BAPTIST CARE AUSTRALIA
A voice for hope

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

Submission to the Independent Health and Aged Care Pricing Authority (IHACPA)

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# About Baptist Care Australia

Baptist Care Australia is the national representative body for Baptist community service organisations and their clients in the national policy debate. Our members employ more than 11,500 staff, work with 3,000 volunteers and have an annual turnover of almost $1 billion. Together, the network of organisations that make up Baptist Care Australia care for over:

- 5,000 residents in over 60 residential aged care facilities
- 1,300 residents in 30 retirement living communities
- 12,000 older Australians in their own home

Baptist Care Australia's members operate over 50 residential aged care facilities across Australia's urban cities, regional centres and remote towns. From single-site operators to large multi-state organisations, our members provide over 1 million days of care each year. We support over 5,000 older Australians with high quality residential aged care to enable them to live and age well, including specialised models of care for people diagnosed with dementia, those seeking respite and palliative care.

Baptist Care Australia is a company limited by guarantee, a registered charity and a public benevolent institution.

### Our perspective as providers

This submission offers our perspective as aged care service providers. The information is intended to help IHACPA understand the range of costs associated with the provision of residential aged care. We are mindful there are many complexities attached to the development of activity-based funding model and price for residential aged care and anticipate IHACPA may be seeking more specific technical data than we can provide. However, we see this as a first step in a longer journey of learning for the pricing of residential aged care and, as such, have been expansive in sharing concerns and information that we deem important from our experience as providers.

# Principles for activity based funding in aged care

This section responds to the content of Section 2 including the question ***What, if any, changes do you suggest IHACPA consider for the residential aged care pricing principles?***

### Using ABF where practicable and appropriate

Activity-based funding makes sense for funding the type of episodic care provided by hospitals. It is harder to understand how it can accurately fund the complex care environment needed to enable older people to live a meaningful life outside of their own home. If an activity based funding model only accounts for a particular set of interactions between residents and staff members, it may well fail to provide the funding required for providers to fulfil the more holistic approach needed to create care environments in which people can live their life to the full as they age.

### Relationship to Aged Care Taskforce Principles

We note the intersection of the proposed Principles with the draft Aged Care Funding Principles put forward for debate by the Aged Care Taskforce. We encourage IHACPA to track the discussion associated with the principles explored by the Taskforce to ensure greatest alignment possible across the sector.

## The Australian National Aged Care Classification funding model

This section responds to Section 3 on the Australian National Aged Care Classification funding model, which included questions 15 – 18.

**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?**

### People living with dementia

Several of our members reported a lack of funding under AN-ACC for the care needs of residents living with dementia. Providers report that many clients with dementia are assessed as 'Class 5' but that this underestimates the significant amount of care required in response to behavioural issues.

For this reason, the branching logic inaccurately assumes physical mobile residents carry a fundamentally lower care load requirement than people with mobility issues. But this underestimates the high care needs of mobile people with major behavioural issues.

Given people living with dementia make up a majority, and growing, proportion of people in residential aged care, then this has significant consequences.

### People living with mental health issues

As is the case in relation to dementia, providers similarly reported that the classification of older people with mental health issues does not correspond to the level of care required. Again, the classification is weighted in a way that inaccurately relies on physical mobility to provide the foundational indicator of care need.

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

### Classification system may need to become more nuanced over time

Some providers are concerned that the AN-ACC classification system may be inadequate for accurately assessing the complexities of care needs across the population of residents. For example, providers have raised concerns about the range of needs arising for people with complex comorbidities and their concern that the AN-ACC classification does not adequately account for residents who require multiple staff members to support them.

**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)**

### Costs of advocating for reassessment of resident's AN-ACC classification

While assessment is not the responsibility of IHACPA, we note that providers undertake a body of work to advocate for residents who need re-assessment when their care needs intensify. Providers regularly advocate for re-assessment for residents whose classification was inadequate upon intake or other situations where the classification is inadequate for their care requirements.

