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By email: submissions.ihacpa@ihacpa.gov.au

RE: Consultation to develop a new Pricing Framework for Australian Aged Care Services

Thank you for the opportunity to make a submission in response to *Towards an Aged Care Pricing Framework Consultation Paper.*

SUMMARY OF KEY POINTS

- The costing undertaken by IHACPA should cover all the costs incurred in providing high quality aged care and services and not be limited to those services set out in Part 2 of the Schedule of Specified Care and Services.
- The benchmark costing should not support inefficient providers and should be based on average costs weighted to reflect the taxation benefits available to 'not for profit' operators.
- The arrangements should recognise that the provision of aged care services is not a parallel to the public hospital system, where activity based costing is more straightforward given the episodic nature of services provided.
- The costing analysis should reflect links between cost, efficiency, and quality.
- The funding of aged care services is not a funding of providers. It is the subsidy a consumer receives from the Commonwealth/taxpayer to contribute to the cost of their aged care services.

INTRODUCTION

The appointment of IHACPA to provide independent advice to Government regarding the cost and price of aged care represents the opportunity for an evidence based aged care funding scheme (revenues, Commonwealth subsidies and consumer co-contribution).

Our expectation is that the Government will respond to the information provided by IHACPA when determining subsidy levels and the subsidy structure, including the role of co-payments.

We support the objective of a sustainable aged care sector. In our view a sustainable sector is characterised by efficient providers delivering high quality services supported by a stable financial environment which secures inward investment of capital and resources. Importantly, the subsidy utilising taxpayer dollars should support the sector but not 'prop up' inefficient providers. This is the value for money proposition to the taxpayer.

We are broadly supportive of many of the propositions in the Consultation Paper. Our response to the specific consultation questions is outlined in the attachment.

The following section sets out issues we see as relevant to the collection of costing information and how that information can be viewed.

Cost and Pricing Advice

There are three key aspects which should be considered in order to develop a funding model that facilitates sector financial viability and ensures the ongoing provision of supply to meet growing demand.

1. A costing system that includes all costs of providing high quality care and services at a 'best practice' level.
2. The cost of doing business and the revenue arrangements recognises the relevance of a reasonable margin that will encourage participation and investment in the sector.
3. The ongoing and regular review of costs responds quickly to historical changes in costs and is forward looking.

Holistic View of Costs and Revenues

The provision of care and services in residential aged care is frequently referred to in three distinct areas, without reference to the overlap or interaction and requiring separate, unrelated consideration:

- Care.
- Accommodation.
- Hotel services.

Estia Health views an approach that attempts to cost a subset of the activities that are an indivisible part of the activities of a residential aged care facility as flawed. Activities in RACF are not mutually exclusive and collectively support quality of life as seen by consumers. Arguably, many consumers place more weight on the hotel services than on 'care'.

This approach then leads to a position of attempting to ring-fence different streams of revenue and only using that funding for specific activities. Residential services have multiple components: the built environment, social interaction and engagement, food and lifestyle activities and clinical care. The underlying proposition is that the objective of delivering improved quality of life for residents is not supported only by an attention to defining inputs and costs.

Any desire to 'quarantine' revenue streams against associated costs would only bring further inefficiencies and inflexibility to the industry. The focus of all approved providers should be to provide quality services and receive funding to provide care and services at a level required by the community, including an appropriate personal contribution that the community is prepared to pay for those services.

Looking to the source of revenue - once the cost of care and services is established - the issue of who pays what proportion of that price is of critical importance to Commonwealth finances, and the ability of consumers to pay, but is considered to be outside the scope of our response.

Measuring Quality of Care

There is no indication in the paper of the consideration of the relationship between the quality of care and services and the cost of provision.

> In order to ensure the financial sustainability of the sector it will therefore be critical that IHACPA's remit is extended to cover the provision of advice on cost and price for all services delivered by providers. This will include care services, accommodation, hotel services and assistance with daily living.

Measuring only a limited range of what is currently and necessarily provided will only be an 'observation' of what is currently happening, as opposed to what is, and should be incurred in order to support residents.

