximum: 5,000 characters)

The delivery cost of respite services is no different to that of permanent residents. They require the same care and services as other residents.

However, the ABF does not reflect the onboarding and compliance costs of setting up care plans, assessments, entering these into a clinical care system to meet their care needs. Therefore, the payment for new people coming into a residential facility on respite should be the same as a permanent resident as the same amount of work is required for the onboarding process. Currently this is $1,253.87 per person.

In the case where someone comes into care on respite and then becomes permanent (which appears to be a large number of situations) then the payment will be made at time of respite and not on permanent occupancy.

The other consideration for those on respite is the three levels of payment. Our experience is the current levels are incorrect. We believe each level should be funded at Class 5 (instead of class 101), 9 (instead of class 102) and 13 (instead of class 103).

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? (maximum: 5,000 characters)

After 25 years of the lack of indexation and being funded at inadequate government indexation rates residential aged care has had over 60% of real funding stripped from care services.

The indexation of funds is vital for a sustainable aged care service.

Indexation should therefore be funded on the following basis:

1 The wage increases applied by the Fair Work Commission each year (whether as part of the yearly wage increase or as a special case).

2 Increases in wage oncosts such as superannuation, workers compensation insurance, payroll tax, etc.

3 The cost increases in utilities.

4 The cost increases for supplies (including medical and food).

5 The cost increases of insurance.

6 The cost increases of administration (compliance) as it increases each year.

The major cost factor are wages which represent between 75-85% of the providers expenditure.

However, our modelling shows the current ABF based on the required minimum minutes per day is not a sustainable model of funding and the rate of indexation needs to increase annual to “catch up” with the funds stripped away over the past 25 years.

The issue for the ABF is, it does not equate to the required minutes per day of Nursing and Care funding. The costs associated with meeting the minutes per day of Nursing and Care should recognised in the following manner:

1 The costs per provider as outlined in the QFR’s.

2 The averaging of these costs across the different geographic domains.

3 A margin which allows the provider to renew its infrastructure when required.

This is further expanded on later in this submission.

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? (maximum: 5,000 characters)

The point in this question is what is “specialised care”?

Given that the current list of classes of care as funded are designed to cover the cost of care (which includes all aspects from nursing, care, and hotel services) then what other funding is required?

In the previous answers we have put forward the case for special funding for those we call Class 3A. People living with dementia who exhibit aggressive and often violent behaviours.

This group is currently ignored by the ABF with aged care providers required to use additional resources for which they are not compensated for.

Given the additional minutes per day of at least 120 minutes then this would equate to $120-$165 per resident per day of additional funding required for these residents which could be made under a special payment similar to that offered for oxygen, enteral feeding and homelessness.

The other additional costs referred to earlier is that of activity/lifestyle & allied health services which should be funded and currently is not. This would equate to around an additional $15-$20 per day per resident.

The other consideration is the model of care that is used. Based on the outline of the model shown in the earlier answer then funding for each of these “activities” can easily be derived to match the costs of services plus the necessary margins to have the sustainable into the future.

Funding can be broken into each of these areas, so the model of care meets the expectations of the residents/families and is able to be delivered.

Building the Relationship (Management)

When a new person Moves in or when a Service start (Management)

Building on the Relationship through service and open Communication (Management & All staff)

Providing the Services that meet their goals and needs (Clinical & Care Staff)

Growing the Organisation Based on Service & Transparency (Management)

Making the Money Count (Finance & Admin)

Again, modelling of this is available upon request which shows how each area should be funded in a sustainable manner. The QFR required each quarter by providers can also be modified to collect this data which will assist with the development of ABF model.

Collecting data such as this through the QFR will show where special services are being delivered by providers.

21.What, if any, care-related costs are impacted by service location that are not currently addressed in the Base Care Tariff (BCT) weighting? (maximum: 5,000 characters)

As we understand it the BCT is based on the Monash Modified Model (MMM) which we consider to be invalid for calculating the ABF across the different geographic domains.

