UTS Ageing Research Collaborative (UARC)

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IHACPA Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25: UARC response

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Background

The UTS Ageing Research Collaborative (UARC) welcomes the opportunity to respond to the Independent Health and Aged Care Pricing Authority's (IHACPA) *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25*.[1] UARC has responded to the consultation questions as set out below.

[1] https://www.ihacpa.gov.au/resources/consultation-paper-pricing-framework-australian-residential-aged-care-services-2024-25

Responses to consultation questions

1. What, if any, changes do you suggest the Independent Health and Aged Care Pricing Authority (IHACPA) consider for the residential aged care pricing principles?

UARC generally supports IHAPCA's residential aged care pricing principles as they are currently formulated. There are, however, two proposed overarching principles which may benefit from further refinement. They relate to access to care and to efficiency.

In the aged care system, access to funded care requires an independent assessment based on government determined criteria which aims to ensure that funded services are targeted to those with greatest need. The funded aged care system is a subset of the general marketplace which offers care and support to older people, including allied health, personal care and a wide range of everyday living support.

UARC suggests the following changes:

Access to care: Funding should support timely and equitable access to appropriate aged care system services, for all ~~those~~ older people who are assessed as requiring ~~require~~ them.

Sustainability of the aged care system is dependent on more than the efficiency with which providers deliver care and support. At a system level, the effectiveness of the services which are funded will also be a significant determinant of sustainability (as will other factors such as workforce availability and the cost required to offer attractive wages and conditions for employment in the sector).

In this respect, UARC notes that the Ministerial Expectations Setting Paper requires the Pricing Framework to identify how IHACPA will "drive efficient, effective and transparent use of resources in the aged care sector." (p.1). Further, given the many factors that will have a bearing on sustainability, UARC considers that the ABF is not able to 'ensure' the sustainability of the aged care system, but can and should facilitate this outcome.

UARC suggests the following changes:

Efficiency and effectiveness: ABF should ~~ensure~~ facilitate the sustainability of the aged care system over time and optimise the value of the public investment in aged care.

2. Do the current Australian National Aged Care Classification (AN-ACC) classes group residents in a manner that is relevant to both care and resource utilisation? (that is, require the same degree of resources to support their care delivery). What evidence is there to support your answer?

In recent forums such as the IHACPA 2023 Conference, various concerns have been raised about the appropriateness of the AN-ACC classes in classifying residents into groups that have similar needs from a resource utilisation perspective. UARC supports ongoing research into these issues.

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

The translation of the AN-ACC classifications into national weighted activity units for the purposes of funding should align with care minute requirements (and associated labour costs) for direct care staff, including registered nurses. Situations of misalignment, i.e. when some classes attract a relatively higher NWAU but lower relative care minute labour costs, are likely to lead to perverse gaming and/or incentives to 'cherry pick' residents that are perceived to deliver a higher relative direct care margin.

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

It is not fully clear to UARC from either the IHACPA Consultation Paper or the wording of this question as to what is meant by entry into or departure from a service in relation to a resident's stage of care.

Funding for a resident's life course in an aged care home does not readily align with the activity-based funding approach for types of care delivered to patients in hospitals. The types of care and intensity of delivery will vary regularly for residents and AN-ACC is not capable of reflecting that variation other than on a macro-scale. The greater the refinement, however, brings with it higher costs of administration and distraction from delivering care. An efficient balance is essential.

Nonetheless, there are certain transitions experienced by residents within an aged care home that may warrant examination. Some transitions represent the need to increase the scope and intensity of services such as becoming non-ambulatory after a fall or becoming infectious and being relocated within the home. In many cases this may result in a change in AN-ACC class (even if only temporarily) but not necessarily incur significant transition costs. In other instances, there can be additional costs, such as a permanent transfer to a Memory Support Unit operated by the aged care home or a temporary transfer to and back from a hospital for treatment. There are studies which quantify transfer costs in related circumstances, including intra-hospital transfers, which would be available to IHACPA.[2,3]