The challenge in determining what constitutes high quality care and services for the purposes of setting prices cannot be separated from the ability or willingness of the community to pay - The Aged Care Financing Authority reported the broader challenges on this topic in the context of maintaining a viable and sustainable aged care sector and accessible services that balance the needs of consumers, providers, the workforce, taxpayers, investors and financiers.[1] It went on to say "there is a balance between the level of care that the community seeks to provide and the level of care it is prepared to pay for."

> In order to attempt to determine the appropriate or required level of cost or input required to deliver 'high quality care and services' it must be first necessary to define what constitutes 'high quality care and services'. This will then enable an assessment of the contributing factors which are required as 'inputs' in order to deliver that outcome.

At what level will cost be set?

Funding has to be sufficient to meet the level and quality of the aged care needs of residents and in doing so also provide the incentive for providers to invest in the sector. The level of funding provided by the Government has to support the delivery of quality aged care services required by Australians. But it should not support inefficient or poorly managed providers, nor should it provide higher than necessary funding.

The consultation paper does not set out how the reported average cost incurred by the sector will be determined, nor provide any guarantee of a like with like comparison, whether that will be the average or median for the whole sector, the average of the top quartile (those who spend most), or average of bottom quartile (those who spend least)? The number of AN-ACC classifications calls into question how each classification can be costed. Largely because the data collection is at service level and services are not homogenous.

A solution may be to measure the costs incurred by above average providers identified in terms of the Quality Indicators and accreditation outcomes, then use the average costs across this cohort as the sector benchmark. The proposed Star Rating scheme may provide some insight in this area.

Accommodating different approaches and innovation to the provision of care and services

There is a danger that costing and public reporting based on prescribed inputs such as mandatory care minutes and the reporting of costs (such as food costs) will lead the reader to assume that 'more is better'. It will not lead to innovation and alternative approaches being explored. It may also lead to care plans and the allocation of resources being developed by reference to mandated time/minutes (with the attendant costs) rather than the needs of the resident.

Accommodating different business structures in the provision of care and services

The costs of doing business are driven by a combination of internal decision making and external influences.

As a principle, the provider should not be funded on the basis of their preferred business model but rather for the benchmark funding for delivery of care and services. Necessarily, the more efficient will derive a benefit as we see in the hospital funding arrangements.

However, there can be no efficiency dividend for the costs incurred or reduced as a result of government policy that distinguishes one ownership model from another.

[1] Annual Report on the Funding and Financing of the Aged Care Sector – 2021

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Not For Profit (NFP) providers have a cost advantage over the For-Profit (FP) providers directly related to their taxation arrangements, such as Payroll Tax.

It is not clear from the paper how this fundamental difference will be reflected. An approach may be to acknowledge higher pricing or weighting for FP providers in order to create an equal playing field and encourage investment in the sector or to weight the costing to compensate for the NFP tax advantage.

> Cost and pricing advice should be such as to ensure that the demonstrable difference in operating costs created between NFP providers and FP providers are addressed in order to create a level playing field.

Yours sincerely

Sean Bilton

Chief Executive Officer

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CONSULTATION QUESTIONS

No.	Questions	Key Points
1	What, if any, may be the challenges in using the Australian National Aged Care Classification (AN-ACC) to support activity based funding (ABF) in residential aged care?	A design weakness is that the proposed costing approach seeks to establish the cost based on provider performance in terms of cost. It does not consider the quality of care and services being delivered nor include quality performance in benchmarking. AN-ACC does not reflect all aspects of care and services that contribute to the resident's quality of life. The key is to ensure that the Activity Based Costing methodology captures all the activities relevant to improving each resident's quality of life and thereby creates the scope from which specific information can be derived. That includes increased effort required to be directed to resident based administration. The notion of using cost in a sector where the costs over the 2,700 RACFs is so variable, challenges how the most efficient price (subsidy plus co-contribution) is derived. On a broader scale, the non-inclusion of some costs relevant to the provision of quality care in the costing is problematic. The baseline should be an understanding of the normal costs of doing business to provide care and services that meet the statutory requirements. ABC, which informs ABF, linked to actual costs rather than the theoretical AN-ACC will inform whether the classification relativities in AN-ACC are valid. What the funder is prepared to pay is influenced by knowledge of the costs of delivering the outcome the funder seeks.
2	What, if any, concerns do you have about the ability of AN-ACC to support long term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe?	AN-ACC is a funding model. A funding model to support the appropriate revenues of providers should be adequate to support efficient operators. A funding model, of itself, will not drive long term improvement unless the actual dollars linked to each class are correctly relative and adequate and the sector has the appropriate leadership and culture focussed on supporting residents and continuous improvement. Subsidy decisions made by government are the key. Quality improvement is an outcome of leadership, internal monitoring, and culture. The goal to 'increase efficiency over time' links to this question. There are competing concepts. An ambition to improve efficiency is hindered by other requirements that establish mandatory inputs and provide for regulatory action for not complying, e.g. mandated care minutes. Mandated inputs are an anathema to innovation and efficiency

