



Royal Commission into Aged Care Quality and Safety


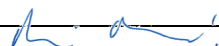
Statement of Nicolas George Mersiades

Name: Nicolas George Mersiades
Address: Level 2, 51 Cooyong Street, BRADDON, ACT, 2612
Occupation: Director of Aged Care, Catholic Health Australia
Date: 11 April 2020

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety in response to questions posed in correspondence from the Royal Commission dated 12 March 2020.
2. This statement is true and correct to the best of my knowledge and belief.
3. The views I express in this statement are my own based on my professional experience, expertise and education. They are not necessarily the views of all members of Catholic Health Australia as time constraints and COVID-19 prevented the usual consultation processes; nor are they necessarily the views of the Aged Care Financing Authority, a statutory committee of which I am Deputy Chair.

PROFESSIONAL BACKGROUND

4. I am currently the Director of Aged Care at Catholic Health Australia, and have held this position since 2009.
5. Catholic Health Australia is a member based organisation that undertakes advocacy and policy development on behalf of its members. Catholic Health Australia is Australia's largest non-government grouping of health and aged care providers, delivering care to all who need it in fulfilment of the Catholic Church's mission.
6. My role as Director of Aged Care involves the monitoring and review of government policies, development of policy options on behalf of members and representing members in consultations with government and other sector stakeholders concerning the aged care system.
7. I hold a Bachelor of Arts Degree (Honours A1, University Medal) from James Cook University and a Master of Urban Studies from the University of Queensland.
8. I have extensive experience of the aged care sector (and to a lesser extent the health care sector) and government gained from having worked for 20 years at senior executive levels for the Australian Government and in the aged care sector.
9. In the Commonwealth Department of Health, I held the following positions:

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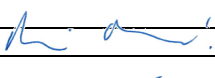
- a. First Assistant Secretary, Aged Care Division
 - b. State Manager Queensland
 - c. State Manager New South Wales
 - d. Principal Advisor, Budget Management Branch
10. In the Commonwealth Department of Finance I held senior and Senior Executive Service positions providing policy advice to government across a number of portfolios, including education, transport, primary industry, immigration and industrial relations.
11. Prior to joining Catholic Health Australia, I held the position of General Manager, Strategic Policy and Communications, Catholic Healthcare, between 2007 and 2009.
12. I have been a member of the Aged Care Financing Authority (ACFA) since its creation in 2014, and was appointed Deputy Chair in 2017. ACFA is a Statutory Committee whose role is to provide independent, transparent advice to the Australian Government on funding and financing issues in the aged care industry.

A. ARE AGED CARE PROVIDERS ADEQUATELY FUNDED TO PROVIDE QUALITY CARE?


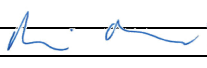
13. The following addresses this question by care type – residential, home care packages and Commonwealth Home Support Program – because different funding arrangements apply to each.
14. The supply of and waiting times for accessing aged care services that meet older peoples' preferences is not addressed, nor is the significant financial impact on aged care providers of responding to the COVID-19 pandemic.

Residential Aged Care

15. There are three separate funding/revenue streams within residential aged care that government controls – personal and nursing care, everyday living expenses and accommodation. There are also other resourcing streams such as volunteering, bequests and donations, more typical of not-for-profit providers.
16. Apart from prudential restrictions on the permitted uses of Refundable Accommodation Deposits (RADs), the revenue under these funding streams can be used flexibly, noting that all streams are critical to overall quality of care and quality of life. For example, the quality of food and nutrition funded under everyday living expenses is fundamental to quality of care and quality of life outcomes, as is pastoral care (some of which is provided by volunteers).
17. It must also be recognised that quality of care and quality of life outcomes in residential aged care are not only a function of the adequacy of funding for aged care providers, but also a function of timely access to high quality health services and strong family relationships.

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18. **Personal and nursing care (basic care subsidy):** There has never been an objective cost of care study used to determine the cost of delivering high quality aged care service outcomes based on an agreed definition or measure of quality aged care, including quality of life, nor used to inform price setting by Government.
19. The current quantum of funding for personal and nursing care largely reflects the accumulation of historic allocations, the basis for which has been lost in the 'mists of time' – noting also that prior to 1996, residential aged care comprised hostels (low care) and nursing homes (high care), each with their separate funding model. Annual indexation has been applied to base allocations and, depending on the funding model applying at the time, the quantum has been increased to reflect increases in acuity of the overall resident profile (as assessed by providers), as well as growth in the resident population.
20. The current funding model (ACFI), and its predecessor funding model (RCS), which were developed after the integration of hostels and nursing homes, are primarily resource allocation tools that distribute available funds budgeted by the Commonwealth across providers according to a resident classification system that aims to differentiate relative resident care needs and primary cost drivers.
21. When determining the annual budget for personal and nursing care, the Commonwealth does not take into account in any meaningful way the implications for the quality of care services. Instead, the Government currently primarily relies on the quality regulatory system to support the delivery of quality aged care services within whatever funding the Commonwealth determines. Commonwealth budgeting does have regard to proxy measures of funding adequacy, such as the level of interest in applications for new places under the annual Aged Care Approvals Round (ACAR), the level of investment in new services and refurbishments (which it surveys annually), and the financial results achieved by the better performing providers, but these are not measures of quality.
22. In short, it is not possible to say whether current funding for personal and nursing care is sufficient to support quality aged care without a common understanding of what constitutes quality care and an independent assessment of the cost of delivering that standard of care. Also, even though aged care is being provided by non-government entities operating in the wider economy, there is no market signal as to what is acceptable quality from a consumer perspective, especially in relation to quality of life, noting that aged care is long term care where quality of life matters, which distinguishes it from hospital-based care which tends to be episodic and time limited.
23. **Everyday living expenses (basic daily fee):** For everyday living expenses, there has been a longstanding policy that these costs are met by residents, with age pensioners expected to use their pension entitlement. However, governments have used price controls to cap the basic daily fee for all residents at 85% of the single age pension, irrespective of means (except for those occupying a restricted number of subsidised


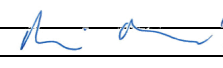
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places in Extra Service facilities¹). Residents in non-Extra Service facilities can agree to pay for additional or higher quality services, but there has been ongoing regulatory uncertainty about what services are actually additional to those specified under Schedule 1 of the Aged Care Act 1997. This regulatory uncertainty discourages many providers from introducing fees for additional services.