An important consideration is the pricing signals that can result from the progressive refinement of the funding arrangements. It is not in the interests of residents, their carers or in the utilisation of public funds to create a funding incentive for a transfer of the resident to a hospital when the care could and should be delivered more effectively in the aged care home. Further, research evidence is pointing to the increased adverse outcomes associated with transfers.[4]

[2] Blay, Nicole, Roche, Michael A., Duffield, Christine and Gallagher, Robyn. (2017). Intrahospital transfers and the impact on nursing workload. *Journal of Clinical Nursing.* 26(23-24), pp. 4822-4829. https://doi.org/10.1111/jocn.13838

[3] Carter, H.E., Lee, X.J., Dwyer, T. et al. The effectiveness and cost effectiveness of a hospital avoidance program in a residential aged care facility: a prospective cohort study and modelled decision analysis. *BMC Geriatrics* 20, 527 (2020). https://doi.org/10.1186/s12877-020-01904-1

[4] Blay, Nicole, Roche, Michael A., Duffield, Christine and Gallagher, Robyn. (2017). Intrahospital transfers and the impact on nursing workload. *Journal of Clinical Nursing.* 26(23-24), pp. 4822-4829. https://doi.org/10.1111/jocn.13838

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

UARC has nothing to add in response to this question.

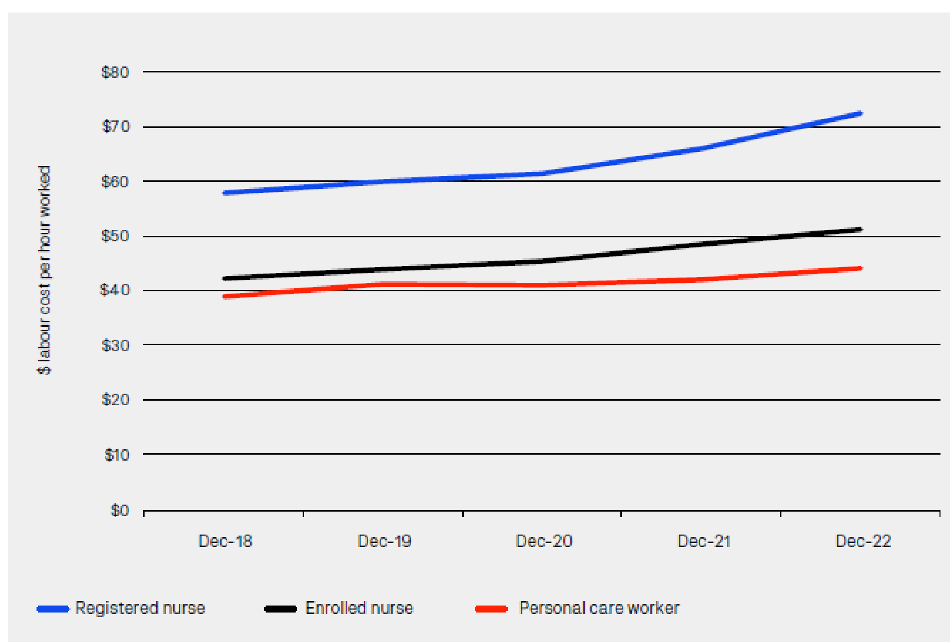
6. What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

UARC notes that one of the potential effects of IHACPA's current indexation methodology is the creation of temporal lags between changes to the actual costs of delivering residential aged care services and the setting of new funding prices. These temporal lags arise from at least two factors:

- **Time difference between actual financial data used in the model and relevant period of pricing advice.** For example, *IHACPA's Residential Aged Care Pricing Advice 2023–24* relied primarily on data in the Aged Care Financial Report 2020-21 (i.e. two years previously). To adjust for pricing differences between 2020-21 and 2022-23 IHACPA applied indexes for labour costs and non-labour costs constructed from Wage Price Index (WPI) and Consumer Price Index (CPI) expenditure subgroups from ABS statistics. However, there is the risk under this approach that the aggregate indexation rates do not fully account for changes to the actual costs of delivering care during this period.
- **Reliance on historical indexation rates to inflate upcoming price settings.** To forecast the likely annual growth in prices for the upcoming financial year, IHACPA's constructs indexation rates based on historical data. For example, the indexation rates used in *IHACPA's Residential Aged Care Pricing Advice 2023–24* were based on data from September 2017-September 2022. However, the actual annual growth in the costs of delivering aged care services may exceed the historically derived indexation rates, particularly in times of high inflation and wage price increases.