3	What, if any, additional factors should be considered in determining the AN-ACC national weighted activity unit (NWAU) weightings for residents?	The classification scale requires review over time. For example, it is of concern that the identification of a person as mobile drives them down a lower classification path, notwithstanding that they may have high level clinical, cognitive and social needs requiring greater investment of time and effort. See more detail in Q4.
4	What should be considered in developing future refinements to the AN-ACC assessment and funding model?	• Introduce an additional Class for Palliative Care Respite admissions with the same application process and funding as permanent ANACC Class 1. Palliative care respite admissions often require emergency entry into aged care. An additional palliative care respite class would make this service more accessible as the respite admission process is much simpler and require less documentation than permanent admissions. It would ease the burden on the care recipient's family and allow the care recipient to be moved from hospital to a RACF sooner. Under ACFI, high-care respite funding was equivalent to the highest ACFI category, HHH. However, the highest Respite ANACC Class 103 attracts lower funding than permanent Class 1. • Extend the application of Class 1 to care recipients who become palliative after admission to permanent care. The care needs of these care recipients are similar to those who are admitted to aged care as a palliative care resident. It would be logical to apply the same assessment process. • Incorporate a validated Cognitive Impairment Assessment into the ANACC tool. The level of cognitive impairment plays a key role in determining Classes 4 to 8. The Australian Modified Functional Independence Measure used in the ANACC tool to determine the level of cognitive impairment requires the assessor to rate the level of cognitive impairment based on a brief observation and conversation with the care recipient. Frequently this rating contradicts the level of cognitive impairment assessed by Medical Practitioners and clinical teams using comprehensive validated tools such as Mini-Mental-State Examination or Psychogeriatric Assessment Scale. The consequence of using The Australian Modified Functional Independence Measure often results in an understated level of cognitive impairment in the ANACC assessment. • ANACC respite classifications currently consider the care recipients' mobility only. Their cognitive impairment and behaviour support needs are not considered, even though they can significantly increase the cost of care. These factors need to be reconsidered in the future refinement of the model. • The RUCS reports outline that technical nursing care needs significantly increase the costs of care and name eight specific technical nursing procedures: Oxygen Therapy, Enteral Feeding, Tracheostomy, Catheter, Stoma, Peritoneal Analysis, Daily Injections and Complex Wound Management. However, only Daily Injections and Complex Wound Management are listed as Contributing Factors in the current version of the ANACC Model. Although the Department of Health and Aged Care never released the full scoring algorithm, it appears that the other six complex nursing procedures may have been excluded from the model despite their direct and significant impact on the cost of care. This needs to be reconsidered in the future refinement of the model. • The ANACC scoring algorithm and assessment methodology should be published. Public knowledge of the scoring and assessment system is good public policy and forms a reasonable base against which providers can seek reclassifications. A transparent process where providers would receive detailed information about each

