UnitingCare

UnitingCare Queensland's Submission to IHACPA

Towards an Aged Care Pricing Framework

Proudly representing
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St Stephen's Hospital | St Andrew's War Memorial Hospital

October 2022

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Executive Summary

UnitingCare Queensland is one of the largest residential aged care providers in Queensland (Blue Care) and the Northern Territory (ARRCS) with over 69 years experience. The residential aged sector is undergoing significant change both cultural and demographic. The new Australian National Aged Care Classification system whilst developed with the best of intentions looks like an institutionalised funding model (paid to keep people alive due to the only mandated compliance requirement being care minutes). This is driving unintended outcomes by redirecting resourcing of other care factors and cherry picking of residents (reducing choice for residents).

Long-term recommendation

Residential Aged Care is about delivering holistic care to residents. An outcome-focused funding model is the right funding model because it will deliver flexible and individualised care. ***In the long-term, IHACPA should replace the care minute requirement with a resident outcome-focused Key Performance Indicators such as Quality of Life, Clinical, and Mental Health measures by aiming to have researched and develop such models over the next few years.*** This has been highlighted by the recent addition of outcomes to the National Aged Care Mandatory Quality Indicator Program (QI Program). ***In the interim IHACPA should supplement the care minute requirement with other resident outcome requirements.***

Short-medium term recommendations

- Incorporate all factors into the Residential Care price to deliver a base level of care i.e. wrap the Basic Daily Living and Accommodation payments in. Means-testing can then be over one payment, instead of three.
- Create a three-tiered standard (e.g. bronze, silver, gold) for residential aged care 'hotel' services (e.g. like Health Insurance) and accommodation (this could be industry led). Depending on the level of complexity for 'hotel' services and accommodation they could have separate standards. Silver and gold level (above bronze) should be wholly consumer funded.
- Publish the makeup of a National Weighted Activity Unit.
- Conduct an urgent review to consider separate funding uplifts for MMM1-MMM4 regional facilities; First Australian services in MMM1-MMM5 regions; CALD focused facilities; severe behaviour cohort focused facilities; and facilities in tropical areas.
- Incorporate other supplements into the AN-ACC pricing model (i.e. oxygen, enteral feeding, veterans and hardship).
- Create a temporary uplift mechanism for areas that face temporary economic changes e.g. mining boom in Darwin, Gladstone, Broome.
- Conduct a review of hotel services funding and requirements.

Executive Summary (Visual)

Diagram 1: Long-term AN-ACC recommendation

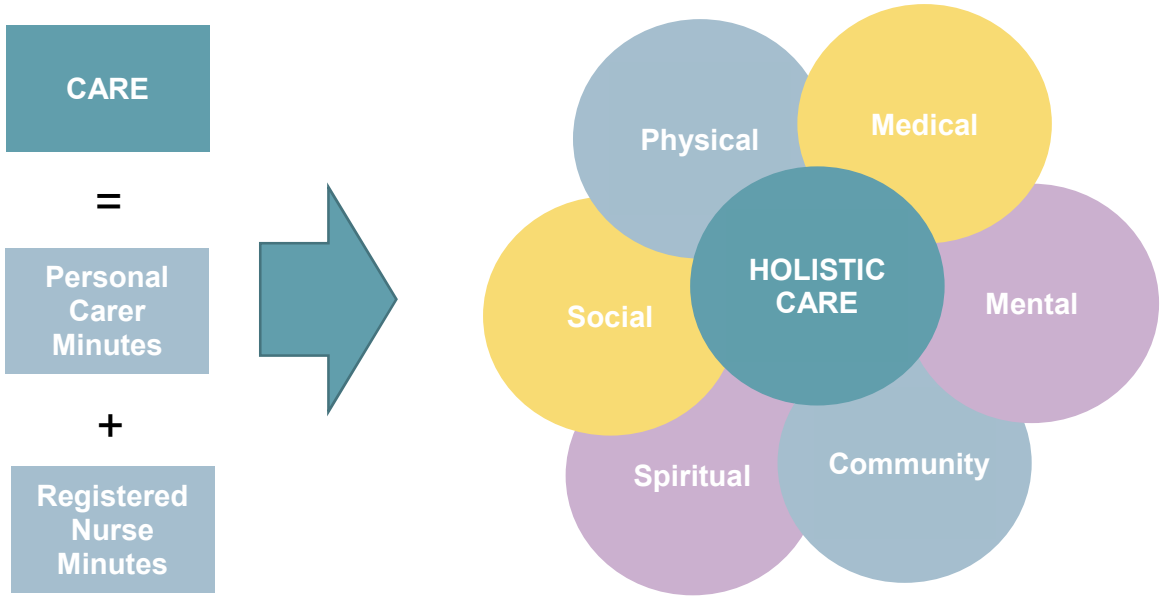


Diagram 2: Short-medium term recommendations

Short-Term (urgent)	Medium-Term
Review of uplifts for First Australian facilities in MMM1 – MMM5 regions	Incorporate other Supplements into AN-ACC pricing model (i.e. oxygen, enteral feeding, veterans and hardship)
Review of uplifts for regional facilities in MMM1 – MMM4 areas	Publish the make-up of a National Weighted Activity Unit
Review of uplifts for Culturally and Linguistically Diverse facilities	Create a temporary uplift mechanism for areas that face temporary economic changes
Review of uplifts for severe behaviour cohort focused facilities	Conduct a review of hotel services funding and requirements
Review of uplifts for facilities in tropical areas	

Diagram 3: Current residential aged care funding (revenue) sources

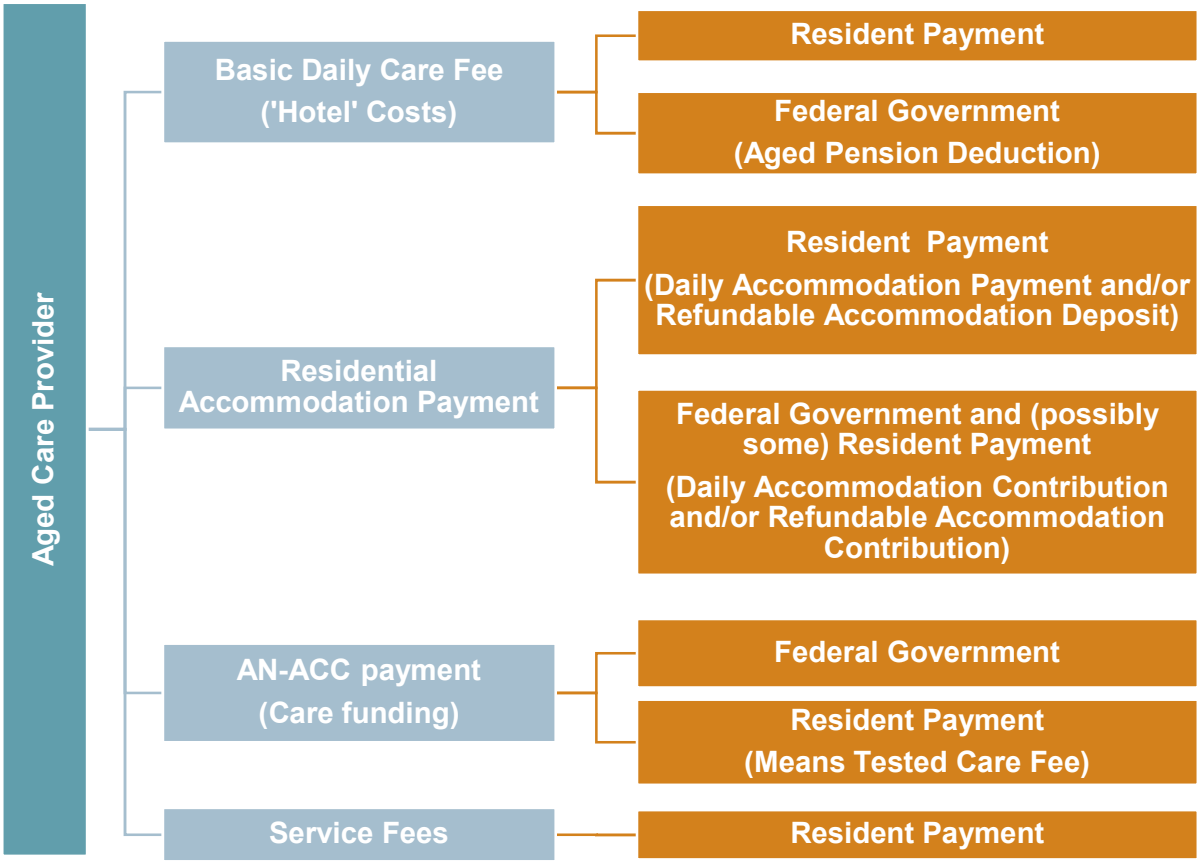
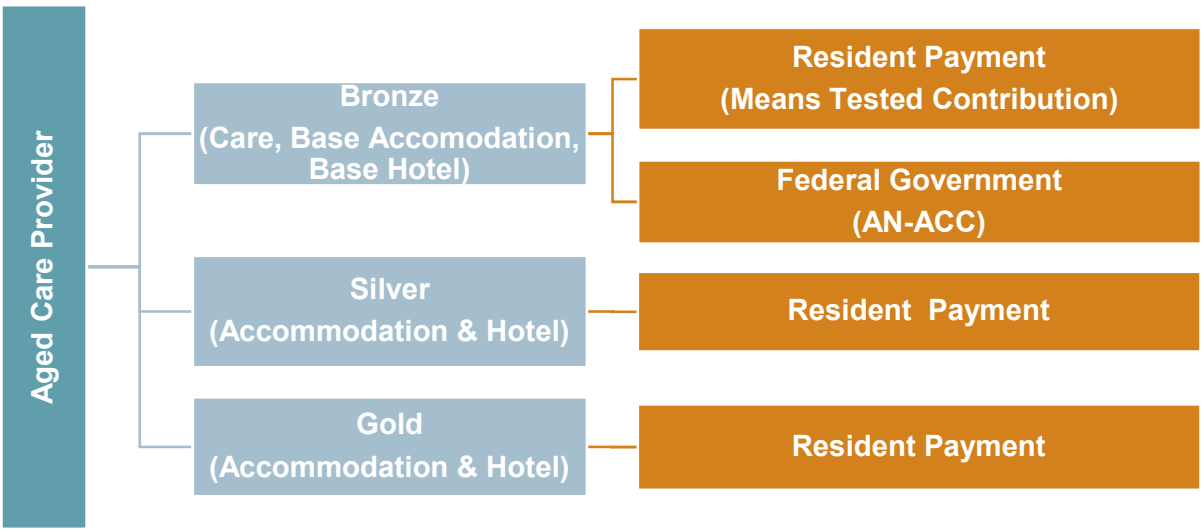


Diagram 4: Proposed residential aged care funding (revenue) sources



Introduction

Every day in the community, we engage with people from all walks of life. We deliver skilled, evidence-based interventions for those facing adversity, and utilise our reach and vision to confront injustice. We are leaders in providing care and support to senior Australians. We meet people where they are and walk alongside them to achieve positive change and growth. Right across Queensland and the Northern Territory, UnitingCare Queensland supports our senior Australians redefining what's possible in their lives.

"Live life in all its fullness"

UnitingCare Queensland provides health, aged care, disability and community services to over 430,000 Australians a year as the largest Queensland based not-for-profit employer with 16,500 staff, 9,000 volunteers. UCQ has over 69 years experience providing in-home care to our older Australians, running 57 aged care facilities as one of the largest aged care providers in Queensland and the Northern Territory and running four private hospitals with over a thousand beds and 9% of the Intensive Care Unit (ICU) capacity in Queensland. A summary of our operations can be found in Appendix 2. Appendix 1 answers the Submission by Question.

Background: residential aged care

When people think of residential aged care, they think of people playing cards around the table, enjoying their golden years. The reality couldn't be further from the truth and in fact should envision a resident in a hospital bed. The interesting thing is this dynamic is recent, in 2009-2010 the Open Gen Data from the Australian Institute of Health and Welfare showed that senior Australians entering the Residential Aged Care system saw only 1 in 25 residents categorised as high needs across the three criteria. In 2020-2021 it was over 1 in 3 residents. The 2020-2021 data also showed the median stay in aged care was 24 months with 25% of residents staying less than 8 months noting the dominant reason for permanent exits of residential aged care (84% in 2020-2021) was death.[1]

With an ageing population in Australia, one would think that residential aged care is a booming industry. The data shows a declining trend over the last four years with negative growth in residents in 2020-2021. Indeed, the latest StewartBrown March 2022 report (based on data from 1,282 facilities – 47% of the residential aged care sector) showed that occupancy for residential aged care homes was at 90.1% compared to occupancy in 2011 of 93.1%.[2] In 2020 the Aged Care Royal Commission noted that "Only 25% of older people would

[1] https://www.gen-agedcaredata.gov.au/Resources/Access-data/2022/July/GEN-data-Admissions-into-aged-care

[2] https://www.stewartbrown.com.au/images/documents/StewartBrown_-_Aged_Care_Financial_Performance_Survey_Sector_Report_March_2022.pdf

prefer to live in a facility should they need care".[3]

This means residential aged care providers are facing a tough financial choice as the market is not growing. Residential facilities as built as recently as ten years ago are not fit for purpose due to the increased needs of senior Australians whilst also facing increasing regulatory burdens. This was evidenced through the StewartBrown March 2022 report that over 38% of residential providers were making a cash loss and 64% of providers were making an operating loss.[2]

Residential aged care funding

Residential aged care providers receive three heavily regulated Federal streams of revenue: Basic Daily Care Fee, Residential Accommodation Payments and the ACFI/AN-ACC care payment which the Means Tested Care Fee offsets for those who are financially secure. Additionally, many providers charge additional services fees which is loosely regulated (for UnitingCare Queensland our services fee is immaterial). Diagram 3 summarises an aged care providers funding (revenue) sources.

The Basic Daily Care Fee is a misleading name and is actually meant to represent the basic living costs of the resident that IHACPA and many in Government refer to as 'hotel' costs. This fee is meant to cover basic daily living costs such as food, cleaning and other basic amenities required to live. It is set at 85% of the aged pension which equates to roughly $45 / day. This cost is paid directly by the resident to the aged care provider either directly or through a deduction of the aged pension (Federal Government payment). In 2021, the Federal Government recognised that this figure was too low and provided a $10 / day supplement (subsidy) to providers. This total spend more closely aligns to the direct cost (excluding overheads) of providing these services.