One pertinent example (relevant for both factors) is the increase in the input cost of direct care labour, shown below in Figure 1.

Figure 1: Median labour cost per worked hour, by staff role



Source: UARC 2023, Australia's Aged Care Sector, Mid-Year report 2022-23

Labour costs have increased as homes have relied more heavily on more expensive staffing strategies such as overtime and agency staff to adjust to workforce shortages.[5]

Focusing on agency staff, as shown in Table 1 below, the median cost per worker differs substantially between internal and agency staff. As of December 2022, the cost of agency direct care staff, per hour worked, was 30% higher for registered nurses ($91.68 compared to $70.52), 37% higher for enrolled nurses ($69.06 compared to $50.46) and 39% higher for personal care workers ($60.00 compared to $43.19). Furthermore, the gap between the rates paid for agency and internal staff is widening. As shown in Table 1, although the hourly cost increased for all staff roles in the last year, the growth rates in the cost of agency staff far outpaced that of internal staff.

[5] In a survey conducted in 2022, UARC research found the majority of providers were experiencing substantial workforce shortages, as a result of a variety of factors including long-term labour market issues (e.g., poor perceived wage and working conditions, lack of career pathways), rapid expansion of home care packages, COVID-19 factors (staff burnout, migration disruptions, increased workload) and the incoming minimum standards in residential care.

Table 1: Median labour cost per hour worked, by staff role

	Dec-22	Dec-21	Change (%)
Internal staff			
Registered nurse	$70.52	$65.65	7.4%
Enrolled nurse	$50.46	$47.52	6.2%
Personal care worker	$43.19	$41.57	3.9%
Agency staff			
Registered nurse	$91.68	$77.00	19.1%
Enrolled nurse	$69.06	$59.59	15.9%
Personal care worker	$60.00	$51.29	17.0%

Source: UARC 2023, Australia's Aged Care Sector, Mid-Year report 2022-23

With the 24/7 registered nurse requirement coming into force in July 2023, the minimum care minute requirements in October 2023, and the increased minimum care minute requirements in October 2024, these workforce pressures are unlikely to abate in the near term.

The IHACPA indexation methodology, in relying on historical price trends, assumes that there will be no change in the proportion of staffing drawn from internally employed staff, overtime utilisation for those staff, and from agency staff. However, if homes require proportionately more internal staff overtime and/or agency staff to cover meet the new minimum requirements (including the 24/7 registered nurse requirement, which will require overnight shift coverage), there will be a further cost to those homes that will not be covered by commensurate increases in funding in the short-term.

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

UARC notes that the funding arrangements already recognise the additional service needs and associated costs for the delivery of some specialised services. UARC has not researched this topic in depth and has no further advice to offer at this stage.

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

UARC has conducted analysis which investigates the differences in the financial outcomes of homes located in areas as classified according to the Modified Monash Model (MMM). This analysis focused on the five-year trend of financial performance for residential aged care homes that participated in the StewartBrown Aged Care Financial Performance Survey for December 2022. This comprehensive dataset comprises about 40% of the total number of homes in Australia, with a geographic spread similar to the population. Sample characteristics are included in Table 2 below.