24. The policy of setting a universal pricing cap for everyday living expenses would seem to have been borrowed from the Commonwealth Government's policy regarding welfare payments such as the age pension, unemployment benefits and rent assistance, where payments are uniform Australia-wide irrespective of regional circumstances. Application of this policy to everyday living expenses for all residents would seem to be at odds with the fact that the basic daily fee is not a welfare payment, and that older people should be able to exercise choice (with appropriate welfare safety nets for those with lower means).
25. Moreover, as is the case for personal and nursing care, there has never been an objective cost study used to determine the cost of everyday living services based on agreed expectations of quality, nor to inform or determine the pricing cap set by Government. Similarly, there is no market signal about consumer expectations and preferences.
26. Financial performance surveys conducted by the accounting firm, StewartBrown², indicate that the basic daily fee does not cover the cost of everyday living expenses. This is an expected outcome because the age pension is set assuming a significant level of self-provision and self-management by retirees regarding daily requirements and activities such as purchasing and preparing and serving food, cleaning, transport, social engagements, gardening and other domestic duties. In a residential setting, most of these activities involve salaried staff. Any economies of scale, such as bulk purchasing of food ingredients, would not offset the additional cost of staff.
27. A consequence of the current price cap on everyday living expenses is that older people and their families have to accept the standard of services that can be delivered within the cap, rather than exercise some choice over living standards. This would lead many to question the appropriateness of a one-size-fits-all policy for everyday living and lifestyle which constrains an individual's ability to choose to pay for the services of their choice. This one-size-fits-all approach does not apply at any other stage of an individual's life cycle.
28. A more market-informed expression of preferences would provide a benchmark for subsidising low means residents, as currently informs accommodation supplements for supported residents.

¹ The Commonwealth has not allocated any additional Extra Service places since the 2014 *Living Longer Living Better* reform package, by implication relying on an ambiguous policy for fees for additional services.

² StewartBrown Q2FY20 *Survey Results Summary* includes trend data on everyday living expenses p18


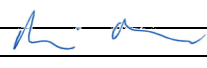
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29. **Accommodation:** Since the 2014 *Living Longer Living Better* reforms, accommodation prices for non-supported residents have been set by providers subject to a price threshold above which prices require the approval of the Pricing Commissioner. Non-supported residents comprise about 50% of residents.
30. The market-informed prices for non-supported residents provide a benchmark for judging the adequacy of Government accommodation supplements for fully and partially supported residents. The current accommodation supplement (\$57.14 per day) is broadly in line with the average market-based Daily Accommodation Payment (\$50).³
31. The Government also conducts an annual capital grants program to support services such as those with less access to Refundable Accommodation Deposits and commercial financing, e.g. services for the homeless or services in areas with low house/land values.
32. On balance, accommodation since 2014 has generally been adequately funded, with two caveats.
33. First, it is unclear on the available public evidence whether the annual capital grants program is sufficient to meet demand. This aspect would be worth further analysis, using data held by the Department of Health as a by-product of the annual grant application processes.
34. Second, there is a growing concern about the impact of record lower interest rates on the Daily Accommodation Payment. That is, under the formula for achieving equivalence between Refundable Accommodation Deposits and daily accommodation payment, the latter reduces as interest rates decline. As a result, the sector has seen a steady and marked decline in daily accommodation prices at the same time as more new admissions are choosing to pay a daily payment.
35. Finally, it is noteworthy that there has been no criticism during the Royal Commission Hearings of the quality of the building stock, as opposed to its institutional design. The latter is in part a legacy of the legislated Building Certification regulations that existed prior to 2016.

Home Care Packages

36. As with residential care, the comments below do not address the supply of and waiting times for home care packages. This issue has been well ventilated elsewhere. The comments below address whether package level funding is adequate to provide quality care, noting that home care package holders are responsible for their everyday living expenses and accommodation.
37. To start with, the level of unspent funds (estimated to be now approaching \$900m) could be taken as an indicator that the current package funding levels are adequate. Unspent

³ Note that because of the equivalence formula that applies to Refundable Accommodation Deposits and Daily Accommodation Deposits, the Daily Accommodation Payment will reduce as interest rates fall, and the gap between payment modes will increase, and vice versa.


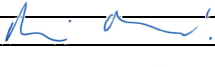
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funds could also reflect that there is some over-assessment taking place, or that the funding gaps between package levels are too great.

38. It is also relevant to take into account that when the funding levels were set for the original packages (CACPs, EACH and EACH-D), packages were seen as an alternative to residential care. As a result some policy alignment was sought in setting package funding levels with the care subsidy that individuals with equivalent assessed needs would attract in residential care. Over time, with the introduction of more funding levels and different indexation arrangements, the alignment is not as evident as it used to be.
39. However, the key policy intent underlying the setting of package levels is that they should not be more than the subsidies applying in residential aged care.
40. Noting that home care packages were conceived of as providing older people an alternative to residential care, judgements about the adequacy of home care package funding levels should also have regard to the expectation that, even when funding is aligned with care subsidies in residential care, the services delivered in a person's home will rarely, if ever, match those that can be provided in a congregate living setting such as residential aged care. Consequently, unlike residential care, home care providers are not responsible for caring for their client on a 24/7 basis.
41. In most cases, home care package holders would have live-in informal carer(s) or other supports, and often a willingness and capacity to top-up their entitlement, in order to realise their preference to remain living in their own home for as long as possible. An important responsibility for home care providers is to engage with older people and their carers regarding the most appropriate setting for receiving care as their care needs increase.
42. Whether to fund individuals so that their assessed care needs can be met irrespective of care setting is a key policy consideration for the Royal Commission and governments. Fundamental funding and sustainability considerations rest on the policy position taken on this question. The assessment that has prevailed to date is that governments cannot afford a funding model in aged care based on providing comprehensive quality care for older people regardless of setting. On this basis, the benchmark for adequate funding for home care packages would be the care funding subsidy that would apply in a residential setting.
43. This matter is a pivotal policy consideration in developing a funding model for home-based care, including when comparing the attributes of funding models for home-based aged care with the funding model used by the NDIS, where the objective is to support individuals living with disabilities to have a better life over a lifetime.