### Funding gaps due to delays in re-assessment

Residents can experience significant deterioration in their health and care needs in a short period of time. Providers immediately adjust their provision of care accordingly but carry the cost of that increased care load while a re-assessment occurs that adjust the resident's AN-ACC classification. As a result, providers carry the cost difference between the existing classification and new care needs and this cost burden can accumulate. One provider noted they are currently short about $400,000 in funding because reassessment has not been done in a

timely manner. Providers will continue to carry these costs until the system's assessment capacity improves. In the meantime, we ask IHACPA to take into account the gap in cost recovery for providers between the date at which a resident's needs change and the subsequent change in classification.

### Activities while a resident is in hospital

Providers described a range of activities that are required for residents who have been admitted to hospital. This includes communicating with the hospital about care needs on intake, communicating with the family about the resident's health, location, and likely future options, adjusting internal systems (such as RN rostering, meals) to account for changes in overall resident composition, liaising with medical specialists who care for that resident, and working on a discharge plan with the hospital.

### Activities when a resident passes away

Providers noted that there are a range of activities required when a person dies. This includes, *inter alia*, appropriate care for the person's physical remains, communication with family, legal notifications and the safe transfer of the person's property. Providers noted this stage also includes support for family members and close friends as they come to terms with the loss and enter the initial stages of grief. While the activities differ, there is a body of work as there is upon intake and note that while the intake work has an upfront payment to account for this, an equivalent upon exit is missing. We encourage IHACPA to undertake analysis of this moment in aged care service delivery in the pricing study.

## Developing aged care pricing advice

This section responds to Section 4 on Developing Care Pricing Advice, which included question 19 on indexation.

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

### Indexation must account for wages being the majority cost

Wages are the major cost in the delivery of residential aged care and so the indexation methodology should place more weight on any shift in wages as a proportion of the overall costs of care. In contrast to wages, other costs are often indexed against CPI (often stipulated in the relevant contract). An indexation methodology that considers these differentials would be appropriate e.g., indexation weighted at 70% for relevant changes in wages and the remaining 30% indexed using CPI for other costs.

We note some of our providers also deliver services for people under the NDIS and are aware that on 1 July 2022 the aged care indexation was 1.7% while the NDIS indexation was 9%. Providers found this difference difficult to comprehend, as their service delivery costs across those programs were not so different. We encourage IHACPA to explore the NDIS indexation methodology to gain insight into indexation of another social service delivery program.

### Indexation and the Annual Wage Review

We appreciate IHACPA must provide its pricing advice to the Government in time for the annual May Federal Budget, but that the Fair Work Commission Annual Wage Review is delivered after the Federal Budget in June. This structural gap means IHACPA will be providing advice ahead of a key decision that impacts costs of service delivery for an entire financial year. We appreciate IHACPA cannot intervene in the timing of the Fair Work Commission process, but instead hope that IHACPA may be privy to the FWC methodology for their Annual Wage Review in order to ensure the most accurate advice possible.

### IHACPA review upon FWC decisions

We note that IHACPA is only able to review its annual pricing advice via a request from the Minister. We believe the pricing process would be stronger if any decision by the Fair Work Commission affecting aged care services (such as the upcoming Stage 3) automatically triggered an update to the pricing advice. Similarly, if there are abnormal movements in inflation.

### Retrospectively accounting for under-estimation in previous year's indexation

In 2023-24, IHACPA's advice included an adjustment to the price to take into account the under-estimate of costs in the year prior. While this kind of retrospective adjustment is not ideal, we want to commend the move to find a way to ensure the costs incurred by providers in the previous financial year were recouped.

### Seasonality of medical supplies

We note a lot of indices from ABS refer to the seasonality of medical supplies. IHACPA may need to consider different ways to collect relevant data to determine accurate indexation of non-labour costs in aged care.

## Adjustments to the recommended price

This section responds to Section 5 on Adjustments to the recommended price, which included questions 20-21.