Table 2: Sample characteristics of MMM analysis

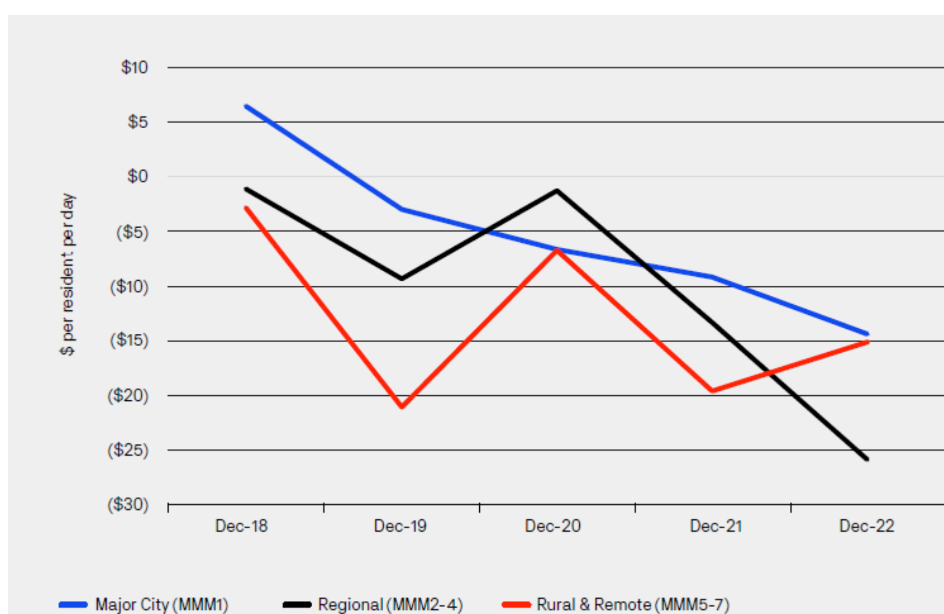
	MY19	MY20	MY21	MY22	MY23
Final sample (number of homes)	**965**	**1,060**	**1,119**	**1,192**	**1,099**
National coverage	35.8%	39.0%	41.1%	44.1%	41.1%
Proportion of sample, by remoteness:					
MMM1 – Major City	64.9%	65.8%	65.5%	63.8%	64.1%
MMM2-4 Regional	25.8%	25.3%	25.1%	25.8%	26.1%
MMM5-7 Rural remote	9.3%	8.9%	9.4%	10.4%	9.7%

Source: UARC analysis of StewartBrown residential aged care data 2018-9 to 2022-23

Noting that AN-ACC was implemented from 1 October 2022, the analysis focused on the mid-year financial results (July-December 2022) and compared this period to similar periods in prior years. Homes are classified as either major city (MMM1), regional (MMM2-4), or rural/remote (MMM5-7). Financial performance is assessed primarily using homes' average Operating Result (Net Profit Before Tax), per resident per day, which is further decomposed into net revenue and expenses for direct care, indirect care (everyday living support) and accommodation services.

The 5-year trend (shown in Figure 2) reveals that non-metropolitan homes (all MMM2-7) have consistently experienced poorer financial outcomes compared to major city homes, except for Dec-20, likely influenced by pandemic-related funding provisions.