The Residential Accommodation Payment is considered to fund the type and quality of the accommodation provided to the resident. There are actually four different ways in which this payment is seen by the resident depending on whether the resident is low means or not. If the resident qualifies as low means, they will be eligible to receive a contribution (possibly a full Government contribution) from the Federal Government and can choose to pay either or a combination of (regularly charged) a Daily Accommodation Contribution amount and/or pay a lump sum through a Refundable Accommodation Contribution. For those residents who don't meet the eligibility they are required to pay either or a combination of (regularly charged) a Daily Accommodation Payment amount and/or pay a lump sum through a Refundable Accommodation Deposit (RADS). Providers are regulated with the Aged Care Pricing Commissioner approval required for RADS above $550,000.

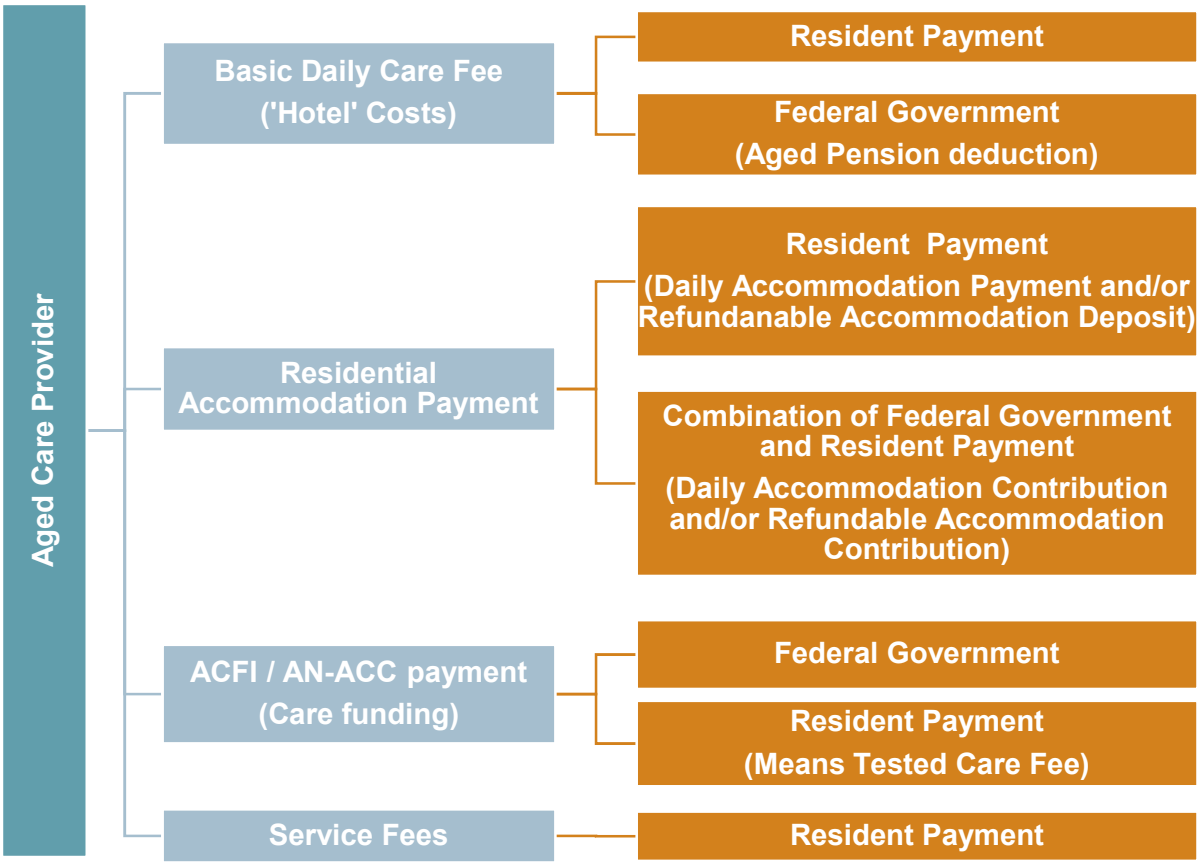
The third stream which is the primary topic of conversation for this consultation is the care payments that age care providers receive from the Federal Government. Prior to 1 October 2022 this was known as the Aged Care Financing Instrument (ACFI) and 1 October 2022 it now known as the Australian National – Aged Care Classification (AN-ACC) payment. The ACFI/AN-ACC is meant to represent the cost caring for aged care residents with well-off residents required to pay a part of this care payment through the Mean Tested Care Fee. The vast majority of funding for age care residents is provided for under this payment.

[3] Page 33, https://agedcare.royalcommission.gov.au/sites/default/files/2020-07/research_paper_4_-_what_australians_think_of_ageing_and_aged_care.pdf

Many aged care providers also choose to charge age care residents a ‘service’ fee for any additional services that they consider above and beyond what should be provided by the three funding arrangements. There is a lack of transparency and comparability of what these ‘service’ fees cover and how they compare with other providers.

UnitingCare Queensland’s submission recommends that these streams of revenue should be bundled up into a singular fee amount to reduce the complexity for residents and their families and a three-tiered structure of services created to give transparency and accountability. By simplifying the way in which funding for aged care works and what age care providers charge, residents can more easily compare providers whilst placing less stress and complexity in working out the financial implications. As a provider, the three different streams of funding can create cultural internal barriers and silos to reallocating resources effectively and efficiently. We look forward to engaging with IHACPA in making residential aged care a simpler and better place.

Diagram 3: Residential aged care funding (revenue) sources



Independent Health and Aged Care Pricing Authority (IHACPA)

The Aged Care Royal Commission recommended that an Independent Pricing Authority be created and with legislation passing in 2022 the Independent Hospital Pricing Authority became the Independent Health and Aged Care Pricing Authority (IHACPA).

IHACPA Pricing Principles

What the principles are and how the Authority acts on them are an important part of gaining trust with Government and the aged care industry. The five proposed overarching principles of: access to care; quality care; fairness; efficiency and; maintaining agreed roles and responsibilities are good overarching principles.

Underlying the overarching principles are the process principles of administrative ease; stability; evidence-based and; transparency are welcome principles. The commitment to transparency could also be an overarching principle, as it is imperative for building trust.

These process principles are complemented by the system design principles of: fostering care innovation, promoting value, promoting harmonisation, minimising undesirable and inadvertent consequences; Activity Based Funding pre-eminence and; recipient based are good design principles however we suggest that an outcomes of residents should be a specific design focus.

The proposed principles generally provide a good framework for analysis and decision-making needed in the Authority's work. They do however highlight some underlying tensions that will need to be negotiated. There is a long history of funding decisions and pricing in aged care being made strongly in favour of efficiency, rather than quality or access. Pricing methodologies were also rarely publicly available. This pattern of funding decisions was made on what Government is willing to pay rather than individual and community need as was observed and documented in detail by the Aged Care Royal Commission.

In recent years, the aged care environment has been one of downward price adjustments, pricing freezes, and below CPI indexation alongside increasing regulatory requirements and consumer expectations. This has created a tough environment for providers and creates challenges for the Authority to negotiate a fair and equitable price for aged care services as there is no clear sense of what is currently funded versus the true cost of service delivery.

The proposed principles will serve as a guide through this, however further thought will need to be given around how they will be weighed against each other when determining price and how this will be made clear and transparent when there are considerable tensions between an elected Government's priorities and delivering quality aged care.

As we move to a rights-based Aged Care Act, further thought could be given to an

additional rights-based principle or a rearticulation of existing ones from that perspective. For example: right to access aged care that upholds dignity and respect and is available to people in home, a home-like environment, or in the community.

The inclusion of a home-like environment in this example serves to highlight that residential aged care is very different from hospital-based care. Residential aged care is a person's home. They live there permanently and have security of tenure. The care to support them in their home, in a way that upholds their dignity, requires more than a transactional model more commonly experienced in hospitals. Achieving this requires a rights-based, person-centred approach i.e. holistic care. From our perspective, holistic care aims to:

- Understand and respect a person's values, past experiences, preferences and expressed needs
- Coordinate and integrate care
- Communicate information and educate
- Maintain physical comfort
- Offer spiritual and emotional support
- Alleviate fear and anxiety
- Involve family and friends
- Transition well with continuity of care
- Provide access to care

This approach requires multidisciplinary teams with strong person-centred cultures, who bring together psychosocial and clinical care on equal footing. This has a range of implications for how to best understand and cost quality aged care services.

Diagram 5: Holistic Care

Cost-Based vs Best Practice Pricing

Residential Aged Care is about delivering holistic care to residents. An outcome focused funding model is the right funding model because it will deliver flexible and individualised care. The current AN-ACC model is an activity-based funding model with the case mix driving the delivery of care minutes. Whether a cost-based or best practice pricing approach is used, the current and proposed approaches miss the point which is that residential aged care pricing should drive outcomes for residents.

Achieving holistic care for residents can be achieved through a cost-based pricing structure if it encourages providers to be innovative and efficient in delivering their services. In order to encourage innovation and efficiency, IHACPA needs to consider what is the outcomes that it wishes to measure for resident wellbeing and quality of life and make those a key driver of funding. It could also be achieved through a best practice pricing approach that rewards best practice behaviour whilst also providing room for other providers to catch-up.

UnitingCare Queensland notes that currently the AN-ACC funding model is driving a 'best practice' approach to care minutes by targeting a level of care minutes beyond what StewartBrown estimated is currently provided for[4] (for UnitingCare Queensland we have some sites over and under these requirements). Furthermore, the focus on Care minutes causes detriment residents as other possible expenditures that might dollar for dollar significantly improve the quality of life and health of residents are lost to the focus on care minutes.

In order to break the cycle of chronic underfunding, an outcomes focused funding approach based on the best practice funding model in the short-medium term is required. This could then eventually be moved to a cost-benefit approach as a cost-based approach may disadvantage certain outcomes.

[4] https://www.stewartbrown.com.au/images/documents/Residential_Aged_Care_Sector_Financial_Sustainability_August_2022_update.pdf

Australian National Aged Care Classification Model

The Basis of AN-ACC: National Weighted Activity Unit

There is no detailed or clear information on how the current National Weighted Activity Unit (NWAU) weightings have been established and it is a cost prohibitive exercise for providers to determine if they are reasonable. This makes it difficult to provide a fully informed view.

UnitingCare recommends publishing the calculation of the National Weighted Activity Unit as an important first step in building a reputation for transparency and trust with the industry.

The NWAU fixed component weightings do not appropriately address the impact of service size on delivery cost relative to other factors. For services with less than 45 occupied beds, the ability to establish economies of scale in direct and indirect staffing, care, hotel services, accommodation and administration costs significantly diminishes when compared with services with higher occupied bed numbers. The former Scheme for the Viability supplement recognised on a sliding scale that residential facilities with less than 45 occupied beds faced increased overheads. This impact is independent of location or Modified Monash Model (MMM) classification.

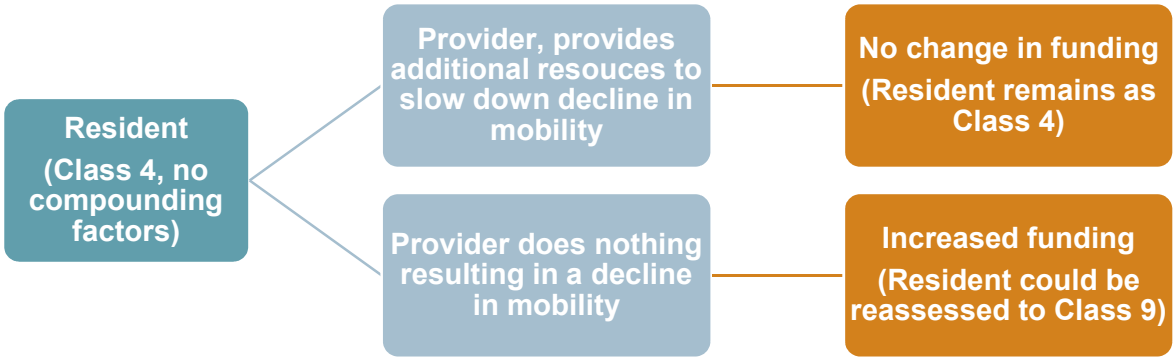
Additionally, the NWAU weightings are, by design, detached from resident outcomes and therefore perpetuate a focus and prioritisation of cost and input drivers rather than outputs and outcomes which are delivered. An application of NWAU which directly considers resident outcomes will promote and support improved resident experience and increased investment and development in where positive outcomes are being achieved. In turn, this would incentivise achievement of resident-based outcomes rather than providing financial incentive for achievement of certain classifications of residents within certain AN-ACC classes and achievement of input-based measures such as care minutes which do not directly represent achievement of resident outcomes.

AN-ACC and the care minute requirements – A fundamental flaw

The AN-ACC model is based on the National Weighted Activity Unit that defines a level of care provision dependent on the classification of a resident. The AN-ACC was largely designed before a care minute requirement existed in residential aged care and does not have any mechanisms built in to manage the significant unintended consequences of this new requirement under the new funding model.

While AN-ACC was designed to incentivise re-enablement and maintain independence for residents as long as possible, the care minute requirement focused on personal and nursing care creates a labour input regulation. Alongside fixed and variable case mix pricing, this regulation limits the ability of providers to flexibly use their resources to deliver multidisciplinary,

Diagram 6: AN-ACC funding disincentive example – slowing a decline in mobility



outcomes focused care to access these incentives.

Fundamentally, this is a flawed way in which a resident should be funded for care as it removes the reward a provider for re-enablement and /or slowing any decline in a person's health. Indeed, the funding models has more in common with a institutionalised funding model then a model of care. With the addition of the care minute requirements, the AN-ACC now incentives a decline in health as more funding would be received by the provider if a resident's health declines in such a way to be given a higher funding classification noting that there is a correspondingly higher care minute requirement. At best, a provider that re-enables a person's health to a lower level of funding classification will keep the current classification funding. No reward is given to a provider that prevents / slows down a decline in health (refer to Diagram 6). This is exactly what AN-ACC was trying to move away from when transitioning from ACFI, and it needs to be addressed as a priority.