**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?**

### Cost variations

Providers noticed cost variations associated with residents with particular types of care requirements commonly experienced by a group of people with a shared identity. Previously, some of these groups attracted different funding to account for their unique care needs. IHACPA may find it educative to explore which groups previously such funding to understand the care needs associated. Along these lines, as providers we note additional psycho-social care needs for the following people:

- Residents without a support person: Our providers noted that residents who do not have a carer or support person in their life (such as a family member or friend) require substantial additional care and support from providers. We encourage IHACPA to consider future work to understand the value carers bring to residential aged care in order to both recognise their significant contribution and also account for the additional working hours needed for residents without that support.
- War-related PTSD: Veterans, refugees and other people exposed to war will often present particular additional care needs relating to post-traumatic stress disorder (PTSD) and the resurfacing of memories.
- Residents with complex chronic health issues: Providers are finding more residents are presenting with co-morbidities that require complex care. At this stage, it is not yet clear whether the AN-ACC approach is adequately accounting for the care needs of these residents.
- Culturally and linguistically diverse community members: CALD communities do not have higher care needs *per se* but service settings are not always equipped to equally care for multi-lingual and multi-cultural communities. As a result, providers that care for a people from a range of cultural backgrounds need to invest in additional supports and activities to provide adequate care. This includes higher use of interpreters, translation of materials, culturally familiar foods, and more diverse social activities.

### Accommodation pricing

We appreciate that the current mechanisms for accessing funds to build or refurbish residential aged care accommodation is an out-of-scope area for this pricing review. While the building and/or refurbishment of facilities

is not part of activity-based funding, we want to note that the built environment is an important component of residential aged care that contributes to care outcomes. We appreciate that this capital cost is meant to be funded via RADs but note this source of funding is not adequate for the amount of capital works needed to refurbish the 25% of facilities that no longer meet community standards, nor to build the number of additional new facilities. We hope IHACPA's understanding of the costs of the infrastructure and equipment in hospital settings can help inform the wider discussion on the funding of capital improvements for aged care.

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

## Care-related costs impacted by service location

Providers are not sure that the Base Care Tariff is adequately accounting for the types of measures currently needed to meet compliance requirements (such as the 24/7 RN minutes). In particular, they noted the costs associated with:

- Flying staff in and out of regional and rural locations to fill roster gaps
- Securing accommodation to enable staff to be brought in to work at a regional or remote facility
- The additional work it takes to keep residents connected with their families in rural areas

## MMM classifications do not align with operational challenges

According to our providers, the MMM classification system does not accurately reflect the cost differences in service provision for facilities in different geographical locations. In particular, there is a sense that facilities in regional centres (e.g., MM 3-4) are not adequately funded for the costs incurred.

There appears to be an assumption that service delivery across categories MMM 1-4 are all the same, as there are only changes to the Base Tariff for MM categories 5-7. However, Baptist providers that operate services in locations with MM 2-4 categories report certain difficulties in delivering that service, particularly in relation to attracting staff.

We note the Government does not consistently map supports to these MMM categories which is both a source of general confusion as well as concern that measures are not being applied where needed. As an example, we note the variations in the government's use of MMM in response to nurse and GP workforce issues. The Aged Care Registered Nurses' Payment – Additional Payment is available to RNs who work in areas MM 3-7. However, the exemption criteria in relation to 24/7 RN coverage only extends to RACs located in MM areas 5, 6 or 7 (with <30 beds). Meanwhile, the Rural Locum Assistance Program (RLAP) Aged Care covers MM 4-7.

We encourage IHACPA to evaluate the gradations of service cost variations across each MMM category, either through its current pricing study or alternative data sources.

## Housing staff in regional and remote locations

The national housing crisis is a significant issue for aged care providers due to its impact on the ability to recruit or retain staff in regional and rural locations.[1] There are multiple instances of providers successfully recruiting to a role but find themselves unable to find suitable housing for the successful applicant. As a result, providers are having to put in the time and money to identify and secure housing for the staff of some of their residential aged care facilities.

[1] Add reference to Anglicare's latest report on Essential workers and housing

**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?**

Providers are not yet confident that the funding for non-direct care costs (9.1%) adequately accounts for the full costs of delivering residential aged care. They noted in particular the need for adequate funds for spiritual care, lifestyle coordinators, education and training, and infection control and expertise.

Additional costs they are not confident have been adequately included are:

- **Governance of volunteers:** Volunteers play a crucial role in supporting the lives of older people living in residential aged care; they provide thousands of dollars of value to the sector. However, providers carry the costs associated with the management and governance of this aspect of aged care delivery, including recruitment, checks, registration, training, and oversight.