Figure 2: Average Operating Result, by location

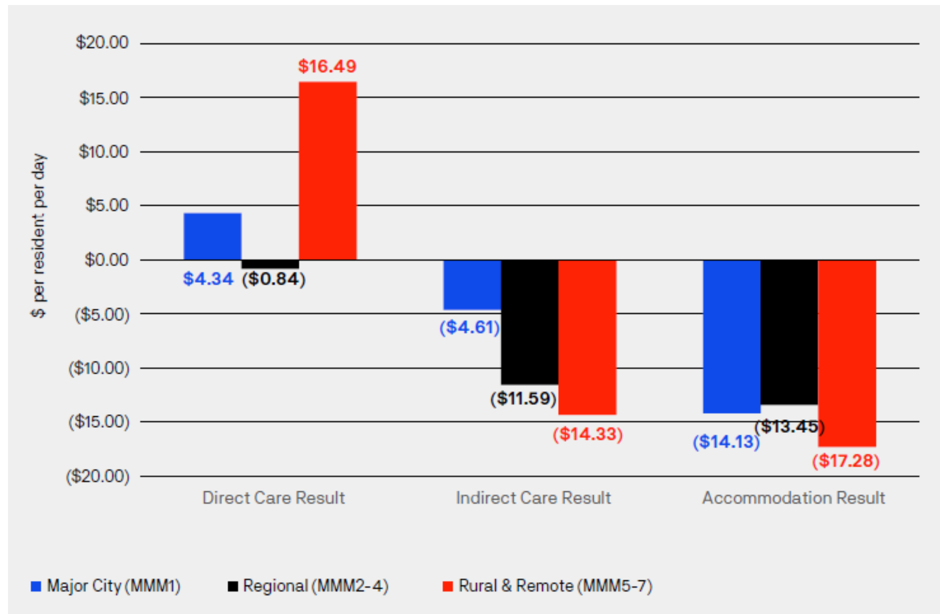


Source: UARC 2023, Australia's Aged Care Sector, Mid-Year report 2022-23

Historically, rural/remote homes have faced the worst financial outcomes; however, as of December 2022, regional homes encountered the most severe financial challenges. With 70.0% of these homes operating at a loss, their average operating profits are substantially lower than those of rural/remote or major city homes.

The primary cause of this disparity lies in direct care services (Figure 3). On a per resident per day basis, metropolitan and rural/remote homes generate margins from direct care services of $4.34 and $16.49 respectively, whereas regional homes report a deficit of $0.84. This arises because regional homes have the lowest average direct care revenue per resident, but commensurate direct care expenditure.

Figure 3: Operating Result breakdown, by location (MY23)



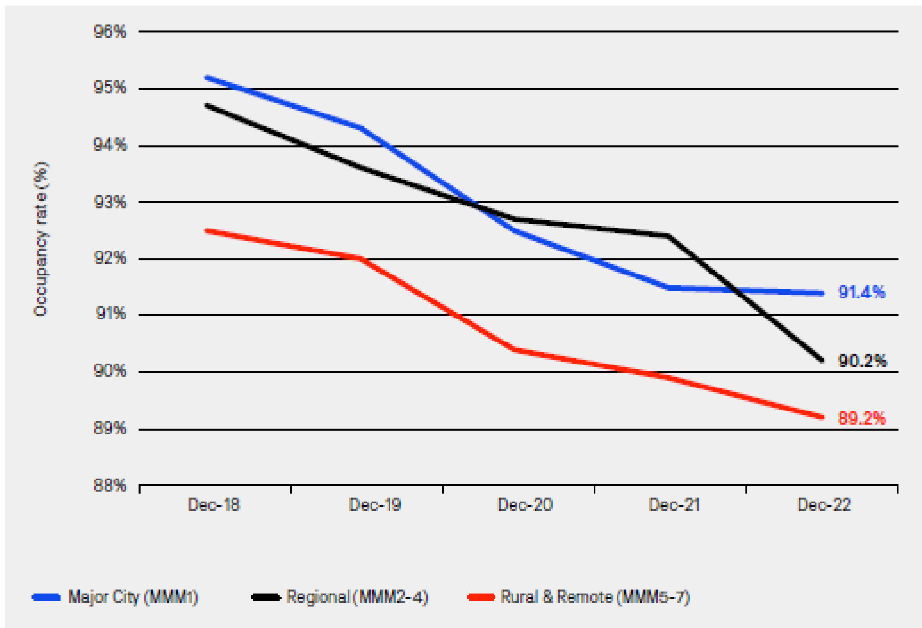
Source: UARC 2023, Australia's Aged Care Sector, Mid-Year report 2022-23

Further analysis by UARC has identified a range of contributing factors.

1. **Effects of occupancy:**

Rural and remote homes typically have lower occupancy but are now funded on operational places under AN-ACC (base care tariff). However, regional homes experienced sharp decline in occupancy rates (see Figure 4) but are funded on occupied places under AN-ACC (base care tariff).