The care minute requirement is currently leading many providers to cost-optimise their operations through considering what is the 'best' classification to take that balances the revenue (funding) and cost (care minutes) of that classification. Certainly, one of the unintended consequences of AN-ACC and the care minute requirement will be reduced choice for residents. Providers will maximise their revenue based on current operations to cherry pick the right classification/s to enter their facility that does not cause significant or new labour costs especially given the

Diagram 7: AN-ACC provider decision making example

ongoing workforce issues providers are facing. Diagram 7 provides a simple example of what decisions a provider faces now under the AN-ACC model.

Additionally, as the care minutes are also a regulatory requirement and form part of how facilities are publicly star rated, there has been a focus by most providers to ensure they meet their targets. This has further unintended consequences of resources being moved to Personal Carers (lowest cost level of staff for a care minute) and Registered Nurses (other care minute requirement) to ensure sufficient staffing to meet these targets. As noted by the Allied Health Professional Associations in Community Affairs Legislation Committee hearing on the Implementing Care Bill,[5] many providers are cutting spending in other areas in order to boost their Personal Carer and Registered Nurse staffing hours.

Nurses and carers deliver excellent care, however specialist services beyond a nurse or personal carer's skillset are required to maintain a resident's health. Dental services, Allied Health (e.g. physio therapy) amongst other specialist services are required to ensure that a resident's well-being and physical health is maximised.

Physical wellbeing is not the only outcome people want for themselves as they age. Maintaining connection with family and friends, having things to do that are meaningful, working through grief to find peace, experiencing joy and laughter everyday are all important outcomes for residents. These are all part of the care picture and require a range of people with the right mix of skills in the right workplace culture to be achieved. The current funding model with a care minute requirement does not support holistic care nor the full breadth of high quality, rights-based care that the new Act and the new standards will demand.

The AN-ACC does not have a strong financial mechanism to reward 'good'/quality care by provider

Consistency of Assessments

Consistent assessments are critical in ensuring that funding is fairly delivered and residents receive the care that they deserve. Due to compressed rollout timeframe of AN-ACC and the hiring freeze of the previous Government, a significant number of assessments were outsourced to private providers resulting in an inconsistent application of the classification standard. For the re-assessments requested, we saw a re-classification of residents that will see a positive and material funding uplift.

Workforce challenges

Workforce challenges presents challenges in the implementation and refinement of AN-ACC primarily through changes in the operating and employment model of providers. For the most part, those changes will eventually be incorporated into the refinement of AN-ACC albeit with a lag as information provided will be retrospectives i.e. changes will take at a least a year to be incorporated. In particular, the increased indirect staffing costs to provide Aged Care services in many regional areas as providers provide accommodation as a standard employment condition. This is because the housing shortage in regional areas is combining with the demand for workers means providers have to provide additional incentives for staff to work in regional areas. This may cause issues given the different taxation treatments under the Fringe Benefit Tax Regime for different areas and may lead to a distortion

[5] https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=COMMITTEES;id=committees%2Fcommsen%2F26028%2F0004;query=Id%3A%22committees%2Fcommsen%2F26028%2F0000%22

of the actual staffing cost to deliver care between areas.

Moving AN-ACC to an Activity Based Funding Model

We note that AN-ACC can already be considered an Activity Based Funding model given it provides funding to Age Care providers based on the activity of care (measured through care minutes).

As noted early this is not ideal way of measuring care. Unlike Hospitals that provide a clear activity (operation) which is supported by ancillary services such as a number of Hospital Bed Days and / or Intensive Care Unit admission, the purpose of Aged Care is to provide continuous care to enable people to live life to their fullest as they age. This means providing holistic, individualised care to a resident, meeting their physical and wellbeing needs.

Serious consideration needs to be given to first define what outcomes are sought before deciding on what an Activity Based Funding Model looks like. Given the deficiencies of the focus on care minutes in the current AN-ACC system, an interim Activity Based Funding Model that complements the current funding model to ensure that key parts of the holistic care are provided to residents should be implemented in the interim. In the long-term an outcome focused funding model should be developed and implemented.

We support the introduction of outcomes into the National Aged Care Quality Care Indicators program as an important first step.

AN-ACC as an Efficient, Sustainable and Safe model of funding

The context of all three words is essential to defining the answer. From a financial point of view (some would argue the Government's Departmental point of view):

- Efficient: the AN-ACC system is financial efficient in the same way the institutionalised model of funding works, i.e. receiving funding by type (class);
- Sustainable: Financially sustainable given that the rate can be easily adjusted to the financial environment;
- Safe: AN-ACC is Financially safe given there is a low risk of fraud (due to independent assessments and the payment mechanism) and safe through compliance.

In the long run AN-ACC will deliver a system that will in the end likely lead to another Royal Commission because of a focus on compliance and cost-cutting (financial efficiency), without regard for resident outcomes.

Improving the AN-ACC Model

We agree with the Authority's view that given the current changes in aged care, any adjustments for quality and safety issues be considered in the long-term development path. Any reference points for future adjustments should be based on measures that genuinely reflect care and quality outcomes. Monitoring and evaluating the effectiveness of the National Aged Care Quality Indicators Program is an important first step in this and we welcome the recently announced new indicators that include customer experience and quality of life measures.

Quality of life is a critical quality indicator in aged care, as person-centred care focuses on individualised and holistic psychosocial outcomes alongside clinical outcomes. However, time is needed for implementation and review of the new measure before it can be considered in a funding adjustment context.

Consideration should also be given if adjustments will be used simply to remove

funding or to incentivise certain outcomes by providing additional funding. We note that the original intention of the AN-ACC model was to incentivise reablement approaches by allowing providers to retain funds should people's function be improved, and they need less support. Unfortunately, the introduction of the care minutes requirement is likely to severely limit the impact of this for the reasons previously described.

Residential Aged Care Price

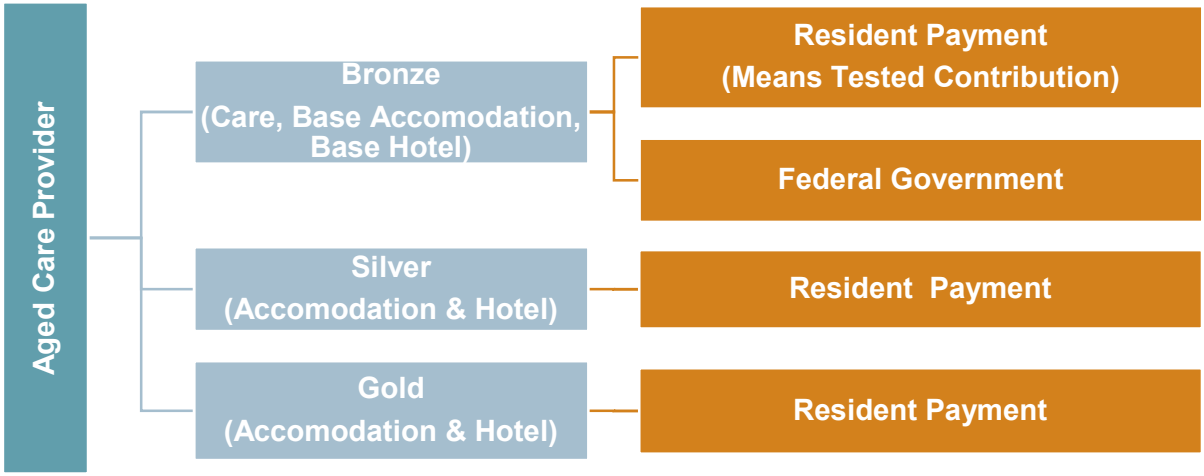
The current definition of the Residential Care Price provides a very narrow view of what care is and what care should be funded. Providing residential aged care is a holistic exercise that includes both the physical and medical care needs covered under AN-ACC (noting that both the physical and medical care is narrowly defined and should cover allied health, dental, GP visits etc.) as well as providing psychosocial support, a sense of community, meaningful activity (both physical and mental) and a base level of what has been defined as hotel costs (accommodation, cleaning and food). By taking such a narrow view of care, the aged care price will not deliver holistic care for residents.

A residential aged care price should incorporate the following factors:

- All factors required to deliver a base level of care to residents such as minimum standards of cleaning, food and accommodation as well as medical, dental and allied health care
- A 'reward' for providers who achieve strong outcomes for residents
- Be a universal price that delivers a base level of care i.e. residents pay additional fees to receive extra hotel and accommodation services in a clear transparent standard (silver and gold) see Diagram 4
- IHACPA cannot exclude out accommodation payments as they help contribute to a base level of care
- There is also a need for a Regulator to set a transparent standard for accommodation payments so residents can accurately compare providers

In the long run the proposed pricing approach will deliver a pricing level that will likely lead to another Royal Commission because of a focus on compliance and

Diagram 4: Proposed residential aged care funding (revenue) sources



cost-cutting (financial efficiency) without regard for the outcomes of the resident.

Additional Issues in Developing a Recommended Residential Aged Care Price

Establishing a pricing methodology and funding model which incentivises and recognises resident outcomes will support improved sector focus on the primary objective of the residential aged care system to provide improved quality of life for residents.

Ensuring the primary focus of funding is inextricably linked to resident quality of life outcomes will support industry level focus on outcomes and remove current systemic barriers. Examples of these barriers are financially incentivising service delivery to particular resident cohorts/classifications and giving primacy to the number of care minutes rather than the resident outcomes such care minutes are assumed to provide. We support the introduction of outcomes into the National Aged Care Quality Care Indicators program as an important first step.

A model under which genuine resident outcomes are the primary provider deliverable (reflected in the funding model's pricing structure and decision making, will address many aspects of residential aged where challenges are currently faced (e.g. quality, safety, community return on investment and innovation).

Providing Specialised Residential Age Care Pricing

Providing specialised Aged Care is a complicated affair. We note that that certain severe behaviour resident cohorts can often require higher level of support e.g. 1:1 – high intensity services. We also note that facilities serving a large number of First Australians in non-MMM6-7 areas and/or Culturally and Linguistically Diverse populations should also receive a certain uplift in funding to recognise the increased costs of providing culturally appropriate services to residents These costs can be evidenced through the higher costs in staffing, food and accommodation requirements.

A review of the costs of providing care for severe behaviour residents, First Australian focus facilities in MMM1-MMM5 regions, and for Culturally and Linguistically Diverse facilities is urgently required to address the potential funding deficit faced by these groups

The following supplements should also form part of the AN-ACC classifications so that funding is from one source and therefore just an application of the funding instrument: oxygen, enteral feeding, veterans and hardship. This would reduce complexity by not having to do things across different mechanisms to ensure the whole amount of funding for a resident is secured. These additional costs are already evidenced through the Government schemes available.

Providing Age Care in Regional Australia

The RUCS findings (2019)[6] and adjustments were developed before the COVID-19 pandemic and have not accounted for the significant social and demographic changes encountered since then. Australian cities, towns and regions are facing significant upheaval due to reduced immigration and many Australians are making sea-change/tree-change decisions due to Work From Home and flexible working arrangements that many organisations offer. In the past,

6 https://www.health.gov.au/resources/publications/resource-utilisation-and-classification-study-rucs-reports

organisation have been able to convince staff to move to these regions because of their lower cost of living.

Since the COVID-19 pandemic, the cost of living in regional regions (MMM1 – MMM4) has been impacted by significant accommodation shortages, increasing house and rental prices. This has left many aged care providers, including UnitingCare Queensland, contemplating expanding staff accommodation arrangements to workers beyond the remote areas (MMM5 - MMM7) to continue to providing residential aged care outside of the major city regions. Anecdotally, we have heard of other providers converting former residential aged care facilities into staff accommodation.

The increased costs in staff accommodation are in addition to increased freight costs due to the supply chain disruptions and significantly increased fuel and staff costs. These regions have also faced increased Agency Labour costs on a like for like basis when compared to MMM1 regions. In a major regional city centre (MMM1), the accommodation costs paid for agency staff outstrips the actual cost the agency staff. Age care providers in major (capital) cities do not usually pay for accommodation for agency staff. We also note in these regional areas the costs of obtaining contractors are also substantially higher than major city areas due to the travel time and costs for them to go to these areas. These difference in costs will be able to be calculated using standard examples and extrapolating the aggregated data provided in the QFR and other information requests.

Under the current model and proposed AN-ACC model, age care providers will be forced to absorb (or abandon) sites in regional MMM1 – MMM4 regions due to the increased cost of construction. The increased cost of construction in these MMM1 – MMM4 region is well known with Insurers providing a building cost uplift for these regional and rural areas due to the limited supply of labour and increased freight costs. The uplift factors can be commercially purchased.

A review of the costs of providing care in MMM1 – MMM4 regions compared to an major (capital) city region is urgently required to address the funding deficit faced by these communities.

In addition to the facilities in MMM1 - MMM4 regions needs, the cost to provide services in the tropical parts to Australia sees a significant increase in the costs of providing services and in particular aged care services. For simplicity, we have defined tropical parts of Australia as those North of the Tropic of Capricorn and close to the coastline. These additional costs include:

- Construction of buildings to a cyclone rated standard and consequentially the increased cost to insure these buildings
- Increased cooling costs as air-conditioners are often required to run 24/7 throughout the year to keep a comfortable temperature with residents resulting in significantly increased maintenance, energy and capital costs
- Increased maintenance, repair and replacement costs to maintain gardens, buildings and equipment due to the tropical environment where there is increased plant growth, mould, rust and other environmental factors.

These costs can be accurately measured using the comparable costs incurred by organisations between the regions.

The AN-ACC model also needs to have temporary uplift for areas that face temporary short-medium escalation of

costs due to temporary economic factors. For example, the rapid cost escalation faced by local organisations in the mining regions of Broome, Port Headland, Darwin, Emerald, and Gladstone (amongst others) have seen the doubling and tripling of house prices and accommodation costs due to these temporary economic factors. Without a temporary uplift, many aged care providers might be forced to close during these periods further increasing upheaval in these communities. The temporary nature of these events means that a targeted data request of costs will be required with that evidence being compared to aggregate information for the period.