- **Student placements:** Providers appreciate the opportunity to help train the next generation of professionals, and benefit from access to students on placement. However, as the quarterly reporting system does not capture student placement hours, we are not confident the funding model accounts for the costs associated with negotiating agreements with training facilities, organising each round of placements and oversight of students on site.

## Final questions

This section provides additional comments on issues not directly related to particular questions posed by IHACPA.

25. Other comments

### The impacts of high staff turnover

Providers have experienced high workforce turnover in recent years (upwards of 25% churn) and this turnover attracts additional costs. We are optimistic that the increase in wages for certain roles resulting from the Fair Work Commission Stage 2 decision, and any future increase attached to Stage 3, will reduce these turnover rates and stabilise our workforce. However, until this stabilisation occurs, high turnover rates continue to accrue substantive costs associated with:

- Recruitment and onboarding
- Training about our sites and resident needs
- Education and professional development
- Higher reliance on agency staff to fill roster gaps

### Costs of compliance activities

Our providers are quite happy to comply with increased compliance and other reporting requirements, but are concerned regulatory reporting and other compliance obligations are not adequately funded. These requirements have recently increased exponentially, with quarterly reporting now taking much longer for providers to complete.

Notwithstanding their commitment to transparency, providers are concerned some of the compliance processes do not appear to add value to the outcome of care. They are interested in how the risk-based approach to quality assessment might reduce unnecessary reporting burdens on providers with low risk in order to increase efficiencies in the system. We hope that IHACPA's experience in hospital pricing – which is known for its low administrative costs when compared with other OECD economies – is a useful foundation in this regard.

- The costs of sponsoring migrants and negotiating MOUs and other industry labour agreements with unions
- Staff turnover not only increases the gaps in the roster but also places additional pressure on remaining nursing staff to take extra shifts. This pressure will only increase with the 24/7 RN requirement, and we anticipate the associated burnout will further impact RN retention rates.

## Accounting for the costs of natural disasters

In 2022, almost 70% of Australians lived in an area covered by a natural disaster declaration and during this time several of our members had to meet the challenge of providing residential aged care during a major disaster. For example, at least two RAC facilities in our network were cut off by flood waters requiring high-cost and unbudgeted activity to protect and care for residents. We note, for context, the additional challenges for rostering given local staff were also dealing with the impact

We anticipate these emergency situations will continue to be a regular yet unpredictable aspect of the provision of residential aged care, and this will put upwards pressure on costs in various ways. Importantly, these events have triggered a rapid increase in the costs of insurance for providers in the past 12 months. We are not entirely clear how such costs are accounted for by IHACPA in the pricing advice.

## Funding for systemic improvements

Providers are concerned that an activity-based funding model will struggle to appropriately fund systems improvements, including innovation in service delivery. Providers just can't afford to be innovative if only paid for the costs of current care delivery. Seeking alternative funding options for this is an *ad hoc* approach that takes time to access.

## Value of Enrolled Nurses

Members would appreciate it if IHACPA could undertake work to tease out the value of Enrolled Nurses and Recreational Officers in the delivery of care. Both of these groups of professionals are vital to our services and yet they are not considered to be part of care when viewed through the lens of the Royal Commission recommendations regarding care minutes. We would appreciate data to validate the importance of these roles.

## Timing of pricing advice

Under the current regime, providers are often informed of the new set rate in late June or July. This rate then has to be implemented as of 1 July. This is entirely too late to inform budget planning, as by this stage budgets will have been set, rosters in place and so forth.

We understand that IHACPA provides its hospital price in February/March.

To ensure greater operational stability, we would appreciate that the date of the advice in relation to aged care services be moved forward. Another possibility is for IHACPA to link their advice with the bi-annual indexation of the pension on 20th March and 20th September, as providers are adjusting elements of their systems on those dates already. It would be better for FWC to do those same dates for their Annual Wage Review also.

## The future of pricing advice

While out of scope of this study, we want to express our confidence that IHACPA has the capability and insight to be able to build a sophisticated understanding of the costs of aged care service delivery and to advise the government on an accurate price to cover the costs associated. We note our concern that IHACPA is limited to providing advice for aged care pricing, rather than setting the price as they do for hospitals and will look to support advocacy efforts to strengthen these powers to be able to set the price in the future.