Commonwealth Home Support Program (CHSP)

44. There is little information to draw on to assess the adequacy of CHSP funding to deliver quality care and home support services. Anecdotal reports tend to focus on access to services rather than quality.

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45. As with home care packages, it is relevant that many older people receiving basic CHSP services will also have live-in informal carers or other supports.

B. IDENTIFY AND EXPLAIN THE KEY FINANCIAL CHALLENGES THAT AGED CARE PROVIDERS EXPERIENCE UNDER THE CURRENT AGED CARE SYSTEM.

Without limitation of the matters you wish to address, your statement should cover:

- a. the factors that exacerbate the key challenges
- b. how the challenges can be addressed, ameliorated or mitigated against
- c. the impact of caps on what can be charged for daily living costs and care
- d. the role of potential variation of the levels of Refundable Accommodation Deposits (RADs) and Daily Accommodation Payments (DAPs) via application for determination by the pricing commissioner
- e. the extent to which care and accommodation subsidy levels appropriately recognise the administrative and overhead costs of delivering those services
- f. any evidence for your response

Residential Aged Care


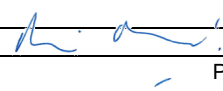
46. The financial challenges in residential aged care under the current funding and financing arrangements primarily relate to the funding of personal and nursing care (the basic care subsidy) and everyday living expenses (the basic daily fee).
47. The following does not address the financial challenges associated with reforms identified by various reviews, such as more and a better remunerated and skilled aged care workforce, or those arising from responding to the COVID-19 pandemic.
48. **Personal and nursing care (the basic care subsidy):** Putting aside rising community expectations, the major underlying causes of the well documented financial pressures being experienced by residential aged care providers⁴ is the punitive indexation formula applying to the basic care subsidy, together with the significant decline in real growth in

⁴ ACFA Update on Funding and Financing Issues in the Residential Aged Care Industry September 2018

ACFA Seventh Annual Report on the Funding and Financing of the Residential Aged Care Industry July 2019

ACFA Submission to the Royal Commission into Aged Care Quality and Safety April 2019

StewartBrown Aged Financial Performance Survey Q2FY20

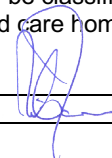
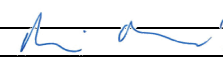
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the average basic care subsidy per resident per day following the 2016-17 changes to ACFI.

49. The component of the indexation formula relating to staff costs (weighted at 75%) assumes a significant, and arguably unsustainable, annual productivity gain for a labour intensive personal care industry, i.e. the formula assumes an ongoing reduction of staffing costs as a proportion of total costs. The formula to determine the annual rate of indexation achieves this outcome by taking the dollar value of the annual Fair Work Australia increase in the minimum weekly wage and discounts it by converting it into a percentage of the average adult weekly wage, which is more than double the minimum wage.⁵
50. In business, productivity gains and improvements in the quality and range of goods and services, and hence market competitiveness and profitability, go hand in hand. In aged care, the productivity gains go straight to the Commonwealth Budget bottom line.
51. The non-wage component of the indexation formula (weighted at 25%) is linked to the Consumer Price Index.
52. For many years, Commonwealth budgeting accepted annual real increases in average care subsidy per resident per day of the order of 3%, known as 'frailty drift', i.e. a gradual increase in the average acuity of residents⁶. These increases helped to compensate for low indexation, noting that claiming assessments for care subsidies are undertaken by providers. From time to time, the real annual average increase in care subsidy claimed by providers exceeded what government considered could be reasonably attributed to an increasing acuity of the resident profile, resulting in indexation pauses to recover what was considered excessive growth, and changes to the ACFI to curtail the level of future real increases (with variable success).
53. As a result, ACFI funding has been characterised by funding volatility, which is undesirable from a Commonwealth budgeting point of view and for business planning by service providers.
54. Following the changes to the ACFI in 2016-17 in response to the most recent spike in real growth of care subsidies, the annual real increase in average care subsidy per resident per day has been minimal compared with past trends, leaving the sector dependent on annual indexation for revenue growth.
55. An analysis of the monthly [ACFI Monitoring Reports](#) published by the Department of Health shows that annual growth in the daily average ACFI expenditure for 2017-18 was forecast to be around 2.4%, whereas the actual growth for the year was 0.0%. For 2018-19, the annual growth in the daily average ACFI expenditure was forecast to be around 1.5% whereas the actual growth for the year was 0.8%. For 2019-20, annual real growth


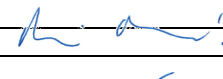
⁵ The current minimum wage is \$740 per week compared with Adult Average Weekly Ordinary Time Earnings of \$1,659 per week

⁶ Note however that annual 'frailty drift' under ACFI is not a sustainable trend as it implies that all residents will eventually be classified as High-High-High (ie the maximum classification). In effect, at this point, aged care homes would be block funded based on occupancy levels.

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in ACFI is forecast to be 1.2%. Real growth up to October 2019 was 0.2%. These low rates of real increase compare with an average annual real increase in care subsidy of 5% prior to the 2016-17 change to ACFI.