Providing Respite Care

We support further work being done to understand the costs of respite care. Respite is often an important part of a person's aged care journey. It can be used to provide rest for carers, but it can also be an opportunity for people to try living in residential aged care services. For many, this can help remove some of the fear and stigma that surrounds entering residential aged care and provide a soft entry point into these services. This is a critical option to ensure providers secure residents in a sustainable way. Important cost drivers to consider are for respite residents on entry are often very similar to entry as a permanent resident. Seamless ability for residents to transition from respite to permanent is an important option as well as reducing the burden and the churn that respite creates.

Transition Costs

There are a range of costs associated with transitioning someone into residential aged care, be they a permanent resident and respite resident. These are outlined in Table 1: Transition activity costs for residential and respite.

Additional Consideration for a Residential Aged Care Price – Hotel Costs

Establishing and ensuring reasonable and appropriate funding for hotel services outcomes (catering, cleaning & laundry) should be considered as part of any independent pricing review for residential

Table 1: Transition activity costs for residential and respite

Transition activity	Residential	Respite
Prospect management before acceptance of a residential bed	X	X
Application process - supported	X	X
Formal offer and agreement – contract outlining rights and responsibilities	X	X
Care planning and assessment of needs and preferences – working with individual and families	X	X
Liaising with General Practitioners and Pharmacists	X	X
Liaising with Hospitals	X	
Advanced care planning	X	
Grief and other social and emotional support through the transition phase	X	
Wait list management in holding potential residents e.g. follow up and regular engagement whilst awaiting bed	X	X

aged care. The incorporation of such funding into the AN-ACC funding model should be subject to consideration following a ***review of hotel services funding and requirements***.

Regardless of the incorporation of such funding into the AN-ACC funding model or otherwise, the basis for funding provision for hotel services outcomes would benefit from independent review. The current funding model, does not consider the outcomes targeted, expected, sought or delivered for hotel services nor the appropriate funding required to deliver such outcomes.

The review of the funding model for hotel services consideration should be given to a range of factors, including:

- Targeted hotel services related to resident outcomes. Funding should directly support and incentivise delivery of resident outcomes rather than being primarily cost or input related.
- Consumer, market and community expectations of hotel services provided. The ability for providers to deliver hotel services in line with or above expectation is impacted significantly by the funding model. Consideration needs to be given to the current state of delivery against expectation alongside evolving and changing levels of expected hotel services provision.
- Hotel services delivery costs including:
    - Wage rates with particular reference to relevant service delivery industries and market rates in addition to award rates.
    - Goods and services rates and market prices with particular reference hotel services related categories. Consideration may also be required where state-based rates materially vary from national movements.
    - Other cost drivers including freight and transport, supply chain/demand factors and availability and accessibility of labour, goods and services where premium prices may be required to ensure continuity of service delivery in real time.
- Evolution and development of operating models and processes and investment required to ensure appropriate continued progression, including contemporary and newly developed hotel services models and technological advancement.
- Appropriate and necessary maintenance and replacement of hotel services related equipment, assets and technology.
- Innovation and improvement development needs and opportunities to support continuous improvement in hotel services related to resident outcomes, operating models and sector efficiency and effectiveness.

The current model, linked to the aged pension, is not based on an assessment of targeted outcomes or cost to deliver on such outcomes. Independent review and assessment of pricing and funding model provides opportunity to establish a targeted level of resident outcomes in relation to hotel services which, with clear articulation and alignment to pricing and funding, could then be supplemented through fee for service additional services where appropriate. This would provide transparency and clarity for residents and

providers on outcome expectations aligned with the funding model.

Additionally, there is no minimum standard for what residents should expect to receive in terms of hotel standards and there is a lack of transparency and comparability of what extra services are provided if they choose to pay for "extra" services or be able to compare services between providers on a like for like basis. ***We recommend as part of the review and assessment of hotel and accommodation costs, consideration for simplified standard be made to create a bronze, silver and gold level of service provision for hotel and accommodation costs that provides a consistent comparison of services across the three levels***. We note that whilst it needs to be Government led, industry, industry bodies and consumer groups play an important role in developing, negotiating and implementing these standards.

Indexation of the Residential Aged Care Price

Methodology for indexation in residential aged care pricing requires consideration of factors across a broad range of areas, including:

- Level of achievement of resident outcomes being delivered. The ability for providers to achieve targeted and expected levels of resident outcomes is impacted significantly by the funding model. Additionally, consideration of indexation decision-making needs to consider the ability of providers to achieve such outcomes under any pricing revision.
- Achievement of, and changes to, consumer, market and community expectations of care and support services provided. The ability for providers to deliver care and support services in line with or above expectation is impacted significantly by the funding model and consideration in indexation decision making needs to be given to the current state of delivery against expectation and also evolving and changing levels of expected care and support provision.

Movement in service delivery costs including:

- Wage rate movements with reference to minimum wage, award rates and market rate movements with particular reference to health, care and support industries.
- Goods and services inflation rates and market price movements with reference to health/care provision, hotel services and accommodation provision categories. Consideration may also be required where state-based movements materially vary from national movements.
- Other cost drivers including freight and transport, supply chain/demand factors and availability and accessibility of labour, goods and services where premium prices may be required to ensure continuity of real time service delivery.
- Evolution and development of operating models and processes and investment required to ensure appropriate continued progression, including contemporary and newly developed care and support practices and technological advancement including assistive technologies.
- Appropriate and necessary maintenance and replacement of care and support related equipment, assets and technology in addition to

and separate from accommodation and living environment equipment, assets and technology.

- Innovation and improvement development needs and opportunities to support continuous improvement in resident outcomes, operating models and sector efficiency and effectiveness.

The findings of the Royal Commission into Aged Care Quality & Safety identifying systemic under funding compounded through decades of insufficient indexation application leading to an estimated ~$9.6b in under funding in 2019 support the critical need to consider indexation with appropriate reference to targeted goals and outcomes and input cost drivers.

The Future

Residential Aged Care is about delivering holistic care to residents. An outcome focused funding model is the right funding model because it will deliver flexible and individualised care. AN-ACC was originally created with this in mind. The removal of the care minute requirement and replacement with a resident outcome focused Key Performance Indicators such as Quality of Life, Clinical, Social and Mental Health measures would deliver an Aged Care System that Australians can be proud of.

The current AN-ACC model is an activity-based funding built on the premise of care minutes and in the interim could be improved by implementing an Activity Based Funding model that delivers care outside of personal care and nursing e.g. Allied Health, Dental, Diet etc.

Improving the IHACPA five-year vision

The IHACPA five-year vision should include the following:

- A vision to implement a set outcome Key Performance Indicators for residents (e.g. resident satisfaction and quality of life indicators) within the five-year vision.
- A vision to research and develop by the end of the five years potential aged care pricing models that incentivise providers to provide holistic care to residents through outcome focused Key Performance Indicators e.g. resident satisfaction and quality of life indicators.
- A pricing model that ensures that there is no geographic or cultural divide in the provision and accessibility of residential aged care.

Future markets of success for the residential aged care price

There are a number of markers which would indicate success in residential aged care pricing and funding models, including:

- Improved resident outcomes including resident satisfaction and quality of life indicators.
- The removal of consideration of resident care needs/classification from financial decision making. This would remain relevant for care and support purposes.
- Increased provider and sector capacity to provide care and support services, indicating improved effectiveness of residential aged care investment.
- Alignment of funding drivers with targeted sector outcomes and removal/reduction of incentivised inputs (e.g. care minutes).
- Improved provider and sector sustainability and viability and a reduction in financial performance driven service closures/rationalisation.
- Innovation and continuous improvement in operating models, leading to improved resident

outcomes, sector efficiency and effectiveness.

- Increased attractiveness of investment in thin markets, regional & remote and specialised services, in addition to residential aged care more generally.

In all cases, resident outcomes should be primary in measuring the success of any aged care pricing and funding model. The above principles apply equally to all aged care pricing and funding models, including community aged care services. A failure to improve resident or care recipient outcomes is a clear and absolute indicator of an ineffective model, be that funding, operating or regulatory, and primary consideration needs to be given to how drivers of pricing decisions and funding models incentivise and create priority for the sector level outcomes of providing improved quality of life for all within the aged care system.

Appendix 1: Submission by Question Number

Answers highlighted in grey indicate answers provided across multiple questions for context

Q1. 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?

Background: residential aged care

When people think of residential aged care, they think of people playing cards around the table, enjoying their golden years. The reality couldn't be further from the truth and in fact should envision a resident in a hospital bed. The interesting thing is this dynamic is recent, in 2009-2010 the Open Gen Data from the Australian Institute of Health and Welfare showed that senior Australians entering the Residential Aged Care system saw only 1 in 25 residents categorised as high needs across the three criteria. In 2020-2021 it was over 1 in 3 residents. The 2020-2021 data also showed the median stay in aged care was 24 months with 25% of residents staying less than 8 months noting the dominant reason for permanent exits of residential aged care (84% in 2020-2021) was death.[7]

With an ageing population in Australia, one would think that residential aged care is a booming industry. The data shows a declining trend over the last four years with negative growth in residents in 2020-2021. Indeed, the latest StewartBrown March 2022 report (based on data from 1,282 facilities – 47% of the residential aged care sector) showed that occupancy for residential aged care homes was at 90.1% compared to occupancy in 2011 of 93.1%.[8] In 2020 the Aged Care Royal Commission noted that "Only 25% of older people would prefer to live in a facility should they need care".[9]

This means residential aged care providers are facing a tough financial choice as the market is not growing. Residential facilities as built as recently as ten years ago are not fit for purpose due to the increased needs of senior Australians whilst also facing increasing regulatory burdens. This was evidenced through the StewartBrown March 2022 report that over 38% of residential providers were making a cash loss and 64% of providers were making an operating loss.[2]

Residential aged care funding

Residential aged care providers receive three heavily regulated Federal streams of revenue: Basic Daily Care Fee, Residential Accommodation Payments and the ACFI/AN-ACC care payment which the Means Tested Care Fee offsets for those who are financially secure. Additionally, many providers charge additional services fees which is loosely regulated (for UnitingCare Queensland our services fee is immaterial). Diagram 1 summarises an aged care providers funding (revenue) sources.

[7] https://www.gen-agedcaredata.gov.au/Resources/Access-data/2022/July/GEN-data-Admissions-into-aged-care

[8] https://www.stewartbrown.com.au/images/documents/StewartBrown_-_Aged_Care_Financial_Performance_Survey_Sector_Report_March_2022.pdf

[9] Page 33, https://agedcare.royalcommission.gov.au/sites/default/files/2020-07/research_paper_4_-_what_australians_think_of_ageing_and_aged_care.pdf

The Basic Daily Care Fee is a misleading name and is actually meant to represent the basic living costs of the resident that IHACPA and many in Government refer to as 'hotel' costs. This fee is meant to cover basic daily living costs such as food, cleaning and other basic amenities required to live. It is set at 85% of the aged pension which equates to roughly $45 / day. This cost is paid directly by the resident to the aged care provider either directly or through a deduction of the aged pension (Federal Government payment). In 2021, the Federal Government recognised that this figure was too low and provided a $10 / day supplement (subsidy) to providers. This total spend more closely aligns to the direct cost (excluding overheads) of providing these services.

The Residential Accommodation Payment is considered to fund the type and quality of the accommodation provided to the resident. There are actually four different ways in which this payment is seen by the resident depending on whether the resident is low means or not. If the resident qualifies as low means, they will be eligible to receive a contribution (possibly a full Government contribution) from the Federal Government and can choose to pay either or a combination of (regularly charged) a Daily Accommodation Contribution amount and/or pay a lump sum through a Refundable Accommodation Contribution. For those residents who don't meet the eligibility they are required to pay either or a combination of (regularly charged) a Daily Accommodation Payment amount and/or pay a lump sum through a Refundable Accommodation Deposit (RADS). Providers are regulated with the Aged Care Pricing Commissioner approval required for RADS above $550,000.

The third stream which is the primary topic of conversation for this consultation is the care payments that age care providers receive from the Federal Government. Prior to 1 October 2022 this was known as the Aged Care Financing Instrument (ACFI) and 1 October 2022 it now known as the Australian National – Aged Care Classification (AN-ACC) payment. The

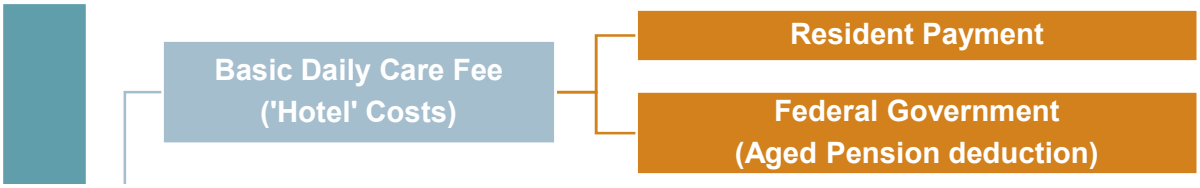
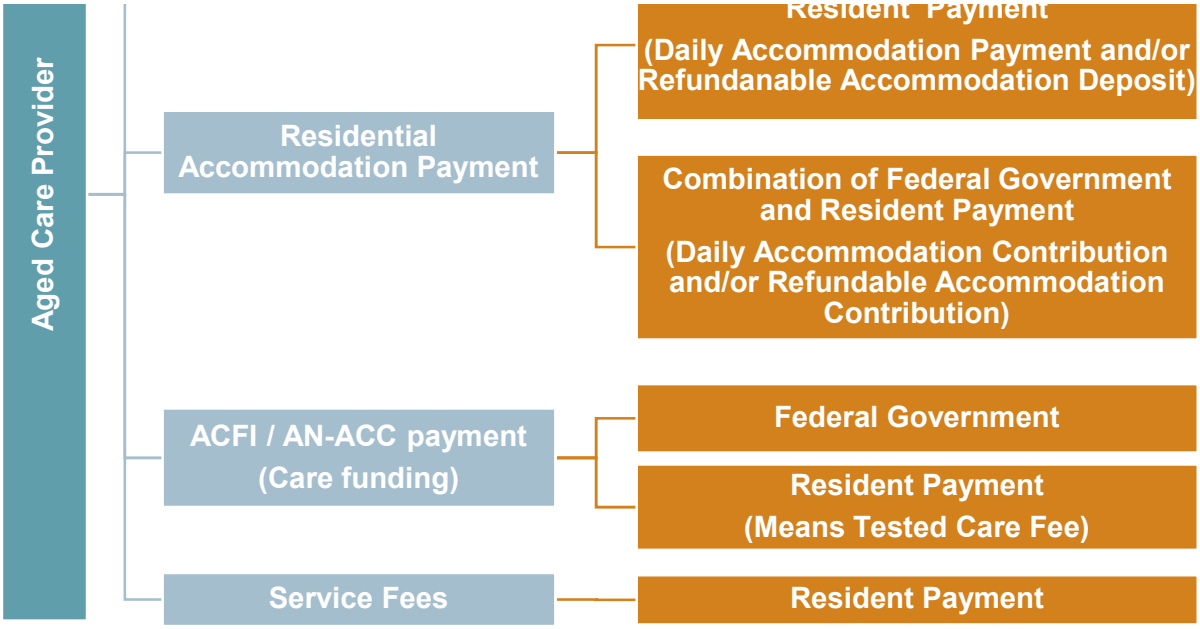


Diagram 3: Residential aged care funding (revenue sources)



ACFI/AN-ACC is meant to represent the cost caring for aged care residents with well-off residents required to pay a part of this care payment through the Mean Tested Care Fee. The vast majority of funding for age care residents is provided for under this payment.