We have already outlined an example where the current MMM is simply unfair and bears no relationship to the cost of care. To change the use of MMM we suggest the following:

The funding should include:

1 The cost of labour being different in terms of trying to attract staff to work in areas outside of the Metropolitan areas. Most Regional/Rural/Remote providers must pay above the award to attract qualified staff such as Registered and Enrolled Nurses.

2 They also face unfair competition from state-based hospitals located in the non-metropolitan areas.

3 In the case where providers from a non-metropolitan area are required to use agency nurses then they pay the extra costs of travel and accommodation, which metropolitan providers do not have to. This often equates to around a 20% additional cost.

4 The cost of goods is also more expensive in Regional/Rural/Remote areas due to the cost of freight.

5 Other services, such as maintaining the infrastructure (call bells, IT systems, maintenance of specialised equipment), include additional costs due to these specialists travelling from the metropolitan areas.

6 The recommendation here is to have the ABF recognise these additional costs and include these in an updated ABF for Metropolitan/Regional/Rural/Remote areas.

The current collection of data on a quarterly basis by the Department of Health through the Quarterly Financial Returns (QFR's) provides most of the data required to be able to determine the cost of care and services in the different geographic domains.

The QFR's detail the cost of care in nursing, care, activities/lifestyle, and allied health. These figures can then be used to determine the cost of care at each residential aged care facility level. Additional information should also be collected for the other costs such as the cost of hotel services, supplies, etc. If this was included, then an average cost could be determined for each of the different geographic domains which best reflects the cost of delivering care and services.

Our modelling shows the cost per minute per resident per day for a Metropolitan/Regional/Rural provider to be different.

Nursing cost per minute per resident per resident per day:

Metropolitan provider: $1.39

Regional provider: $1.60

Rural provider: $1.93

Care costs per minute per resident per resident per day (including Care, Activities/Lifestyle, Allied Health, Hotel Services)

Metropolitan provider: $1.07

Regional provider: $1.16

Rural provider: $1.38

These are examples taken from just one QFR for providers in each of these geographic domains.

This is a small sample but shows the difference in costs when using minutes to work out the costs of care and therefore how the ABF should be constructed. Data from all residential aged care providers across several QFR reporting periods would enable an ABF to be built that applies across each of the geographic domains.

This would also allow individual providers to compare their costs against the average to see where changes could be made leading to improve their operations.

These three examples are from different states so it would be relevant to produce these results state by state to establish what the average in each state is as costs are different across the domains.

We see this as a far better way of establishing the ABF rather than the current method which we believe is based on incorrect data and lack the foundation to arrive at correct funding.

Again, we can share the modelling with the IHACPA that provides better financial sustainability for residential care in all geographic domains.

We also acknowledge that building a fair and equitable ABF must consider the funds paid by residents as part of their Baic Daily Fee (BDF). There has never been a clear understanding as to what the BDF is to pay for.

It would therefore be sensible to build the ABF based on the complete cost of care and services (plus the required margin) and then showing the contribution by the resident through the BDF for this. But this requires a high level of transparency to all stakeholders involved so the funding can be fully understood.

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?
(maximum: 5,000 characters)

As outlined previously, the lack of transparency in developing the ABF makes it difficult to offer other considerations into the future. Having studied the cost of care in residential care for over 25 years and collected empirical data over the past 7 years from organisations we are unable to align the current ABF funding to this data.

Apart from the areas already outlined in these answers' consideration should be given to the macro view of long-term development and sustainability for residential aged care providers.

This involves a model that not only addresses the funding of care but also of future requirements in infrastructure.

Given that a large percentage of residential aged care providers are operating at a financial loss (as indicated by the Department of Health data and the Stewart Brown reports) and some at a cash loss then unless the ABF reflects the cost of services in each of the geographic domains and the future cost of infrastructure then services will not be available in most of these areas.

Addressing the infrastructure question (building stock) and being able to replace this in the future is a key fundamental of maintaining the safety and quality requirements for residents. It has been considered normal practice that a provider should be able to renew its infrastructure around every 25 to 30 years. This did require an EBTDA of at $10,000 per place per annum. This would allow the renewal of each place at a cost of around $250-300K.