56. With ACFI payments representing 61% of the revenue of residential aged care providers, it was inevitable that such a large decrease in average real growth in per resident per day ACFI care revenue would result in a deterioration in financial performance across the board, exacerbated by the average annual increase of 3.3% in minimum wages granted by Fair Work Australia over the last three years.
57. The volatility in care funding levels addressed above is canvassed in more detail in the Aged Care Funding Authority's [submission](#) to the Royal Commission.
58. The Government has responded to the flaws in the current ACFI funding model by commissioning work to develop a new resident classification system and funding model (the AN-ACC), with prices to be informed by independent costing studies and funding claim assessments no longer to be undertaken by providers. The introduction of independent arrangements for resident classification would remove the influence of provider claiming behaviour on subsidy levels, and independent costing studies should avoid the need for annual indexation arrangements.
59. However, the effectiveness of the new funding model in reflecting cost increases in prices will depend on the design and implementation of the new funding model, especially the methodology that will underpin the independent costing studies, and definitions of what constitutes high quality care and quality of life outcomes. The costing study methodology will also need to take into account the contribution everyday living requirements have on overall quality of life outcomes, as well as additional services that may be purchased. Cross-subsidisation across services will also need to be addressed, as well as cross-subsidisation from other business lines, such as seniors' independent living units.
60. The Government recognised the financial pressures in the residential care sector by providing a one-off increase in subsidies paid between March and June 2019. While this funding helped, ad hoc short term funding increases do not lend themselves to sound budgeting and business management, and do not address the underlying causes of the financial pressures.
61. The other concern is that the introduction of a new funding model based on a contemporary costing study is at least 24 months away, noting that the government has suspended the AN-ACC external assessment pilot in light of the COVID-19 pandemic. A pressing question is how many providers, especially some thinly capitalised for-profit providers, will have the cash reserves to wait that long for funding relief. Given the timelines, and the expectation of minimal real growth in care subsidies and minimal indexation, there is a strong case for an increase in care prices pending the implementation of the new funding model.
62. That said, there has always been a significant spread in financial performance across aged care providers, partly a legacy of a highly regulated and protected cottage industry

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fostered by successive Australian governments. ACFA published a report in 2014 on factors influencing the financial performance of residential aged care providers⁷, followed by a similar report in 2016 that considered factors influencing the financial performance of residential aged care services in rural and remote locations⁸. The considerations in these reports, taken together with increasing expectations regarding the quality of care and quality of life and overall governance, suggest that reform to address the poor financial performance of providers should be undertaken in conjunction with incentives to support structural adjustment in the sector. The 2019-20 Government decision to establish a Business Improvement Fund which includes incentives for poor performers to leave the industry is a worthwhile policy measure, but still leaves long term funding and financing issues unresolved and uncertain.

63. **Everyday living expenses (the basic daily fee):** The inadequacy of the universally applied basic daily fee for everyday living expenses (capped at 85% of the single age pension) to support quality services was discussed earlier in this Statement. The current cap poses a financial challenge for providers in their endeavours to respond, in an increasingly competitive service environment as occupancy rates fall, to rising community expectations concerning quality of life outcomes.
64. A possible solution is to remove or lift the price cap for non-supported residents, along the lines recommended in the *Legislated Review of Aged Care 2017*⁹. It is noteworthy that the Minister for Aged Care has asked the Aged Care Financing Authority to review the role of the basic daily fee, including what role the fee should have in future. As noted earlier in this Statement, prices that non-supported residents are prepared to pay for services in a competitive market that meet their expectations would provide a benchmark for government subsidies for those with low means.
65. **Accommodation:** While accommodation has generally been adequately funded and financed since the *Living Longer Living Better* reforms, providers, investors and financiers will not support service renewal and expansion if services are not viable or if there is uncertainty about future reform directions – unpredictable sovereign risk.
66. Hence, notwithstanding reasonable funding arrangements for accommodation, the Aged Care Financing Authority¹⁰ is reporting a significant decline in providers reporting that they are planning to rebuild or upgrade their facilities because of the uncertainty of reform directions flowing from the Royal Commission, the current financial pressures, and uncertainty about the funding model to replace the ACFI.
67. Another financial pressure that could arise for some residential aged care providers is a liquidity squeeze in the event of any sudden increase in the proportion of new admissions favouring daily payments over lump sum deposits, or a significant reduction

⁷ Aged Care Financing Authority *Factors Influencing the Financial Performance of Residential Aged Care Services* May 2015

⁸ Aged Care Financing Authority *Issues Affecting the Financial Performance of Rural and Remote Providers, Both Residential and Home Care Providers* January 2016

⁹ Legislated Review of Aged Care Reform July 2017

¹⁰ Aged Care Financing Authority *Seventh Annual Report on the Funding and Financing of the Aged Care Industry* July 2019

in occupancy levels. Either would result in a significant outflow of Refundable Accommodation Deposits and a need for providers to seek re-financing options, noting that some providers are not as well placed as others to secure re-financing¹¹. Currently Refundable Accommodation Deposits total \$30 billion, and represent 75% of the sector's capital funding.

68. As noted in response to Question A, there is a growing concern associated with the formula used to convert a Refundable Accommodation Deposit set by the provider to a Daily Accommodation Payment. The objective of the formula is to make the choice between a daily payment and a RAD neutral for the resident. The formula uses an interest pegged to the 90 day bill rate. As interest rates have fallen to record low levels, daily payments have fallen, from \$100.89 for a \$550,000 RAD in July 2014 to \$63.89 currently. With more new admissions choosing to use daily payments, this trend is diluting accommodation revenues.

Home Care Packages


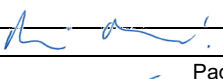
69. As noted earlier, home care package funding can be seen as a contribution to individuals' aged care and support costs, and is not intended to cover the cost of providing 24/7 care and support.
70. Home care package providers are also not directly accountable for delivering precise volume of services, and hence have flexibility to set prices and deliver services within individual budgets and package levels determined by government.
71. Putting aside the impact of COVID-19, the main financial challenge currently facing home care package providers is adjusting to a more competitive service environment following the introduction of funding following the consumer in February 2017, including increased competition from a large number of new entrants¹² and increased price disclosure. Responding to these changes has required considerable adjustment by home care providers as they transition to a more competitive service environment and increasingly more informed older people and families.
72. It is anticipated that there will be a rationalisation of home care package providers in the short to medium term, with only those who have managed the transition successfully remaining in the industry.