Many aged care providers also choose to charge age care residents a 'service' fee for any additional services that they consider above and beyond what should be provided by the three funding arrangements. There is a lack of transparency and comparability of what these 'service' fees cover and how they compare with other providers.

UnitingCare Queensland's submission recommends that these streams of revenue should be bundled up into a singular fee amount to reduce the complexity for residents and their families and a three-tiered structure of services created to give transparency and accountability. By simplifying the way in which funding for aged care works and what age care providers charge, residents can more easily compare providers whilst placing less stress and complexity in working out the financial implications. As a provider, the three different streams of funding can create cultural internal barriers and silos to reallocating resources effectively and efficiently. We look forward to engaging with IHACPA in making residential aged care a simpler and better place.

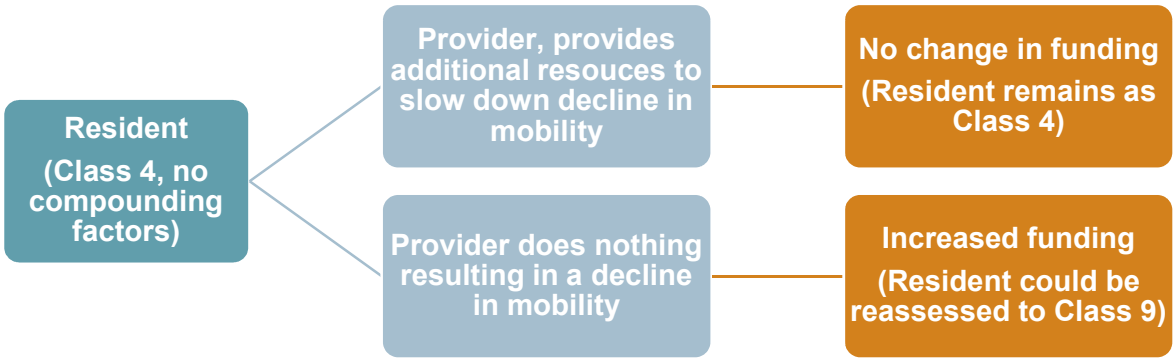
AN-ACC and the care minute requirements – A fundamental flaw

The AN-ACC model is based on the National Weighted Activity Unit that defines a level of care provision dependent on the classification of a resident. The AN-ACC was largely designed before a care minute requirement existed in residential aged care and does not have any mechanisms built in to manage the significant unintended consequences of this new requirement under the new funding model.

While AN-ACC was designed to incentivise re-enablement and maintain independence for residents as long as possible, the care minute requirement focused on personal and nursing care creates a labour input regulation. Alongside fixed and variable case mix pricing, this regulation limits the ability of providers to flexibly use their resources to deliver multidisciplinary, outcomes focused care to access these incentives.

Fundamentally, this is a flawed way in which a resident should be funded for care as it removes the reward a provider for re-enablement and /or slowing any decline in a person's health. Indeed, the funding models has more in common with a institutionalised funding model then a model of care. With the addition of the care minute requirements, the AN-ACC now incentives a decline in health as more funding would be received by the provider if

Diagram 6: AN-ACC funding disincentive example – slowing a decline in mobility



a resident's health declines in such a way to be given a higher funding classification noting that there is a correspondingly higher care minute requirement. At best, a provider that re-enables a person's health to a lower level of funding classification will keep the current classification funding. No reward is given to a provider that prevents / slows down a decline in health (refer to Diagram 6). This is exactly what AN-ACC was trying to move away from when transitioning from ACFI, and it needs to be addressed as a priority.

The care minute requirement is currently leading many providers to cost-optimise their operations through considering what is the 'best' classification to take that balances the revenue (funding) and cost (care minutes) of that classification.

Certainly, one of the unintended consequences of AN-ACC and the care minute requirement will be reduced choice for residents. Providers will maximise their revenue based on current operations to cherry pick the right classification/s to enter their facility that does not cause significant or new labour costs especially given the ongoing workforce issues providers are facing. Diagram 7 provides a simple example of what decisions a provider faces now under the AN-ACC model.

Additionally, as the care minutes are also a regulatory requirement and form part of how facilities are publicly star rated, there has been a focus by most providers to ensure they meet their targets. This has further unintended consequences of resources being moved to Personal Carers

Diagram 7: AN-ACC provider decision making example

(lowest cost level of staff for a care minute) and Registered Nurses (other care minute requirement) to ensure sufficient staffing to meet these targets. As noted by the Allied Health Professional Associations in Community Affairs Legislation Committee hearing on the Implementing Care Bill,[10] many providers are cutting spending in other areas in order to boost their Personal Carer and Registered Nurse staffing hours.

Nurses and carers deliver excellent care, however specialist services beyond a nurse or personal carer's skillset are required to maintain a resident's health. Dental services, Allied Health (e.g. physio therapy) amongst other specialist services are required to ensure that a resident's well-being and physical health is maximised.

Physical wellbeing is not the only outcome people want for themselves as they age. Maintaining connection with family and friends, having things to do that are meaningful, working through grief to find peace, experiencing joy and laughter everyday are all important outcomes for residents. These are all part of the care picture and require a range of people with the right mix of skills in the right workplace culture to be achieved. The current funding model with a care minute requirement does not support holistic care nor the full breadth of high quality, rights-based care that the new Act and the new standards will demand.

The AN-ACC does not have a strong financial mechanism to reward 'good'/quality care by provider

Consistency of Assessments

Consistent assessments are critical in ensuring that funding is fairly delivered and residents receive the care that they deserve. Due to compressed rollout timeframe of AN-ACC and the hiring freeze of the previous Government, a significant number of assessments were outsourced to private providers resulting in an inconsistent application of the classification standard. For the re-assessments requested, we saw a re-classification of residents that will see a positive and material funding uplift.

Moving An-ACC to an Activity Based Funding Model

We note that AN-ACC can already be considered an Activity Based Funding model given it provides funding to Age Care providers based on the activity of care (measured through care minutes).

As noted early this is not ideal way of measuring care. Unlike Hospitals that provide a clear activity (operation) which is supported by ancillary services such as a number of Hospital Bed Days and / or Intensive Care Unit admission, the purpose of Aged Care is to provide continuous care to enable people to live life to their fullest as they age. This means providing holistic, individualised care to a resident, meeting their physical and wellbeing needs.

Serious consideration needs to be given to first define what outcomes are sought before deciding on what an Activity Based Funding Model looks like. Given the deficiencies of the focus on care minutes in the current AN-ACC system, an interim Activity Based Funding Model that complements the current funding model to ensure that key parts of the holistic care are provided to residents should be implemented in the interim. In the long-term an outcome focused funding model should be developed and implemented.

We support the introduction of outcomes into the National Aged Care Quality Care

[10] https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=COMMITTEES;id=committees%2Fcommsen%2F26028%2F0004;query=Id%3A%22committees%2Fcommsen%2F26028%2F0000%22

Indicators program as an important first step.

AN-ACC as an Efficient, Sustainable and Safe model of funding

The context of all three words is essential to defining the answer. From a financial point of view (some would argue the Government's Departmental point of view):

- Efficient: the AN-ACC system is financial efficient in the same way the institutionalised model of funding works, i.e. receiving funding by type (class);
- Sustainable: Financially sustainable given that the rate can be easily adjusted to the financial environment;
- Safe: AN-ACC is Financially safe given there is a low risk of fraud (due to independent assessments and the payment mechanism) and safe through compliance.

In the long run AN-ACC will deliver a system that will in the end likely lead to another Royal Commission because of a focus on compliance and cost-cutting (financial efficiency), without regard for resident outcomes. We support the introduction of outcomes into the National Aged Care Quality Care Indicators program as an important first step.

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The current AN-ACC model is an activity-based funding built on the premise of care minutes and in the interim could be improved by implementing an Activity Based Funding model that delivers care outside of personal care and nursing e.g. Allied Health, Dental, Diet etc.

Q2. 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 and the care minute requirements – A fundamental flaw

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While AN-ACC was designed to incentivise re-enablement and maintain independence for residents as long as possible, the care minute requirement focused on personal and nursing care creates a labour input regulation. Alongside fixed and variable case mix pricing, this regulation limits the ability of providers to flexibly use their resources to deliver multidisciplinary, outcomes focused care to access these incentives.

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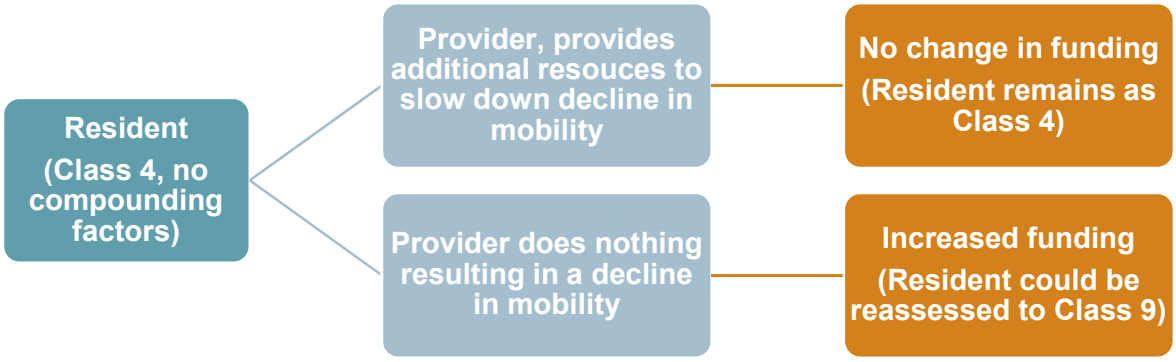

incentives a decline in health as more funding would be received by the provider if a resident's health declines in such a way to be given a higher funding classification noting that there is a correspondingly higher care minute requirement. At best, a provider that re-enables a person's health to a lower level of funding classification will keep the current classification funding. No reward is given to a provider that prevents / slows down a decline in health (refer to Diagram 6). This is exactly what AN-ACC was trying to move away from when transitioning from ACFI, and it needs to be addressed as a priority.

The care minute requirement is currently leading many providers to cost-optimise their operations through considering what is the 'best' classification to take that balances the revenue (funding) and cost (care minutes) of that classification. Certainly, one of the unintended consequences of AN-ACC and the care minute requirement will be reduced choice for residents. Providers will maximise their revenue based on current operations to cherry pick the right classification/s to enter their facility that does not cause significant or new labour costs especially given the ongoing workforce issues providers are facing. Diagram 7 provides a simple example of what decisions a provider faces now under the AN-ACC model.

Additionally, as the care minutes are also a regulatory requirement and form part of how facilities are publicly star rated, there has been a focus by most providers to ensure they meet their targets. This has further unintended consequences of resources being moved to Personal Carers

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AN-ACC as an Efficient, Sustainable and Safe model of funding

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In the long run AN-ACC will deliver a system that will in the end likely lead to another Royal Commission because of a focus on compliance and cost-cutting (financial efficiency), without regard for resident outcomes.

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The current AN-ACC model is an activity-based funding built on the premise of care minutes and in the interim could be improved by implementing an Activity Based Funding model that delivers care outside of

[11] https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=COMMITTEES;id=committees%2Fcommsen%2F26028%2F0004;query=Id%3A%22committees%2Fcommsen%2F26028%2F0000%22

personal care and nursing e.g. Allied Health, Dental, Diet etc.

Q3. What, if any, additional factors should be considered in determining the AN-ACC national weighted activity unit (NWAU) weightings for residents?

AN-ACC and the care minute requirements – A fundamental flaw

The AN-ACC model is based on the National Weighted Activity Unit that defines a level of care provision dependent on the classification of a resident. The AN-ACC was largely designed before a care minute requirement existed in residential aged care and does not have any mechanisms built in to manage the significant unintended consequences of this new requirement under the new funding model.

While AN-ACC was designed to incentivise re-enablement and maintain independence for residents as long as possible, the care minute requirement focused on personal and nursing care creates a labour input regulation. Alongside fixed and variable case mix pricing, this regulation limits the ability of providers to flexibly use their resources to deliver multidisciplinary, outcomes focused care to access these incentives.

Fundamentally, this is a flawed way in which a resident should be funded for care as it removes the reward a provider for re-enablement and /or slowing any decline in a person's health. Indeed, the funding models has more in common with a institutionalised funding model then a model of care. With the addition of the care minute requirements, the AN-ACC now incentives a decline in health as more funding would be received by the provider if a resident's health declines in such a way to be given a higher funding classification noting that there is a correspondingly higher care minute requirement. At best, a provider that re-enables a person's health to a lower level of funding classification will keep the current classification funding. No reward is given to a provider that prevents / slows down a decline in health (refer to Diagram 6). This is exactly what AN-ACC was trying to move away from when transitioning from ACFI, and it needs to be addressed as a priority.