		resident's funding assessments and how the final score was derived would build confidence in the system. Providers' ability to interpret the assessment information against a clear set of rules in conjunction with the reconsideration process would ensure consistency in the application of the tool and the balance of the new funding system. We understand that the DHAC rationale behind withholding the scoring algorithm from the industry is to alleviate the risk of 'gaming' by some providers. However, the external assessment approach to AN-ACC is an effective safeguard of taxpayer money against such actions. The external assessors complete the entire suite of AN-ACC assessments by personally assessing the resident and having full access to clinical documentation. There is no input from the provider, therefore, the provider cannot interpret or manipulate the rules to achieve an advantage.
5	What, if any, changes do you suggest to the proposed principles to guide the development and operation of the Pricing Framework for Australian Aged Care Services?	**Fairness** – the proposal says the principle reflects 'equitable'. It is not equitable where the Government has a policy that advantages one seller/provider over another and the buyers/consumers are required to make the same contribution. e.g., The ABC should capture and 'call out' the impact of the taxation arrangements for NFP providers and their staff vis a vis FP providers. These are material cost differentials that can influence subsidy decisions.
6	What, if any, additional principles should be included in the pricing principles for aged care services?	The Principles should include a requirement to consider all the costs of doing business. That includes direct care and support costs plus an appropriate return on financial capital, and for the acceptance and management of risk. The Pricing Principle need to be clear regarding what is being priced and the required standard. Looking at 'average' cost without certainty regarding (say) a measure of quality is fraught.
7	What, if any, issues do you see in defining the overarching, process and system design principles?	Refer to covering letter.
8	What, if any, concerns do you have about this definition of a residential care price?	The concern is in regard to methodology. The baseline is not clear, particularly when considered in conjunction with page 37 '*The recommended residential aged care price is intended to predominantly cover the cost of care. Elements of care in-scope for the price are specified under Part 2 of the Schedule of Specified Care and Services*.' The starting point should identify the cost of all activities that are required to optimize each resident's quality of life and support their health, safety and wellbeing. Having determined the total cost, Government is then informed regarding what the subsidy is intended to cover and the cost and make policy decisions regarding co-contribution funding of the balance.
9	What, if any, additional aspects should be covered by the residential aged care price?	See above. The non-inclusions cause potential concern. The proposal does not even cover the specified care and services The methodology should include all services in the *Schedule 1 (Quality of Care Principles 2014) – Care and services for residential care services.*

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10	What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?	The hypothesis (page 38) seems to be that 'many aged care providers are currently not meeting the minimum standards …' and that is linked to revenue built around subsidy levels. ACQSC data reports c 90% of services are accredited for 3 years from which one can conclude that some, rather than many services are not currently meeting minimum standards. If failure to achieve minimum standards was directly linked to the inadequacy of funding, then the number of failures would be a multiple of the current number. While a revenue uplift is required to sustain the development of the sector, the notion that inadequate funding is the only driver of failure is flawed. Demonstrably, the key reason for quality failure is poor culture, poor monitoring of performance, a lack of leadership and non-conformance with policy and procedures at service level. As a principle, the funding model should not be designed with a view of supporting inefficient providers. Consequently, the benchmark cost should be developed by reference to those providers who are demonstrably providing services that meet the minimum requirements and whose revenues are adequate to fund the 'costs of doing business' plus the margin necessary to secure and sustain investment in the sector.
11	How should 'cost-based' and 'best practice' pricing approaches be balanced in the short-term and longer-term development path of the Independent Health and Aged Care Pricing Authority's (IHACPA) residential aged care pricing advice?	See response to question 10. The use of 'cost based' without reference to quality outcomes creates the real risk of funding inefficient and poor quality providers. The development of a 'best practice' pricing model will require IHACPA to develop a competency to measure quality and its links to cost. The Royal Commission Research Paper No 9 *The cost of residential aged care* provides some insight into this work.
12	What should be considered in the development of an indexation methodology for the residential aged care price?	Estia Health supports the theme of the IHACPA proposal. Specifically, the indexation while based on historical data, must also be forward looking and respond to unforeseen changes in costs outside the control of providers.
13	What, if any, additional issues do you see in developing the recommended residential aged care price?	Simply reporting actual costs without reference to quality and efficiency or with an eye to best practice leads to embedded structural inefficiency.
14	What, if any, changes are required to the proposed approach to adjustments?	The speed of evolution of aged care practice and statutory requirements suggests that the use of historical data will not suffice. The annual review of costs should specifically seek out changes in regulatory requirements and innovations. <u>Base Care Tariff (BCT)</u>