Commonwealth Home Support Program

73. Because the CHSP is grant funded, CHSP providers who manage their grant funds effectively do not face financial challenges of the type faced by residential and home care providers. A management challenge faced by CHSP providers is stretching grant

¹¹ For example, cash held as a percentage of accommodation deposit balances in 2018-19 averaged 44% for not-for-profit entities compared with 15% for for-profit entities.

¹² The number of home care providers has increased by 90% since June 2016 to 928 as at June 2019, with the proportion of for-profit providers increasing from 13% to 36% over the same period.

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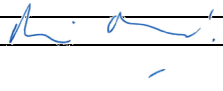
funds so that the maximum benefit is achieved for the maximum number of people in a supply constrained environment.

C. ARE THERE FEATURES OF THE AGED CARE SYSTEM THAT IMPACT ON AGED CARE SERVICES BEING DELIVERED IN A COST-EFFECTIVE MANNER?

Without limitation of the matters you wish to address, your statement should describe:


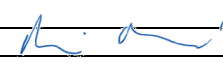
- a. the ideal characteristics of efficient delivery of aged care**
- b. whether and how the design and operation of the current system aligns or does not align with or incentivise these characteristics**
- c. any evidence for your responses**

74. Australia's economy overall relies on competition policy as a primary driver for the efficient and responsive supply of goods and services provided by non-government entities, supplemented by consumer protections. Some of these protections apply economy wide (such as regulations concerning misuse of market power) and others are sector specific (such as food processing and food preparation). Most facets of the economy are regulated in one way or other, while at the same time fostering competition in service delivery wherever possible.
75. In contrast, a primary feature of the current aged care system is that competition in service delivery is weak or non-existent due to demand exceeding supply and regulation which dilutes or inhibits competition in service delivery.
76. The aged care system still largely embodies the features of a government outsourced service, characterised by a high degree of regulation and inflexibility, even though services are delivered by a range of non-government entities, including for-profit, listed for-profit and not-for-profit service providers. Government regulations determine:
- (a) the type of services that are funded/purchased on behalf of eligible consumers;
 - (b) the volume of each service type, i.e. services are rationed and not determined in response to consumer need and preference;
 - (c) the volume and the service types each contracted/approved service provider may deliver;
 - (d) the services that are to be provided in residential care (the Schedule of Specified Care and Services);
 - (e) the geographic distribution of services;
 - (f) the price providers receive for care services, everyday living expenses and accommodation for supported residents;

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- (g) how much consumers of the service are expected to contribute to the cost of services;
- (h) who can access the services; and
- (i) regulate aged care services for quality and safety.

77. Key exceptions where choice and competition have been introduced are market-informed accommodation prices for non-supported residents since 2014, and the assignment of home care packages and individual budgets to eligible older people since 2017, rather than allocating packages in perpetuity to home care providers.
78. The main reason for the system's current design is that it maximises the capacity of governments to control Budget outlays, short of owning and operating aged care services.
79. It is noteworthy that the Royal Commission's Counsel Assisting has proposed the continuation of aged care service delivery by a mix of for-profit and not-for-profit non-government entities, rather than, by implication, a government agency. This provides the platform for extending competition enhancing policies in aged care service delivery, rather than the current over reliance on regulation and self-motivated providers to deliver quality and safety, high standards of governance, and innovation.
80. Related features of the current system that impact on aged care services being delivered in a cost efficient manner include constraints on choice, information asymmetry, paucity of comparative information about quality, older people who need additional guidance and support to access services, and the existence of thin markets, variously defined.
81. Uncapped supply, or an entitlement based funding approach as proposed by Counsel Assisting to the Royal Commissioners, supports choice of provider and choice of service type, and creates a more competitive service environment to support greater efficiency and greater responsiveness in service delivery. It is noteworthy that, even within a rationed supply environment, choice of provider through funding following the consumer can generate a competitive service environment, as is happening with home care packages.
82. The absence of funding following the consumer in residential aged care and the CHSP dilutes competition in the provision of services in these programs, though the increased availability of home care packages, a gradual decline in occupancy rates in residential care and the publication of accommodation prices has seen increased competition beginning to emerge in the residential aged care sector.
83. Note that the government has indicated its intention to introduce funding following the consumer in residential aged care, and to remove the annual Aged Care Approvals Round (ACAR) for allocating subsidised residential aged care places to approved providers in perpetuity.
84. A threshold issue is whether to introduce funding following the consumer and individual budgets for CHSP services in conjunction with the proposal to create a single home-

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based care program. Under CHSP, each older person is expected to find a provider with a suitable menu of services that meets their needs¹³ and has spare capacity, which inhibits choice and control. Extending individual budgets to CHSP users, as occurs for home care packages, is one way to introduce greater choice and control. Given the large (850,000 in 2018-19) and growing potential CHSP client base (9 million aged 65 and over by 2054-55), and limited services used by each client, an administratively simpler option which would still provide a good measure of choice and control in a competitive environment would be to allow CHSP recipients to enrol with a CHSP provider and fund the provider on an average capitation basis or according to a casemix classification system to provide a wide range of services using pooled resources, supplemented by robust performance measures.