The care minute requirement is currently leading many providers to cost-optimise their operations through considering what is the 'best' classification to take that balances the revenue (funding) and cost (care minutes) of that classification. Certainly, one of the unintended consequences of AN-ACC and the care minute requirement will be reduced choice for residents. Providers will maximise their revenue based on current operations to cherry pick the right classification/s to enter their facility that does not cause significant

Diagram 6: AN-ACC funding disincentive example – slowing a decline in mobility

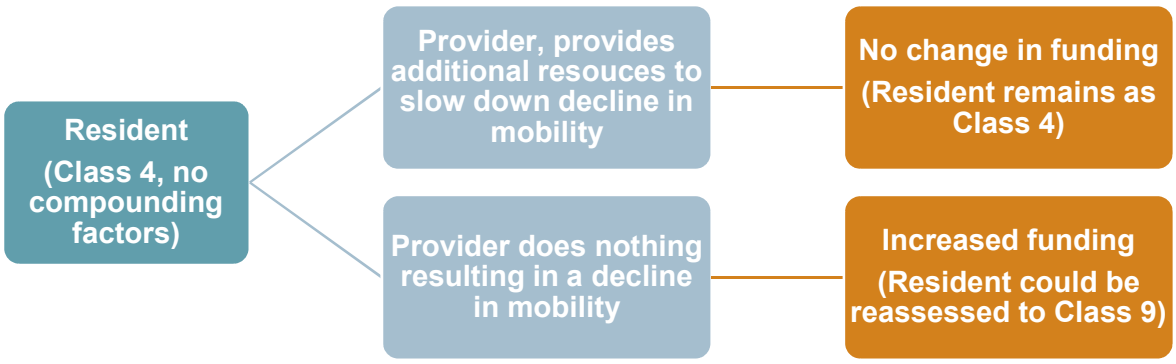

Diagram 7: AN-ACC provider decision making example

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Nurses and carers deliver excellent care, however specialist services beyond a nurse or personal carer's skillset are required to maintain a resident's health. Dental services, Allied Health (e.g. physio therapy) amongst other specialist services are required to ensure that a resident's well-being and physical health is maximised.

Physical wellbeing is not the only outcome people want for themselves as they age. Maintaining connection with family and friends, having things to do that are meaningful, working through grief to find peace, experiencing joy and laughter everyday are all important outcomes for residents. These are all part of the care picture and require a range of people with the right mix of skills in the right workplace culture to be achieved. The current funding model with a care minute requirement does not support holistic care nor the full breadth of high quality, rights-based care that the new Act and the new standards will demand.

The AN-ACC does not have a strong financial mechanism to reward 'good'/quality care by provider

The Basis of AN-ACC: National Weighted Activity Unit

There is no detailed or clear information on how the current National Weighted Activity Unit (NWAU) weightings have been established and it is a cost prohibitive exercise for providers to determine if they

[12] https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=COMMITTEES;id=committees%2Fcommsen%2F26028%2F0004;query=Id%3A%22committees%2Fcommsen%2F26028%2F0000%22

are reasonable. This makes it difficult to provide a fully informed view.

UnitingCare recommends publishing the calculation of the National Weighted Activity Unit as an important first step in building a reputation for transparency and trust with the industry.

The NWAU fixed component weightings do not appropriately address the impact of service size on delivery cost relative to other factors. For services with less than 45 occupied beds, the ability to establish economies of scale in direct and indirect staffing, care, hotel services, accommodation and administration costs significantly diminishes when compared with services with higher occupied bed numbers. The former Scheme for the Viability supplement recognised on a sliding scale that residential facilities with less than 45 occupied beds faced increased overheads. This impact is independent of location or Modified Monash Model (MMM) classification.

Additionally, the NWAU weightings are, by design, detached from resident outcomes and therefore perpetuate a focus and prioritisation of cost and input drivers rather than outputs and outcomes which are delivered. An application of NWAU which directly considers resident outcomes will promote and support improved resident experience and increased investment and development in where positive outcomes are being achieved. In turn, this would incentivise achievement of resident-based outcomes rather than providing financial incentive for achievement of certain classifications of residents within certain AN-ACC classes and achievement of input-based measures such as care minutes which do not directly represent achievement of resident outcomes.

Residential Aged Care is about delivering holistic care to residents. An outcome focused funding model is the right funding model because it will deliver flexible and individualised care. AN-ACC was originally created with this in mind. The removal of the care minute requirement and replacement with a resident outcome focused Key Performance Indicators such as Quality of Life, Clinical, Social and Mental Health measures would deliver an Aged Care System that Australians can be proud of.

The current AN-ACC model is an activity-based funding built on the premise of care minutes and in the interim could be improved by implementing an Activity Based Funding model that delivers care outside of personal care and nursing e.g. Allied Health, Dental, Diet etc.

Q4. What should be considered in developing future refinements to the AN-ACC assessment and funding model?

AN-ACC and the care minute requirements – A fundamental flaw

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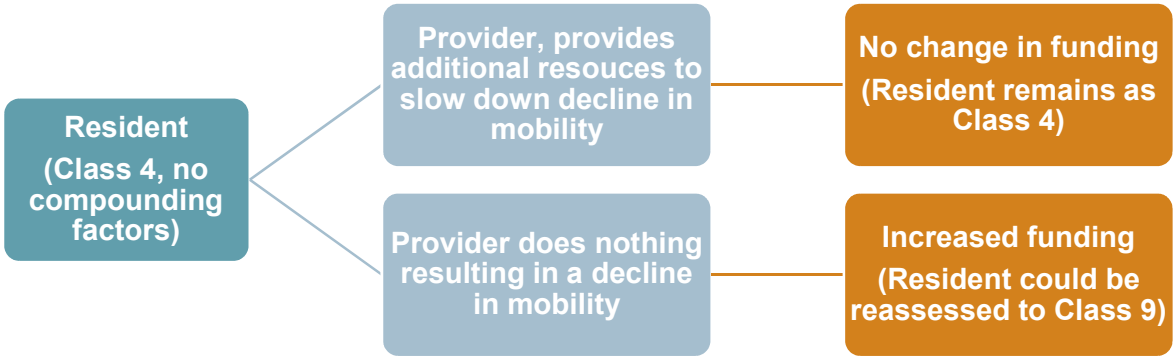

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Improving the AN-ACC Model

We agree with the Authority's view that given the current changes in aged care, any adjustments for quality and safety issues be considered in the long-term development path. Any reference points for future adjustments should be based on measures that genuinely reflect care and quality outcomes. Monitoring and evaluating the effectiveness of the National Aged Care Quality Indicators Program is an important first step in this and we welcome the recently announced new indicators that include customer experience and quality of life measures.

Quality of life is a critical quality indicator in aged care, as person-centred care focuses on individualised and holistic psychosocial outcomes alongside clinical outcomes. However, time is needed for implementation and review of the new measure before it can be considered in a funding adjustment context.

Consideration should also be given if adjustments will be used simply to remove funding or to incentivise certain outcomes by providing additional funding. We note that the original intention of the AN-ACC model was to incentivise reablement approaches by allowing providers to retain funds should people's function be improved, and they need less support. Unfortunately, the introduction of the care minutes requirement is likely to severely limit the impact of this for the reasons previously described.

Residential Aged Care is about delivering holistic care to residents. An outcome focused funding model is the right funding model because it will

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Q5. 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?

IHACPA Pricing Principles

What the principle are and how the Authority acts on them are an important part of gaining trust with Government and the aged care industry. The five proposed overarching principles of: access to care; quality care; fairness; efficiency and; maintaining agreed roles and responsibilities are good overarching principles.

Underlying the overarching principles are the process principles of administrative ease; stability; evidence-based and; transparency are welcome principles. The commitment to transparency could also be an overarching principle, as it is imperative for building trust.

These process principles are complemented by the system design principles of: fostering care innovation, promoting value, promoting harmonisation, minimising undesirable and inadvertent consequences; Activity Based Funding pre-eminence and; recipient based are good design principles however we suggest that an outcomes of residents should be a specific design focus.

Q6. What, if any, additional principles should be included in the pricing principles for aged care services?

As we move to a rights-based Aged Care Act, further thought could be given to an additional rights-based principle or a rearticulation of existing ones from that perspective. For example: right to access aged care that upholds dignity and respect and is available to people in home, a home-like environment, or in the community.

The inclusion of a home-like environment in this example serves to highlight that residential aged care is very different from hospital-based care. Residential aged care is a person's home. They live there permanently and have security of tenure. The care to support them in their home, in a way that upholds their dignity, requires more than a transactional model more commonly experienced in hospitals. Achieving this requires a rights-based, person-centred approach i.e. holistic care. From our perspective, holistic care aims to:

- Understand and respect a person's values, past experiences, preferences and expressed needs
- Coordinate and integrate care
- Communicate information and educate
- Maintain physical comfort
- Offer spiritual and emotional support
- Alleviate fear and anxiety
- Involve family and friends
- Transition well with continuity of care
- Provide access to care

This approach requires multidisciplinary teams with strong person-centred cultures, who bring together psychosocial and

clinical care on equal footing. This has a range of implications for how to best understand and cost quality aged care services.

Q7. What, if any, issues do you see in defining the overarching, process and system design principles?

The proposed principles generally provide a good framework for analysis and decision-making needed in the Authority's work. They do however highlight some underlying tensions that will need to be negotiated. There is a long history of funding decisions and pricing in aged care being made strongly in favour of efficiency, rather than quality or access. Pricing methodologies were also rarely publicly available. This pattern of funding decisions was made on what Government is willing to pay rather than individual and community need as was observed and documented in detail by the Aged Care Royal Commission.

In recent years, the aged care environment has been one of downward price adjustments, pricing freezes, and below CPI indexation alongside increasing regulatory requirements and consumer expectations. This has created a tough environment for providers and creates challenges for the Authority to negotiate a fair and equitable price for aged care services as there is no clear sense of what is currently funded versus the true cost of service delivery.

The proposed principles will serve as a guide through this, however further thought will need to be given around how they will be weighed against each other when determining price and how this will be made clear and transparent when there are considerable tensions between an elected Government's priorities and delivering quality aged care.

Q8. What, if any, concerns do you have about this definition of a residential care price?

The current definition of the Residential Care Price provides a very narrow view of what care is and what care should be funded. Providing residential aged care is a holistic exercise that includes both the physical and medical care needs covered under AN-ACC (noting that both the physical and medical care is narrowly defined and should cover allied health, dental, GP visits etc.) as well as providing psychosocial support, a sense of community, meaningful activity (both physical and mental) and a base level of what has been defined as hotel costs (accommodation, cleaning and food). By taking such a narrow view of care, the aged care price will not deliver holistic care for residents.

Q9. What, if any, additional aspects should be covered by the residential aged care price?

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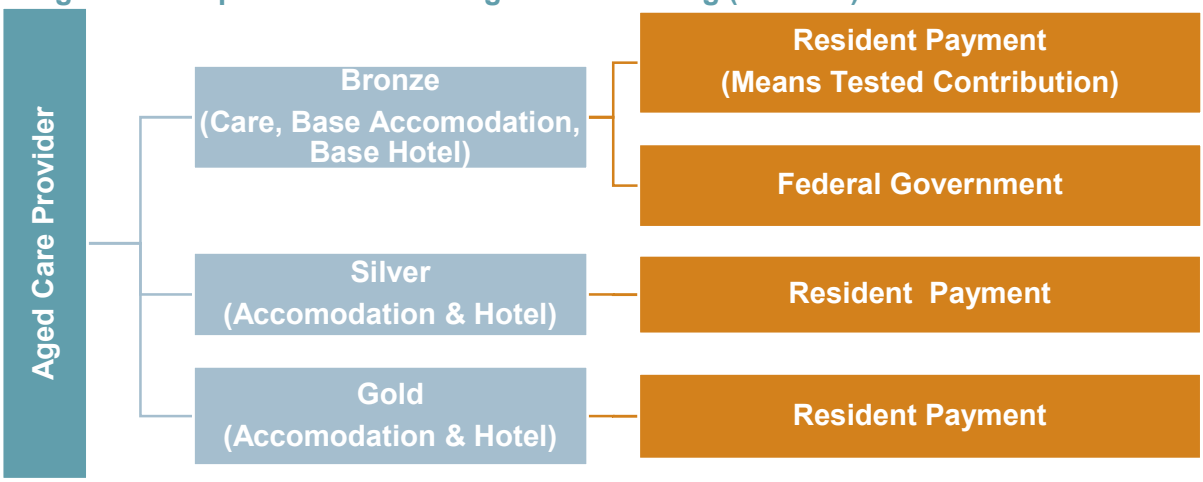
Diagram 4: Proposed residential aged care funding (revenue) sources



A residential aged care price should incorporate the following factors:

- factors required to deliver a base level of care to residents such as minimum standards of cleaning, food and accommodation as well as medical, dental and allied health care
- A 'reward' for providers who achieve strong outcomes for residents
- Be a universal price that delivers a base level of care i.e. residents pay additional fees to receive extra hotel and accommodation services in a clear transparent standard (silver and gold) see Diagram 4
- IHACPA cannot exclude out accommodation payments as they help contribute to a base level of care
- There is also a need for a Regulator to set a transparent standard for accommodation payments so residents can accurately compare providers

Q10. What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?