However, given the latest costs of building this figure now sits at around $15,000 - $20,000 EBITDA per place per annum. Given the financial results currently being experienced by residential aged care providers a majority will not be able to renew their infrastructure in the future and will eventually have to close.

This will occur over a period and is likely to be addressed too late to maintain services in the different geographic domains. If the IHACPA is willing to look far enough ahead, then it is not difficult to determine when services will no longer be available based on previous years of underfunding. A provider's current financial statements can easily reveal what funds they have, how they are operating and with an audit of their current infrastructure stock the number of years left before they must renew. This is highly important for Regional/Rural/Remote providers as without a facility the elderly will have to leave their communities.

The Department of Health already has most of this data to carry out some actuarial studies.

This is a major issue for the future safety and quality of aged care as without up-to-date buildings and equipment the care and services will not be able to be delivered safe or quality care services required. This area has been ignored for many years in the hope it will resolve itself, which it cannot. Transparency in this area is required urgently to reduce the possibility of the withdrawal of services from different geographic domains. From governance

perspective boards are currently struggling with how to address this with a minimal amount of resources.

Added to the above is the fact that the current Residential aged care (RAD) system mimics a Ponzi scheme (A Ponzi scheme is an investment fraud that involves the payment of purported returns to existing investors from funds contributed by new investors).

Whilst there are no promises of increased returns funds repaid require new funds to come in. The security for the contributor is the Commonwealth Government who under-writes the scheme. In the medium to long run the current RAD scheme (which is government guaranteed) is unstainable as the amount of deposits held are likely to continue to decrease and providers become unable to provide the liquid assets to make payments. In the end the government will be forced to pay out the refunds.

The aged care industry is reminiscent of the Forestry industry that collapsed after the Global Financial Crisis in 2008-9. Having been involved on the Creditors Committee of the receivership and wind up of the Great Southern Group I know firsthand how such a scheme ends with billions of dollars lost by investors (in this case the losses will be the Commonwealth Government's). Using new money to pay out old money has been, and will always be, doomed to failure.

Therefore, current Capital funding system for aged care is unstainable for several reasons:

1 The length of stay in residential care is projected to become shorter as entry will be at the later stages of life.

2 The preference for many people will be for services to be received in their home with the rate of entry into residential likely to remain at the current supply levels (as the population ages the percentage accessing residential aged care will fall but the actual number of places is likely to remain stable).

3 It is a myth that a payment of a RAD is a none intertest loan to be used to build aged care places. The RAD is not a loan as there is no loan term and the full amount is repaid on the call of the contributor and can occur at any point in time.

4 Much of the current RAD's are held in non-liquid assets which are new buildings whose worth is determined by the profitability of the aged care operation, and which have no other use. The total cash available across the aged care sector is 20.79% of the value of Accommodation Deposits held. The total liquid assets available is 34.72% of the value of Accommodation Deposits held. **

5 The preference for people to pay a RAD is decreasing as the choice moves towards paying a combination for accommodation (refer the earlier comment).

The result of falling RAD deposits in the future will apply significant pressure to current operators and at some point, there will be an inability to repay RAD's as and when they fall due. **Aged Care Financing Authority Report 2020 page 115.

Priorities for future development

23.How could, or should the AN-ACC model be modified to be used for Multi-Purpose Services (MPS) and are there any factors that aren't accounted for under the AN-ACC model? (maximum: 5,000 characters)

Our knowledge of MPS operations is limited with a majority operated by various state governments.

These services are often cross subsided by state governments as they are sometimes located within a general health hubs.

Therefore, we are unable to provide any useful comments in this area.

24.How could, or should the AN-ACC model be modified to be used for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and are there any factors that aren't accounted for under the AN-ACC model?
(maximum: 5,000 characters)

Having consulted to several Aboriginal and Torres Strait Islander organisations we have found the NATSIFACP funding inadequate.

Most of these organisations are in remote regions of Australia and require qualified staff to work on a "fly in fly" out basis. This comes at a large cost to the provider and in most cases, they cross subsidise this from other operations.