Figure 4: Occupancy rate, by location

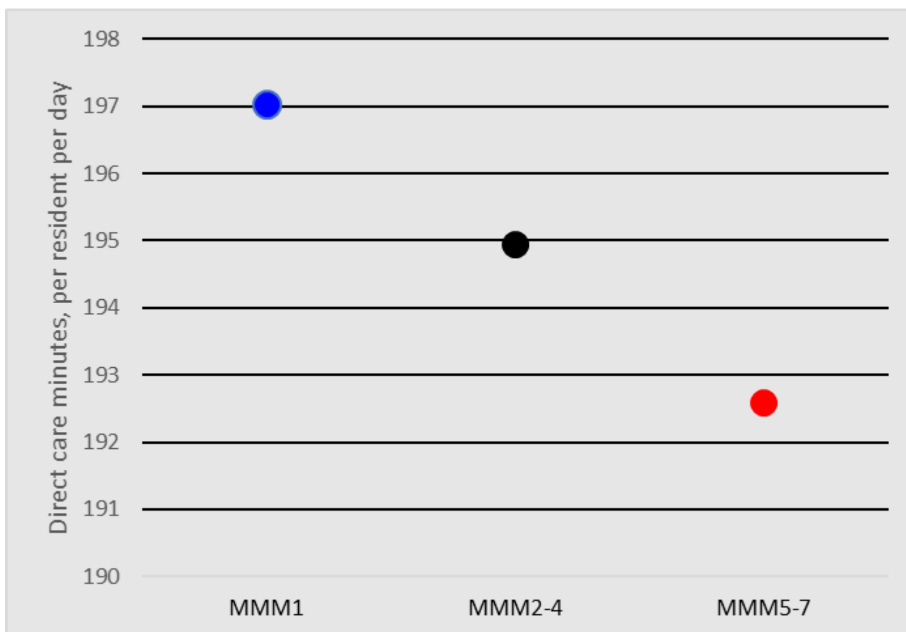


Source: UARC 2023, Australia's Aged Care Sector, Mid-Year report 2022-23

2. Homes' resident profile

Homes outside the metropolitan centres tend to service a more diverse cohort of residents, including more low-care residents, that attract lower variable direct care subsidies under AN-ACC (see Figure 5).

Figure 5: Average target for total direct care minutes (estimated), MY23

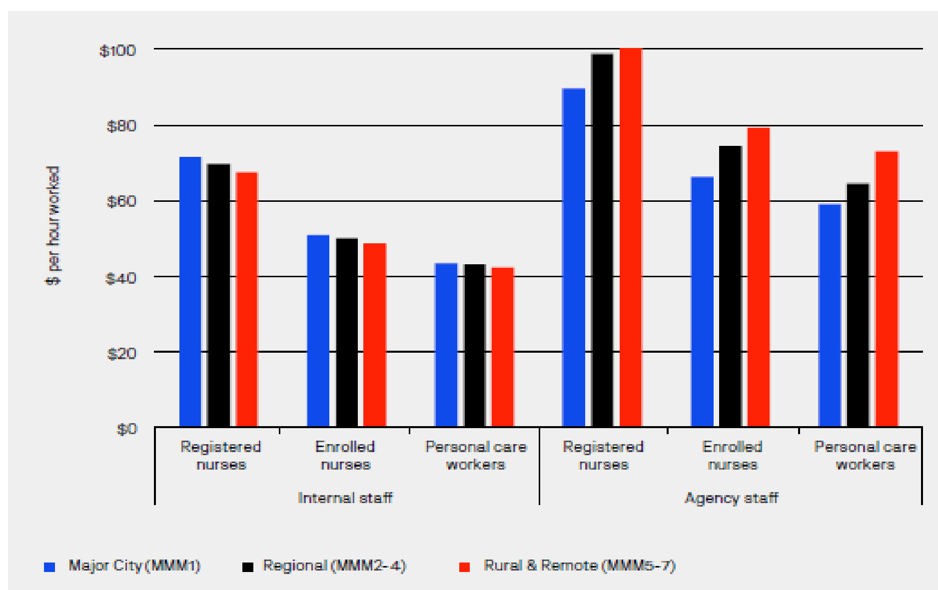


Source: UARC 2023, Australia's Aged Care Sector, Mid-Year report 2022-23

3. **<u>Higher relative input costs of nursing staff in regional homes</u>**:

Outside major cities, homes' labour costs for internal staff tend to be lower, per hour worked. However, non-metropolitan homes incur a higher premium for the cost of agency staff (see Figure 6), which are increasing as a proportion of total staff.