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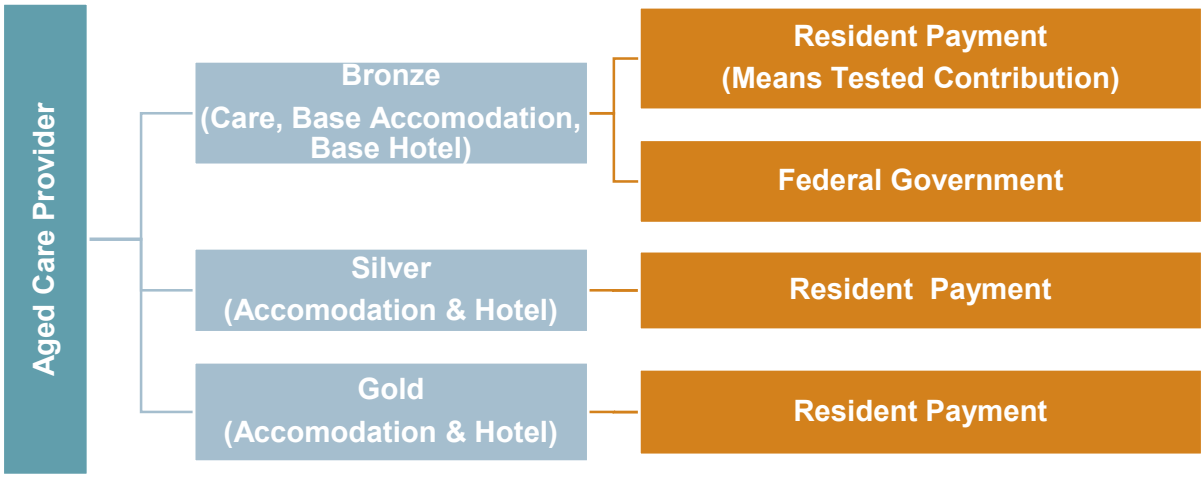

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In the long run the proposed pricing approach will deliver a pricing level that will likely lead to another Royal Commission because of a focus on compliance and cost-cutting (financial efficiency) without regard for the outcomes of the resident.

Q11. 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?

Cost-Based vs Best Practice Pricing

Residential Aged Care is about delivering holistic care to residents. An outcome focused funding model is the right funding model because it will deliver flexible and individualised care. The current AN-ACC model is an activity-based funding model with the case mix driving the delivery of care minutes. Whether a cost-based or best practice pricing approach is used, the current and proposed approaches miss the point which is that residential aged care pricing should drive outcomes for residents.

Achieving holistic care for residents can be achieved through a cost-based pricing structure if it encourages providers to be innovative and efficient in delivering their services. In order to encourage innovation and efficiency, IHACPA needs to consider what is the outcomes that it wishes to measure for resident wellbeing and quality of life and make those a key driver of funding. It could also be achieved through a

best practice pricing approach that rewards best practice behaviour whilst also providing room for other providers to catch-up.

UnitingCare Queensland notes that currently the AN-ACC funding model is driving a 'best practice' approach to care minutes by targeting a level of care minutes beyond what StewartBrown estimated is currently provided for (for UnitingCare Queensland we have some sites over and under these requirements). Furthermore, the focus on Care minutes causes detriment residents as other possible expenditures that might dollar for dollar significantly improve the quality of life and health of residents are lost to the focus on care minutes.

In order to break the cycle of chronic underfunding, an outcomes focused funding approach based on the best practice funding model in the short-medium term is required. This could then eventually be moved to a cost-benefit approach as a cost-based approach may disadvantage certain outcomes.

Q12. What should be considered in the development of an indexation methodology for the residential aged care price?

Indexation of the Residential Aged Care Price

Methodology for indexation in residential aged care pricing requires consideration of factors across a broad range of areas, including:

- Level of achievement of resident outcomes being delivered. The ability for providers to achieve targeted and expected levels of resident outcomes is impacted significantly by the funding model. Additionally, consideration of indexation decision-making needs to consider the ability of providers to achieve such outcomes under any pricing revision.
- Achievement of, and changes to, consumer, market and community expectations of care and support services provided. The ability for providers to deliver care and support services in line with or above expectation is impacted significantly by the funding model and consideration in indexation decision making needs to be given to the current state of delivery against expectation and also evolving and changing levels of expected care and support provision.

Movement in service delivery costs including:

- Wage rate movements with reference to minimum wage, award rates and market rate movements with particular reference to health, care and support industries.
- Goods and services inflation rates and market price movements with reference to health/care provision, hotel services and accommodation provision categories. Consideration may also be required where state-based movements materially vary from national movements.
- Other cost drivers including freight and transport, supply chain/demand factors and availability and accessibility of labour, goods and services where premium prices may be required to ensure continuity of real time service delivery.
- Evolution and development of operating models and processes and investment required to ensure appropriate continued progression, including contemporary and newly developed care and support practices and technological advancement including assistive technologies.
- Appropriate and necessary maintenance and replacement of care and support related equipment, assets and

technology in addition to and separate from accommodation and living environment equipment, assets and technology.

- Innovation and improvement development needs and opportunities to support continuous improvement in resident outcomes, operating models and sector efficiency and effectiveness.

The findings of the Royal Commission into Aged Care Quality & Safety identifying systemic under funding compounded through decades of insufficient indexation application leading to an estimated ~$9.6b in under funding in 2019 support the critical need to consider indexation with appropriate reference to targeted goals and outcomes and input cost drivers.

Q13. What, if any, additional issues do you see in developing the recommended residential aged care price?

AN-ACC and the care minute requirements – A fundamental flaw

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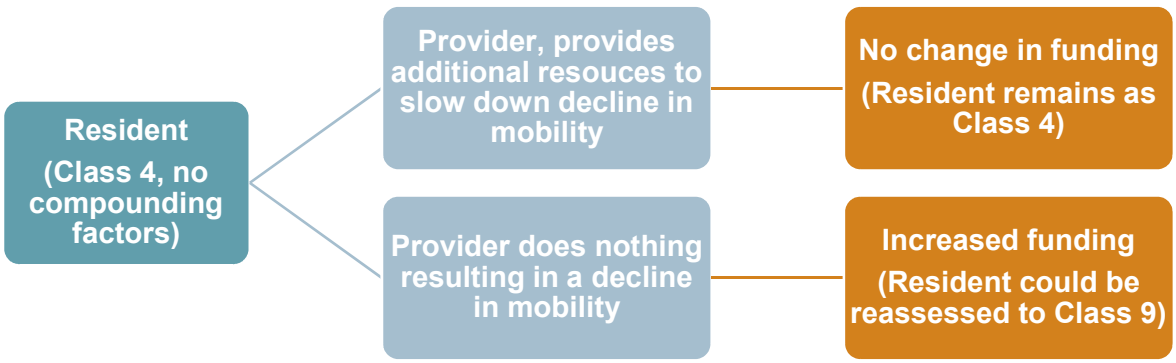

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Additional Issues in Developing a Recommended Residential Aged Care Price

Establishing a pricing methodology and funding model which incentivises and recognises resident outcomes will support improved sector focus on the primary objective of the residential aged care system to provide improved quality of life for residents.

Ensuring the primary focus of funding is inextricably linked to resident quality of life outcomes will support industry level focus on outcomes and remove current systemic barriers. Examples of these barriers are financially incentivising service delivery to particular resident cohorts/classifications and giving primacy to the number of care minutes rather than the resident outcomes such care minutes are assumed to provide. We support the introduction of outcomes into the National Aged Care Quality Care Indicators program as an important first step.

A model under which genuine resident outcomes are the primary provider deliverable (reflected in the funding model's pricing structure and decision making, will address many aspects of residential aged where challenges are currently faced (e.g. quality, safety, community return on investment and innovation).

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Q14. What, if any, changes are required to the proposed approach to adjustments?

The NWAU fixed component weightings do not appropriately address the impact of service size on delivery cost relative to other factors. For services with less than 45 occupied beds, the ability to establish economies of scale in direct and indirect staffing, care, hotel services, accommodation and administration costs significantly diminishes when compared with services with higher occupied bed numbers. The former Scheme for the Viability supplement recognised on a sliding scale that residential facilities with less than 45 occupied beds faced increased overheads. This impact is independent of location or Modified Monash Model (MMM) classification.

Providing Age Care in Regional Australia

The RUCS findings (2019)[15] and adjustments were developed before the COVID-19 pandemic and have not accounted for the significant social and

[15] https://www.health.gov.au/resources/publications/resource-utilisation-and-classification-study-rucs-reports

demographic changes encountered since then. Australian cities, towns and regions are facing significant upheaval due to reduced immigration and many Australians are making sea-change/tree-change decisions due to Work From Home and flexible working arrangements that many organisations offer. In the past, organisation have been able to convince staff to move to these regions because of their lower cost of living.

Since the COVID-19 pandemic, the cost of living in regional regions (MMM1 – MMM4) has been impacted by significant accommodation shortages, increasing house and rental prices. This has left many aged care providers, including UnitingCare Queensland, contemplating expanding staff accommodation arrangements to workers beyond the remote areas (MMM5 - MMM7) to continue to providing residential aged care outside of the major city regions. Anecdotally, we have heard of other providers converting former residential aged care facilities into staff accommodation.

The increased costs in staff accommodation are in addition to increased freight costs due to the supply chain disruptions and significantly increased fuel and staff costs. These regions have also faced increased Agency Labour costs on a like for like basis when compared to MMM1 regions. In a major regional city centre (MMM1), the accommodation costs paid for agency staff outstrips the actual cost the agency staff. Age care providers in major (capital) cities do not usually pay for accommodation for agency staff. We also note in these regional areas the costs of obtaining contractors are also substantially higher than major city areas due to the travel time and costs for them to go to these areas. These difference in costs will be able to be calculated using standard examples and extrapolating the aggregated data provided in the QFR and other information requests.

Under the current model and proposed AN-ACC model, age care providers will be forced to absorb (or abandon) sites in regional MMM1 – MMM4 regions due to the increased cost of construction. The increased cost of construction in these MMM1 – MMM4 region is well known with Insurers providing a building cost uplift for these regional and rural areas due to the limited supply of labour and increased freight costs. The uplift factors can be commercially purchased.

A review of the costs of providing care in MMM1 – MMM4 regions compared to an major (capital) city region is urgently required to address the funding deficit faced by these communities.

In addition to the facilities in MMM1 - MMM4 regions needs, the cost to provide services in the tropical parts to Australia sees a significant increase in the costs of providing services and in particular aged care services. For simplicity, we have defined tropical parts of Australia as those North of the Tropic of Capricorn and close to the coastline. These additional costs include:

- Construction of buildings to a cyclone rated standard and consequentially the increased cost to insure these buildings
- Increased cooling costs as air-conditioners are often required to run 24/7 throughout the year to keep a comfortable temperature with residents resulting in significantly increased maintenance, energy and capital costs
- Increased maintenance, repair and replacement costs to maintain gardens, buildings and equipment due to the tropical environment where there is increased plant

growth, mould, rust and other environmental factors.

These costs can be accurately measured using the comparable costs incurred by organisations between the regions.

The AN-ACC model also needs to have temporary uplift for areas that face temporary short-medium escalation of costs due to temporary economic factors. For example, the rapid cost escalation faced by local organisations in the mining regions of Broome, Port Headland, Darwin, Emerald, and Gladstone (amongst others) have seen the doubling and tripling of house prices and accommodation costs due to these temporary economic factors. Without a temporary uplift, many aged care providers might be forced to close during these periods further increasing upheaval in these communities. The temporary nature of these events means that a targeted data request of costs will be required with that evidence being compared to aggregate information for the period.

Q15. What, if any, additional adjustments may be needed to address higher costs of care related to resident characteristics?

Providing Specialised Residential Age Care Pricing

Providing specialised Aged Care is a complicated affair. We note that that certain severe behaviour resident cohorts can often require higher level of support e.g. 1:1 – high intensity services. We also note that facilities serving a large number of First Australians in non-MMM6-7 areas and/or Culturally and Linguistically Diverse populations should also receive a certain uplift in funding to recognise the increased costs of providing culturally appropriate services to residents These costs can be evidenced through the higher costs in staffing, food and accommodation requirements.

A review of the costs of providing care for severe behaviour residents, First Australian focus facilities in MMM1-MMM5 regions, and for Culturally and Linguistically Diverse facilities is urgently required to address the potential funding deficit faced by these groups

The following supplements should also form part of the AN-ACC classifications so that funding is from one source and therefore just an application of the funding instrument: oxygen, enteral feeding, veterans and hardship. This would reduce complexity by not having to do things across different mechanisms to ensure the whole amount of funding for a resident is secured. These additional costs are already evidenced through the Government schemes available.

Q16. What evidence can be provided to support any additional adjustments related to people receiving care?

Providing Specialised Residential Age Care Pricing

Providing specialised Aged Care is a complicated affair. We note that that certain severe behaviour resident cohorts can often require higher level of support e.g. 1:1 – high intensity services. We also note that facilities serving a large number of First Australians in non-MMM6-7 areas and/or Culturally and Linguistically Diverse populations should also receive a certain uplift in funding to recognise the increased costs of providing culturally appropriate services to residents These costs can be evidenced through the higher costs in staffing, food and accommodation requirements.

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Q17. What should be considered in reviewing the adjustments based on facility location and remoteness?

Providing Age Care in Regional Australia

The RUCS findings (2019)[16] and adjustments were developed before the COVID-19 pandemic and have not accounted for the significant social and demographic changes encountered since then. Australian cities, towns and regions are facing significant upheaval due to reduced immigration and many Australians are making sea-change/tree-change decisions due to Work From Home and flexible working arrangements that many organisations offer. In the past, organisation have been able to convince staff to move to these regions because of their lower cost of living.

Since the COVID-19 pandemic, the cost of living in regional regions (MMM1 – MMM4) has been impacted by significant accommodation shortages, increasing house and rental prices. This has left many aged care providers, including UnitingCare Queensland, contemplating expanding staff accommodation arrangements to workers beyond the remote areas (MMM5 - MMM7) to continue to providing residential aged care outside of the major city regions. Anecdotally, we have heard of other providers converting former residential aged care facilities into staff accommodation.

The increased costs in staff accommodation are in addition to increased freight costs due to the supply chain disruptions and significantly increased fuel and staff costs. These regions have also faced increased Agency Labour costs on a like for like basis when compared to MMM1 regions. In a major regional city centre (MMM1), the accommodation costs paid for agency staff outstrips the actual cost the agency staff. Age care providers in major (capital) cities do not usually pay for accommodation for agency staff. We also note in these regional areas the costs of obtaining contractors are also substantially higher than major city areas due to the travel time and costs for them to go to these areas. These difference in costs will be able to be calculated using standard examples and extrapolating the aggregated data provided in the QFR and other information requests.

Under the current model and proposed AN-ACC model, age care providers will be forced to absorb (or abandon) sites in regional MMM1 – MMM4 regions due to the increased cost of construction. The increased cost of construction in these MMM1 – MMM4 region is well known with Insurers providing a building cost uplift for these regional and rural areas due to the limited supply of labour and increased freight costs. The uplift factors can be commercially purchased.