In our consulting we have dealt with Aboriginal and Torres Strait Islander services that come under both the NATSIFACP and AN-ACC (previously ACFI).

Prior to AN-ACC both NATSIFACP and ACFI funded services we dealt with lost money from operating their services.

The services that were ACFI funded and have now moved across to AN-ACC funding are funded based on allocate places versus actual places. This has provided a major improvement in their ability to operate.

However, those funded under NATSIFACP have not benefited from the changes and we are at a loss as to why the Department of Health has not acted on the Aged Care Royal Commission recommendations under the Aboriginal and Torres Strait Islander area.

This requires urgent attention, and the recommendations need to be implemented sooner rather than later.

Final questions

25.Other comments (maximum: 5,000 characters)

Given that residential aged care providers operate in a “price taker” market they do not have the ability to recoup costs based on known expenditure. They rely entirely on funding from the Government and the resident both of which are regulated. Therefore, determining the price that should be paid for services requires a holistic approach rather than simply targeting parts of the system.

Given experience of over 40 years of modelling costs and funding for various organisations both nationally and internationally and the last 25 years of modelling aged care services it can only determine the current ABF model, minutes per resident per day and overall funding for residential aged care is inadequate and will not provide medium to long term sustainability.

To address funding in residential aged care the points made in this submission would need to be addressed as part of the overall solution to the position:

1 An update of the principles used to determine the ABF.
2 The allocation of minutes per class per resident per day be adjusted to reflect the actual times required to attend to residents’ care and services.
3 The inclusion of activities/lifestyle/allied health in the minutes per day.
4 The addition of a class for those living with various types of dementia.
5 The ABF to recognise the different cost structures applicable to Metropolitan/Regional/Rural/Remote geographic domains and fund them accordingly.
6 The discontinuance of the notion of fixed and variable costs as most are fixed.
7 The discontinuance of the Monash Modified Model for classifying residential aged care facilities and replaced by data collected from the Quarterly Financial Reports (QFR’s) to average costs in the various geographic domains.
8 The use of care models to determine differences in cost of operations between providers and to better understand the correlation between model of care, care minutes and the cost of care.
9 The inclusion of all cost of operations including care and infrastructure.
10 The payment of an “onboarding” amount for people on respite.
11 The reclassification of the three levels of respite funding to better match the cost associated with care and services.
12 The correct indexation to be applied and a “catch-up” percentage to be added each year to recoup the funds stripped out of aged care over the past 25 years.
13 Addressing the required funding to renew the infrastructure in the various geographic domains. This is can again be based on the information reported in the QFR’s.
14 The immediate implementation of the Aged Care Royal Commission recommendations for Aboriginal and Torres Strait Islander services.

Having costed and mapped services for years the introduction of the IHACPA is a positive step in funding residential aged care.

However, the funding neglect that has taken place over the past 25 years leaves the task of developing a sustainable residential aged care into the future very difficult. While we make no comment about where the funds will come from it is an issue that must be faced or in the medium term the aged care facilities required will no longer be available.

As mentioned throughout this submission we and the Department of Health have the necessary data to build a sustainable aged care sector. This data needs to be used.

26.Please indicate if there are specific sections of your submission that you wish to remain confidential and the reasons for this. (maximum: 5,000 characters)

No - there are no parts that need to remain confidential.

27.I consent to IHACPA contacting me for further information or clarification about my submission.

☒ Yes, I consent

Thank you for your submission

Your feedback will contribute to the development of the *Pricing Framework for Australian Residential Aged Care Services 2024-25* and a Consultation Report, which will both be published in early 2024.

If you have any questions or need to contact us about your submission, please email submissions.ihacpa@ihacpa.gov.au or phone +61 2 8215 1100.

If you would like to receive updates about IHACPA's work in aged care costing and pricing, please subscribe to our mailing list.

To participate in future aged care costing studies with IHACPA, please contact agedcarecosting@ihacpa.gov.au.

Ways to submit your response

- email this questionnaire to submissions.ihacpa@ihacpa.gov.au
- print this questionnaire and mail it to:
  PO Box 483
  Darlinghurst NSW 1300