85. Information asymmetry between providers and older people and their families and improved transparency about quality and price have to be addressed and improved in order to support a more competitive service environment that fosters efficient service delivery. An effective market requires a reasonably large proportion of informed consumers to engender more responsive services. The Royal Commission has already heard evidence that the introduction of comparative quality information through the CMS in the United States had an impact on occupancy rates and people's choice of service provider. Hence improving accessibility to and knowledge of comparative information about service quality (as distinct to inputs) is essential for fostering a competitive market. The work currently being progressed by the Government to develop a performance rating system is a step in the right direction.
86. The Royal Commission's concept of creating a regional network of face-to-face 'care finders' to provide assistance with accessing aged care services for anyone who needs it, both upfront and ongoing if needed, will be critical to supporting a more efficient and competitive aged care system.
87. Compared with most other sectors, however, the circumstances of many older people requires that the aged care industry must also operate within a robust quality regulatory framework calibrated to the provision of long term care, which entails both clinical and quality of life outcomes and levels of personal responsibility, especially in home-based care. The Carnell/Paterson Report contained many useful recommendations for strengthening the regulatory environment, some of which are still in the development stage. It is important that these are progressed.
88. There are, however, thin markets, such as rural and remote communities, where competition in service delivery is mostly absent. Indeed, many goods and services are not available in such communities. Many that are depend on government subsidies that compensate for the additional costs of providing services and to keep prices reasonable. Although competitive pressures may be absent, where they are delivered by non-government entities, even with government subsidies, one should not under-estimate

¹³ Many CHSP providers are contracted under the CHSP to provide a limited range of specified services, rather than a full menu of services.

the incentive of being seen as a 'good citizen' by a close knit local community as a motivator for fair and reasonable service behaviour.

89. In practice, many essential services are supported by government, directly or indirectly. This is the case for basic health and aged care services, and appropriate government support should continue to be a feature of the future aged care funding system. There are, however, persistent questions about the adequacy of current subsidies.
90. Responsiveness in service delivery to special interest groups is also an issue. This is likely to be the case even in a highly regulated system, whereas a more competitive market has the potential to support greater responsiveness as providers seek to attract business by catering to the preferences and needs of members of special interest groups. Community leaders and support agencies such as the PICACS could also help identify and encourage providers catering for special interest groups. This approach would complement the current aged care Quality Standards which require providers to be responsive to individual cultural and emotional needs.
91. Such responsiveness is generally unrelated to funding levels, or involve significant additional costs for older people that are not already catered for, such as through means testing arrangements for low means individuals.

D. ARE RESIDENTIAL AGED CARE SERVICES (THAT IS, THE OPERATIONS OF APPROVED PROVIDERS BY WHICH AGED CARE IS PROVIDED TO RESIDENTS OF RESIDENTIAL AGED CARE FACILITIES) CROSS-SUBSIDISING THE PROVISION OF PERSONAL AND CLINICAL CARE THROUGH FUNDING OBTAINED FOR ACCOMMODATION AND HOTEL SERVICES?

If so, include in your statement, if possible:

- a. any evidence for your response
 - b. your views as to the reasons why cross-subsidising is occurring
 - c. your views as to whether this presents problems affecting the efficiency, quality or safety of aged care
 - d. your views as whether and how this could be avoided under a new system?
92. The StewartBrown surveys¹⁴ have consistently reported that everyday living expenses in residential care on average are being provided at a loss, which suggests that other funding streams are subsidising their cost. Given that the cost of inputs vary by geography and socio-economic context, the extent of cross-subsidisation would vary across services and providers.


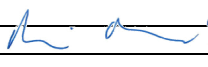
¹⁴ StewartBrown Aged Care Financial Performance Survey: Q2FY20 Survey Results Summary p.18

93. It is inevitable that across providers and from time to time, there will also be some cross-subsidisation associated with the use of Daily Accommodation Payments and interest earned on Refundable Accommodation Deposits. It is instructive that the Aged Care Financing Authority found that, inter alia, there was an association of higher levels of financial performance for providers with higher levels of revenue from accommodation payments by non-supported residents.
94. Segmentation of prices for elements of a discrete service is unusual – what is more usual is that prices reflect the quality of the good or service, e.g. goods and services which fulfil a similar purpose can range from basic to premium.
95. The main justification for price segmentation in residential aged care is to support the administration of different means testing and user contribution policies for different elements of the service. The segmentation of personal and nursing care in residential aged care also provides a benchmark for setting home care package levels (individual budgets), thereby supporting policies aimed at facilitating consumer choice of setting. Nevertheless, as noted earlier, apart from permitted uses relating to Refundable Accommodation Deposits, total revenue is used flexibly by residential aged care service providers.
96. Within limits intended to reduce cross-subsidisation across care recipients, what matters is whether overall revenue is sufficient to meet the Quality Standards applying within a robust quality regulatory framework, and to respond to community expectations. If revenue is to continue to be segmented and price controlled in residential aged care to reflect segment-specific user contribution policies, it is important that the funding streams recognise as much of the costs relating to that segment as possible.
97. However, it does not logically follow that total revenue should not be pooled and used to best effect to achieve the Quality Standards. Quarantining revenue streams to particular inputs would introduce unnecessary regulatory-related administrative and compliance costs and inflexibility.

E. AT A GENERAL LEVEL, WHAT ARE THE INPUT COSTS THAT PROVIDERS FACE IN DELIVERING AGED CARE SERVICES (BOTH RESIDENTIAL AND HOME CARE SERVICES)?

In your answer describe:

- a. how these costs can be expressed and measured
- b. whether these costs vary by reference to:
 - i. the location in which the aged care service is being delivered (i.e. collective living as against living in the community)

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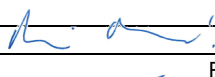
- ii. the geographic location of the service (i.e. metro, regional, remote services)
- iii. the population served (e.g. socio-economic status, CALD, indigenous etc)

c. If these costs do vary, how do they vary?


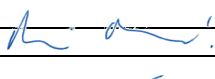
d. What can be done to meet these costs?

98. As would be the case for any service, the classification of input costs used for aged care will be influenced by the intended use of the classification, e.g. to support different forms of analysis, survey collection or public disclosure.
99. ACFA's Annual Reports use the following classification of inputs for residential aged care providers and home care providers, with data derived from General Purpose Financial Statements and Aged Care Financial Reports respectively. This classification is quite different, for example, to that used by StewartBrown for their service level financial performance surveys and benchmarking reports.