		The current structure of BCT has MMM1-4 grouped at the same level. Estia Health data leads to the conclusion that there are material cost differences between MMM1 and MMM2-4 that supports an intermediate BCT for MMM2-4.
15	What, if any, additional adjustments may be needed to address higher costs of care related to resident characteristics?	Noting the inclusion of veterans (services related to mental health), we note the increasing number of older Australians who suffer mental health issues as a result of trauma in a conflict zone and have come to Australia as refugees or migrants. These people have similar cost profiles. There is also the increasing number of residents who do not have a support group or connections outside the RAC. The reasons are many and may include underlying mental health or addiction problems, or life choices and behaviors that have led to marginalization. The benefits of 'companionship' cannot be overstated when considering a resident's quality of life. Necessarily that staff provides additional companionship.
16	What evidence can be provided to support any additional adjustments related to people receiving care?	The related costs for permanent residents can be significant. Such as costs associated with tours of the facility, the resident agreement, installation of any personal goods and chattels and, support for engagement with Services Australia. Our reference to cost is the cost of labour to support the resident.
17	What should be considered in reviewing the adjustments based on facility location and remoteness?	Current costs should be considered. However, as a principle, providers should be funded at best practice level. The important construct is the ABF is NOT a reimbursement or cost recovery model as existed pre ACFI where the providers choice drove their revenues. Notwithstanding the notion of neutrality, the pricing cannot ignore Government policies, such as the taxation treatment of NFP that influences costs. There is risk to taxpayer dollars in paying a BCT in MMM 6-7 based on operational places, without some examination of the efforts made by the provider to actually seek to have the beds occupied. This situation is compounded by the pronounced labour shortages in rural and remote sites.
18	What evidence can be provided to support any additional adjustments for unavoidable facility factors?	The 'unavoidable facility factors' must only be external factors which are beyond the control or influence of providers in that location and not a result of any particular provider's operating model or quality. See above
19	How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?	There should not be adjustments for 'quality and safety issues'. The funding should be linked to meeting Government requirements. The fact that some providers will exceed those requirements brings competition into the sector.

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20	Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?	The reference to the BDF as the funder of hotel costs and implying that the cost structure is divisible reflects an inadequate understanding of the operations of (say) residential aged care. Our proposition is that the IHACPA should, as a first step, develop the cost of care defined as services necessary to support the health, wellbeing, and safety of residents. The exclusion of hotel services from consideration is to deny the reality (as promoted by Government) of the importance of the dining experience and activities that give meaning to a resident's life (by way of example). All costs related to services set out in the Schedule of Specified Care and Services should be measured.
21	What should be considered in future refinements to the residential respite classification and funding model?	A one-off admission subsidy should be payable to the provider. This recognises that there are admission and planning activities and costs associated with respite care. We recommend that the payment be payable to the provider for the first admission to a service. See further Q4.

22	What are the costs associated with transitioning a new permanent resident into residential aged care?	The related costs for permanent residents can be significant. Such as costs associated with tours of the facility, the resident agreement, installation of any personal goods and chattels and, support for engagement with Services Australia. Our reference to cost is the cost of labour to support the resident.
		
		After admission costs include:
		
		• Comprehensive clinical assessment
		  ○ medical information can be variable depending on how well the resident is known to the referring doctor and at times non-existent.
		  ○ Families do not always provide comprehensive information regarding care needs and behaviors
		• Contact with the residents treating doctor to access records
		• Development of care plans including risk assessments
		
		Respite residents require a similar amount of effort albeit is in a compressed timeframe.

23	How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?	Workforce challenges are not relevant to the funding model. While the funding model must provide for funding of labour, it of itself does not influence labour costs. The influences of labour costs are the unit price of labour, providers model of care, statutory input requirements such as the 200 minutes and administrative and regulatory burden.

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		The costing model should be sophisticated enough to determine labour needs, changes in need and unit price and fund that labour.
24	What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?	Given that the Government will be making subsidy decisions based on IHACPA information there is an imperative to have a sophisticated system of ABC in place sooner rather than later.
25	What would be considered markers of success in IHACPA's aged care costing and pricing work?	There is evidence IHACPA was able to provide timely, accurate information regarding the 'better practice' costs of providing care and services. The costing information published by IHACPA is able to withstand scrutiny.