16 https://www.health.gov.au/resources/publications/resource-utilisation-and-classification-study-rucs-reports

A review of the costs of providing care in MMM1 – MMM4 regions compared to an major (capital) city region is urgently required to address the funding deficit faced by these communities.

In addition to the facilities in MMM1 - MMM4 regions needs, the cost to provide services in the tropical parts to Australia sees a significant increase in the costs of providing services and in particular aged care services. For simplicity, we have defined tropical parts of Australia as those North of the Tropic of Capricorn and close to the coastline. These additional costs include:

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- Increased maintenance, repair and replacement costs to maintain gardens, buildings and equipment due to the tropical environment where there is increased plant growth, mould, rust and other environmental factors.

These costs can be accurately measured using the comparable costs incurred by organisations between the regions.

The AN-ACC model also needs to have temporary uplift for areas that face temporary short-medium escalation of costs due to temporary economic factors. For example, the rapid cost escalation faced by local organisations in the mining regions of Broome, Port Headland, Darwin, Emerald, and Gladstone (amongst others) have seen the doubling and tripling of house prices and accommodation costs due to these temporary economic factors. Without a temporary uplift, many aged care providers might be forced to close during these periods further increasing upheaval in these communities. The temporary nature of these events means that a targeted data request of costs will be required with that evidence being compared to aggregate information for the period.

Q18. What evidence can be provided to support any additional adjustments for unavoidable facility factors?

Providing Age Care in Regional Australia

The RUCS findings (2019)[17] and adjustments were developed before the COVID-19 pandemic and have not accounted for the significant social and demographic changes encountered since then. Australian cities, towns and regions are facing significant upheaval due to reduced immigration and many Australians are making sea-change/tree-change decisions due to Work From Home and flexible working arrangements that many organisations offer. In the past, organisation have been able to convince staff to move to these regions because of their lower cost of living.

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to continue to providing residential aged care outside of the major city regions. Anecdotally, we have heard of other providers converting former residential aged care facilities into staff accommodation.

The increased costs in staff accommodation are in addition to increased freight costs due to the supply chain disruptions and significantly increased fuel and staff costs. These regions have also faced increased Agency Labour costs on a like for like basis when compared to MMM1 regions. In a major regional city centre (MMM1), the accommodation costs paid for agency staff outstrips the actual cost the agency staff. Age care providers in major (capital) cities do not usually pay for accommodation for agency staff. We also note in these regional areas the costs of obtaining contractors are also substantially higher than major city areas due to the travel time and costs for them to go to these areas. These difference in costs will be able to be calculated using standard examples and extrapolating the aggregated data provided in the QFR and other information requests.

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communities. The temporary nature of these events means that a targeted data request of costs will be required with that evidence being compared to aggregate information for the period.

Q19. How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?

Improving the AN-ACC Model

We agree with the Authority's view that given the current changes in aged care, any adjustments for quality and safety issues be considered in the long-term development path. Any reference points for future adjustments should be based on measures that genuinely reflect care and quality outcomes. Monitoring and evaluating the effectiveness of the National Aged Care Quality Indicators Program is an important first step in this and we welcome the recently announced new indicators that include customer experience and quality of life measures.

Quality of life is a critical quality indicator in aged care, as person-centred care focuses on individualised and holistic psychosocial outcomes alongside clinical outcomes. However, time is needed for implementation and review of the new measure before it can be considered in a funding adjustment context.

Consideration should also be given if adjustments will be used simply to remove funding or to incentivise certain outcomes by providing additional funding. We note that the original intention of the AN-ACC model was to incentivise reablement approaches by allowing providers to retain funds should people's function be improved, and they need less support. Unfortunately, the introduction of the care minutes requirement is likely to severely limit the impact of this for the reasons previously described.

Residential Aged Care is about delivering holistic care to residents. An outcome focused funding model is the right funding model because it will deliver flexible and individualised care. AN-ACC was originally created with this in mind. The removal of the care minute requirement and replacement with a resident outcome focused Key Performance Indicators such as Quality of Life, Clinical, Social and Mental Health measures would deliver an Aged Care System that Australians can be proud of.

The current AN-ACC model is an activity-based funding built on the premise of care minutes and in the interim could be improved by implementing an Activity Based Funding model that delivers care outside of personal care and nursing e.g. Allied Health, Dental, Diet etc.

Q20. Should hotel costs be incorporated into the AN-ACC funding model and what should be considered in doing this?

Additional Consideration for a Residential Aged Care Price – Hotel Costs

Establishing and ensuring reasonable and appropriate funding for hotel services outcomes (catering, cleaning & laundry) should be considered as part of any independent pricing review for residential aged care. The incorporation of such funding into the AN-ACC funding model should be subject to consideration following a ***review of hotel services funding and requirements***.

Regardless of the incorporation of such funding into the AN-ACC funding model or otherwise, the basis for funding provision for hotel services outcomes would benefit

from independent review. The current funding model, does not consider the outcomes targeted, expected, sought or delivered for hotel services nor the appropriate funding required to deliver such outcomes.

The review of the funding model for hotel services consideration should be given to a range of factors, including:

- Targeted hotel services related to resident outcomes. Funding should directly support and incentivise delivery of resident outcomes rather than being primarily cost or input related.
- Consumer, market and community expectations of hotel services provided. The ability for providers to deliver hotel services in line with or above expectation is impacted significantly by the funding model. Consideration needs to be given to the current state of delivery against expectation alongside evolving and changing levels of expected hotel services provision.
- Hotel services delivery costs including:
    - Wage rates with particular reference to relevant service delivery industries and market rates in addition to award rates.
    - Goods and services rates and market prices with particular reference hotel services related categories. Consideration may also be required where state-based rates materially vary from national movements.
    - Other cost drivers including freight and transport, supply chain/demand factors and availability and accessibility of labour, goods and services where premium prices may be required to ensure continuity of service delivery in real time.
- Evolution and development of operating models and processes and investment required to ensure appropriate continued progression, including contemporary and newly developed hotel services models and technological advancement.
- Appropriate and necessary maintenance and replacement of hotel services related equipment, assets and technology.
- Innovation and improvement development needs and opportunities to support continuous improvement in hotel services related to resident outcomes, operating models and sector efficiency and effectiveness.

The current model, linked to the aged pension, is not based on an assessment of targeted outcomes or cost to deliver on such outcomes. Independent review and assessment of pricing and funding model provides opportunity to establish a targeted level of resident outcomes in relation to hotel services which, with clear articulation and alignment to pricing and funding, could then be supplemented through fee for service additional services where appropriate. This would provide transparency and clarity for residents and providers on outcome expectations aligned with the funding model.

Additionally, there is no minimum standard for what residents should expect to receive in terms of hotel standards and there is a lack of transparency and comparability of what extra services are provided if they choose to pay for “extra” services or be able to compare services between providers on a like for like basis. ***We***

recommend as part of the review and assessment of hotel and accommodation costs, consideration for simplified standard be made to create a bronze, silver and gold level of service provision for hotel and accommodation costs that provides a consistent comparison of services across the three levels. We note that whilst it needs to be Government led, industry, industry bodies and consumer groups play an important role in developing, negotiating and implementing these standards.

Q21. What should be considered in future refinements to the residential respite classification and funding model?

Providing Respite Care

We support further work being done to understand the costs of respite care. Respite is often an important part of a person's aged care journey. It can be used to provide rest for carers, but it can also be an opportunity for people to try living in residential aged care services. For many, this can help remove some of the fear and stigma that surrounds entering residential aged care and provide a soft entry point into these services. This is a critical option to ensure providers secure residents in a sustainable way. Important cost drivers to consider are for respite residents on entry are often very similar to entry as a permanent resident. Seamless ability for residents to transition from respite to permanent is an important option as well as reducing the burden and the churn that respite creates.

Q22. What are the costs associated with transitioning a new permanent resident into residential aged care?

Transition Costs

There are a range of costs associated with transitioning someone into residential aged care, be they a permanent resident and respite resident. These are outlined in Table 1: Transition activity costs for residential and respite.

Table 1: Transition activity costs for residential and respite

Transition activity	Residential	Respite
Prospect management before acceptance of a residential bed	X	X
Application process - supported	X	X
Formal offer and agreement – contract outlining rights and responsibilities	X	X
Care planning and assessment of needs and preferences – working with individual and families	X	X
Liaising with General Practitioners and Pharmacists	X	X
Liaising with Hospitals	X	
Advanced care planning	X	
Grief and other social and emotional support through the transition phase	X	
Wait list management in holding potential residents e.g. follow up and regular engagement whilst awaiting bed	X	X

Q23. How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?

Workforce challenges

Workforce challenges presents challenges in the implementation and refinement of AN-ACC primarily through changes in the operating and employment model of providers. For the most part, those changes will eventually be incorporated into the refinement of AN-ACC albeit with a lag as information provided will be retrospectives i.e. changes will take at a least a year to be incorporated. In particular, the increased indirect staffing costs to provide Aged Care services in many regional areas as providers provide accommodation as a standard employment condition. This is because the housing shortage in regional areas is combining with the demand for workers means providers have to provide additional incentives for staff to work in regional areas. This may cause issues given the different taxation treatments under the Fringe Benefit Tax Regime for different areas and may lead to a distortion of the actual staffing cost to deliver care between areas.

Q24. What areas should be included in the proposed five-year vision for IHACPA's aged care pricing advice?

Residential Aged Care is about delivering holistic care to residents. An outcome focused funding model is the right funding model because it will deliver flexible and individualised care. AN-ACC was originally created with this in mind. The removal of the care minute requirement and replacement with a resident outcome focused Key Performance Indicators such as Quality of Life, Clinical, Social and Mental Health measures would deliver an Aged Care System that Australians can be proud of.

The current AN-ACC model is an activity-based funding built on the premise of care minutes and in the interim could be improved by implementing an Activity Based Funding model that delivers care outside of personal care and nursing e.g. Allied Health, Dental, Diet etc.

Improving the IHACPA five-year vision

The IHACPA five-year vision should include the following:

- A vision to implement a set outcome Key Performance Indicators for residents (e.g. resident satisfaction and quality of life indicators) within the five-year vision.
- A vision to research and develop by the end of the five years potential aged care pricing models that incentivise providers to provide holistic care to residents through outcome focused Key Performance Indicators e.g. resident satisfaction and quality of life indicators.
- A pricing model that ensures that there is no geographic or cultural divide in the provision and accessibility of residential aged care.

Q25. What would be considered markers of success in IHACPA's aged care costing and pricing work?

Future markets of success for the residential aged care price

There are a number of markers which would indicate success in residential aged care pricing and funding models, including:

- Improved resident outcomes including resident satisfaction and quality of life indicators.
- The removal of consideration of resident care needs/classification from financial decision making. This would remain relevant for care and support purposes.
- Increased provider and sector capacity to provide care and support

services, indicating improved effectiveness of residential aged care investment.

- Alignment of funding drivers with targeted sector outcomes and removal/reduction of incentivised inputs (e.g. care minutes).
- Improved provider and sector sustainability and viability and a reduction in financial performance driven service closures/rationalisation.
- Innovation and continuous improvement in operating models, leading to improved resident outcomes, sector efficiency and effectiveness.
- Increased attractiveness of investment in thin markets, regional & remote and specialised services, in addition to residential aged care more generally.

In all cases, resident outcomes should be primary in measuring the success of any aged care pricing and funding model. The above principles apply equally to all aged care pricing and funding models, including community aged care services. A failure to improve resident or care recipient outcomes is a clear and absolute indicator of an ineffective model, be that funding, operating or regulatory, and primary consideration needs to be given to how drivers of pricing decisions and funding models incentivise and create priority for the sector level outcomes of providing improved quality of life for all within the aged care system.

Appendix 2: UnitingCare Queensland at a Glance

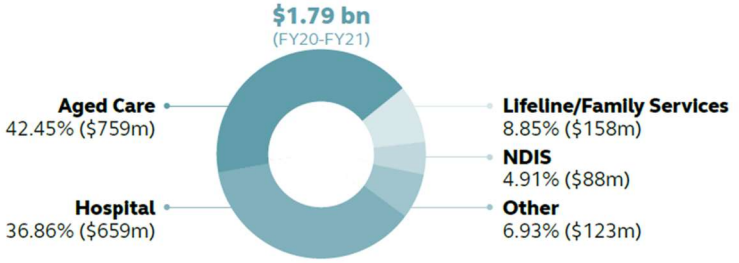
UnitingCare

Proudly representing
Blue Care | Lifeline | ARRCS | The Wesley Hospital | Buderim Private Hospital
St Stephen's Hospital | St Andrew's War Memorial Hospital

unitingcareqld.com.au

Servicing **430,000** Australians

16,500 staff and **9,000** volunteers (2nd largest not for profit employer)



Aged Care and Community Services

1 in 7 Residential Aged Care residents in Queensland

1 in 3 Community Care (CHSP and HCP) users in Queensland

BlueCare

One of Queensland's **largest and most trusted aged care providers**

47 aged care facilities across Queensland

Indigenous Australian focused services

ARRCS Australian Regional & Remote Community Services

One of Northern Territory's **largest and most trusted aged care providers**

10 aged care facilities in the Northern Territory
Nhulunbuy due to open late 2022

Pinangba

4 aged care facilities across Queensland

Hospitals

Our **4** private hospitals provide over **1,000 beds**

9% of the **ICU capacity** in Queensland

The Wesley Hospital

One of Australia's **largest** not-for-profit, private hospitals

St Andrew's War Memorial Hospital

Queensland's **first** private hospital with a cardiac surgical unit

Buderim Private Hospital

DVA's **only** accredited post traumatic stress disorder service between Brisbane and Townsville

St Stephen's Hospital

Australia's **first** fully-integrated digital hospital

Family and Disability Services

48,013 people receiving support

One of Queensland's largest **NDIS** providers

UnitingCare

UnitingCare Family and Disability Services is one of Queensland's largest community services providers, supporting vulnerable individuals, families and communities.

Lifeline

Lifeline Queensland is the largest Lifeline Member organisation

126 Lifeline Retail stores

165,309 contacts through the 10 (out of 40) Lifeline 24/7 crisis support centres

145,278 people reached by events, referral and calls to our Seniors telephone services

11,657 calls to the National Debt Hotline