Residential	Home Care Packages
Care	Care costs
Employee Expenses	Wages and salaries – care staff
Other	Subcontracted or brokered customer services
Accommodation	Care related expenses
Employee expenses	Administration costs
Repair and maintenance	Wages and salaries – administration staff
Hotel	Administration costs and management fees
Employee expenses	Depreciation and interest costs
Contracted expenses	Other expenses
Other	Total expenses
Administration	
Employee expenses	
Management fees	
Other	
Financing	
Depreciation	
Amortisation	
Interest	
Other	
Revaluation of assets (decrease)	
Loss on sale of assets	
Other	
Total expenses	

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100. The classification of inputs for determining prices or for accountability purposes could be different again.
101. That said, the Royal Commission should also be mindful not to repeat the mistakes of the past by attempting to rigidly specify the use of inputs or second guess the preferences of older people. Within limits, the new system should allow flexibility and incentives that foster the development and adoption of best practice in service delivery, nursing and personal care and behaviour management, including the best use of new technology and adoption of international best practice. This flexibility should occur within a framework where those who can afford to contribute more do so, but on the condition that older people have choice and control over the services they receive, who provides them, and where they live.
102. As recognised by the Royal Commission, there will need to be special arrangements to support those who need additional support when accessing aged care services. But the system should not assume that the circumstances of the latter are reflective of all older people and their families.
103. As with any goods and services, the cost of aged care inputs will vary across geographies, e.g. due to degree of remoteness and the socio-economic status of the region being served, as will prices.
104. In the private market for goods and services, such cost variations together with market characteristics, will mean that certain locations are more profitable than others (after attribution of any corporate overheads), rather than be reflected in widespread cross-subsidisation of loss making services. Unprofitable locations are avoided and unprofitable businesses or business lines are closed.
105. By way of contrast, apart from accommodation, the pricing regime for aged care services begins with the premise that input costs (of personal and nursing care and everyday living expenses) are uniform across Australia. As suggested in response to Question A, this premise seems to stem, in part, from the Commonwealth's approach to welfare payments. An attempt is made to compensate for this through viability supplements, but there is limited financial analysis available to judge how well the supplements reflect the additional costs. The proposed AN-ACC funding model for residential aged care proposes significant changes to current arrangements designed to cater better for these variations, e.g. block funding and increased weightings for small rural and remote services.
106. Some entities, especially not-for-profit providers that operate across regions of varying socio-economic status, degrees of remoteness and input costs, will cross-subsidise poorer performing services as part of their mission objective. Many not-for-profit providers will also cross-subsidise residents within a service and may also draw on other business lines, such as seniors housing developments in metropolitan areas, to subsidise aged care services.
107. A related question that arises is whether it is appropriate for a funding model to accept a level of cross-subsidisation within organisations to support loss making services, either

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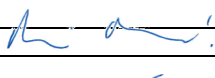
because Australia-wide prices apply or because compensating funding, such as viability supplements, is inadequate.

108. On equity grounds, such cross-subsidisation should not be relied upon by a funding model because it means that some older people may be receiving fewer services than their needs or are being 'taxed' through their contributions to support services that are not financially viable in their own right. In principle, therefore, the design of funding models should not as a matter of policy intentionally incorporate an expectation that such hidden transfer payments will apply.
109. As has been the policy to date, there will be a continuing need to compensate providers for delivering services in high cost areas or to communities with a high proportion of low means residents, generally through pricing arrangements and capital grants.

F. WHAT EVIDENCE IS THERE THAT THERE IS A MARKET FOR THE PROVISION OF AGED CARE SERVICES, ESPECIALLY GIVEN THE MARKET FAILURES INHERENT IN THE CURRENT CAPS ON SUPPLY, THE INFORMATION ASYMMETRIES BETWEEN PROVIDERS AND CLIENTS, AND THE INCUMBANCY ADVANTAGE THAT CURRENT PROVIDERS HAVE?

a. Is there evidence that prices are being set by the market rather than by providers based on the wealth of individuals? If so, identify that evidence.

110. This question was partly addressed in response to Question C.
111. In summary, the current market for aged care services, meaning the competitive supply and availability of a wide range of aged care services, is not well developed.
112. In any sector of the economy, a functioning market also needs supportive regulation to ensure competition and choice, an informed population and consumer protections, and the ever present threat of new entrants and new service models.
113. Aged care, because of the vulnerability of many older people to exploitation and neglect, also requires more comprehensive consumer protections and information disclosure. This does not negate the role that competition and choice can play in fostering more responsive and higher quality services. The two are complementary.
114. Aged care also requires the gradual removal of supply constraints that govern the overall supply of services and service types (subject to sustainability considerations), or allowing older people to direct their funding entitlement to their preferred service provider. Aged care requires timely and reliable performance rating information; it requires tailored access and support arrangements for the most vulnerable; it requires adaptations where demand is insufficient to support a competitive market, but policy designed for such circumstances should not dictate policies to apply where demand is sufficient to support a competitive service environment.

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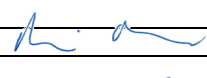
115. While removal of rationing is an important attribute of a competitive market, competitive forces can be achieved by introducing funding following the consumer, as is happening for home care packages.
116. As to whether prices are being set by the market or by providers having regard to the wealth of individuals, there is a clear risk that rationed supply and the absence of competition and choice will create fertile ground for the latter behaviour. That said, even in competitive markets, prices invariably will be higher for goods and services in higher socio-economic areas, reflecting capacity to pay, willingness to purchase higher quality services, and higher input costs, e.g. land costs.

G. SHOULD THE CURRENT PRICE CAPS APPLYING IN AGED CARE (EG THE BASIC DAILY FEE, DAILY CARE FEE, AND CAPS ON RADS AND DAPS VARIABLE BY THE PRICING COMMISSIONER) TO THE PRICES OF AGED CARE SERVICES BE DETERMINED BY THE "MARKET"

b. If so, what level of regulation, support or planning would a market require?


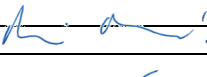
c. If not, how should prices be determined?