Figure 6: Median labour cost per hour worked, by location (MY23)



Source: UARC 2023, Australia's Aged Care Sector, Mid-Year report 2022-23

UARC's preliminary results indicate that the AN-ACC funding model has positively addressed some financial disparities for rural and remote homes. However, despite facing similar operational challenges, such as low occupancy, diverse resident profiles, and higher input costs, regional homes remain ineligible for higher base care tariff funding under AN-ACC. Further analysis will be required to track the full-year implications of AN-ACC (and any further adjustments to the targets and funding model).

Nonetheless, regional homes, which comprise a quarter of the sector, confront the most pressing financial viability concerns within the aged care sector, highlighting the need for potential policy adjustments.

These policy adjustments could include:

1. Differentiation of MMM2-4 homes in the Base Care Tariff, with a higher base care tariff rate than MMM1 homes. Further analysis is required to understand the appropriate calibration of funding rates for homes in each MMM classification.
2. Differentiation of MMM2-4 homes in the Base Care Tariff, with funding being provided for operational, rather than occupied places. However, this option runs the risk of perverse incentives to game the provision of operational places. Whereas it is a priority to ensure 'capacity availability' in rural and remote areas, this is a less pressing issue in regional areas where there are more homes.
3. Review of the MMM classification system. UARC notes that this is likely outside the scope of review of Base Care Tariffs by IHACPA.

On balance, UARC supports Option 1.

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

UARC proposes that IHACPA consider the extent to which funding provided under AN-ACC is calibrated to deliver quality and safe care. Within this broad area, issues include:

- **Calibration with Star Ratings**. Under the Star Ratings, homes can only achieve a 5-star rating for staffing if their direct care minutes are at least 105% above their service-level targets and their registered nurse minutes are at least 125% above their service-level targets. However, it may not be possible to achieve this level of staffing within the mandated input-based direct care funding provided under AN-ACC.
- **Costing based on actual practice.** In costing studies which determine the actual cost of delivering residential aged care services, IHACPA should take appropriate measures to upscale the cost of delivering services which fall short of achieving required quality levels. Consideration should also be given to ensuring that the level of funding provided is appropriate to deliver quality care efficiently and effectively.
- **Constraints on innovation.** IHACPA should consider the extent to which care minute targets for AN-ACC classifications acts as a constraint on innovation, e.g. around alternative work models that could lead to services quality improvement while not being constrained by mandated minimum inputs.

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

The Multi-Purpose Service model is a complex integration of State-level acute and community care service provision and an adaptation of the Commonwealth's aged care arrangements, together with associated pooling of funding. That complexity is compounded by variations occurring at State level as the jurisdictions adapt the program to meet their own particular circumstances. As such, the current mainstream version of AN-ACC is not an easy fit with MPS arrangements.

Issues relating to funding, resource allocation, staffing, reporting, and other alignment between mainstream aged care and the arrangements prevailing in MPSs were analysed in detail in a Commonwealth commissioned report undertaken by UTS in 2019.

For an understanding of these issues, UARC draws attention to the report *Aged care in MPS: Response to the Australian Government Terms of Reference*, which was led by UARC's Policy Advisor.[6]

The Government's response in 2020 was to accept or agree in principle with all twelve recommendations. The Government's response also noted progress on resolving some of the issues.[7]

UARC notes that the review was supportive of the MPS program and recommended the deployment of the services in more rural areas. Thus, despite the various misalignments

[6] https://www.health.gov.au/resources/publications/aged-care-in-mps-response-to-the-australian-government-terms-of-reference?language=en
[7] https://www.health.gov.au/sites/default/files/documents/2020/04/australian-government-response-mps-review-recommendations.pdf

with mainstream aged care, it is their flexibility that enables aged care services and resources to respond to the unique needs of each rural town and village and to the needs of their elderly citizens. The pooling of Commonwealth and State funds in each MPS also enables those towns and villages to retain registered nurses and acute care capabilities. IHACPA should work closely with all jurisdictions to ensure that MPS funding arrangements enhance the considerable benefits of MPS services so that they are retained and potentially expanded.

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

UARC offers no comment on this issue.