117. Essential pre-conditions for removing price caps are:
- The existence of a competitive market through the removal of rationing, or at least introducing funding following the consumer and choice of service option (residential or home-based setting)
 - A robust and cost-effective quality regulatory framework
 - Reliable, timely, readily accessible and easy to understand comparative information about quality and price, including consumer experience
 - Support for vulnerable older people and their families and for vulnerable communities, and where competitive markets are absent.
118. These pre-conditions have been addressed in the *Legislated Review of Aged Care Reform 2017*, along with a number of recommended strategies for their phased implementation.
119. Until a competitive service provision environment is in place, it would be prudent to have price caps for all three main revenue streams in residential aged care, or price thresholds beyond which approval of prices is required. In contrast, it is appropriate that price caps continue not to apply for services purchased using individual budgets in home care where services are being provided in a competitive service environment, supported by regulations concerning price disclosure and a quality assurance framework. The introduction of a competitive environment was a significant change, and both providers and the community are still transitioning to the new arrangements.

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H. SHOULD AN INDEPENDENT AUTHORITY, OR ALTERNATIVELY THE GOVERNMENT, SET LEVELS OF FUNDING BASED ON ACTUAL COST DATA? IF SO, SHOULD THE LEVELS BE SET AT BENCHMARK EFFICIENT LEVELS OR MERELY AVERAGE LEVELS?

120. As noted earlier, price setting in residential aged care for personal and nursing care and everyday living expenses by government has no direct 'line of sight' to the cost of delivering these services, nor the quality/volume of these services, nor community expectations. Home care package funding levels have some alignment with residential care subsidies/prices, and CHSP is grant funded.
121. Using benchmark efficient levels or average levels for setting prices is more readily applied when there is an agreed measurable outcome of quality or volume for a service or good. Setting prices using either benchmark efficient levels or average levels based on cost data from residential aged care services operating under the today's system would perpetuate the current overall quality of care being delivered, which the Royal Commission has identified as being inadequate. Moreover, there would need to be confidence that there is an association between quality of care and quality of life and financial performance or efficiency.
122. It is unclear how a costing methodology would factor in service quality variations or define an acceptable quality standard. Another complication is the wide variation in resident acuity profiles across services. The long term nature of aged care and its co-mingling with life style preferences, expectations and outcomes further complicates the picture. A further complication is that there are a wide variety of models of care emerging which are being provided in a variety of building designs and layouts. Then there is the problem of disentangling to what extent fees for additional services are supporting higher quality outcomes, and the extent to which quality of care is influenced by access to the services of the wider health system, which are separately funded.
123. If prices are to be set at benchmark levels of efficiency, the above factors would need to be taken into consideration in the costing methodology. For instance, it may be possible to identify homes that are delivering what is judged to be quality care and lifestyle outcomes and base pricing on service costs in those homes.
124. Having prices set by an independent pricing authority, as opposed to informed by an independent authority's transparent analysis, would mean that aged care funding would be more insulated from the demands of other Budget priorities and economic fluctuations. There are attractions in this approach for older Australians dependent on aged care services, as well as for service providers who are seeking greater consistency and transparency in price setting.
125. The arrangements for funding public hospitals provide a precedent for independent price setting. The Independent Health Pricing Authority (IHPA) is charged by COAG with determining an annual National Efficient Price for public hospital services to support a national Activity Based Funding system that is used to calculate the amount of

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Commonwealth contribution to Local Health Networks. However, government would need to have confidence about future demand and costs of aged care before it would be likely to agree to independent price setting arrangements, especially noting that aged care's call on the Budget is projected to increase significantly¹⁵. The creation of the national prioritisation system for home care and declining occupancy in residential aged care have provided a better understanding of demand in these areas, but still leaves a big question mark over the demand for CHSP services.

126. Given the comments above about the links between setting prices and quality of services, it is instructive that IHPA works in "partnership" with the Australian Commission on Safety and Quality in Health Care to ensure that pricing, quality, and performance measures for public hospitals are complementary. Similar arrangements that are transparent and fit-for-purpose would need to be developed for aged care services.

I. IN THE LONG TERM, WHAT WOULD BE THE OPTIMAL FINANCING ARRANGEMENTS OR ARRANGEMENTS TO SUPPORT THE ECONOMIC SUSTAINABILITY OF THE AGED CARE SECTOR?

127. The optimal financing arrangements for aged care in Australia require a judgement on the appropriate balance of public and private financing of aged care overall and of the components of aged care – accommodation, everyday living expenses and personal and nursing care.
128. The Productivity Commission¹⁶ outlined the following principles as a guide to funding aged care:
- Accommodation and everyday living expenses should be the responsibility of individuals, with a safety net for those of limited needs
 - Health care services provided through aged care (such as nursing and allied health care), should be subject to charging arrangements consistent with those for the health system
 - Individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic cost.
129. These principles should underpin the design of optimal financing arrangements, noting the following caveats:
- In practice, many health care services will also involve the provision of personal care as a matter of course, so drawing a distinction between personal and

¹⁵ The 2015 *Intergenerational Report* projected, based on aged care policies that applied at the time, projected that government spending on aged care services would likely almost double, from less than 1% of GDP in 2014-15 to 1.7% by 2054-55.

¹⁶ Productivity Commission *Caring for Older Australians* June 2011

nursing care is questionable, especially in aged care where frailty and the need for personal care and nursing care often come together.

- Notwithstanding Medicare, many aspects of Australian health care are privately financed, including co-payments and private (subsidised) health insurance.
- The Medicare Levy covers only a relatively small proportion of government outlays on health, and Levy proceeds are not hypothecated. The Medicare Levy is an income tax by another name, and any increase in the Levy would be analogous to increasing income tax.

130. Given the projected increase in age-related government outlays and the implications for economic policy, and the sustainability of aged care services in particular, the Productivity Commission also reviewed options for broadening the funding base for aged care services, including private savings (aged care savings accounts and quarantined superannuation contributions), equity release products and insurance (both voluntary and compulsory).



131. The Productivity Commission's review supported the continuation of the current pay-as-you-go tax financed system supplemented by higher co-contributions and a lifetime stop-loss mechanism, a form of social insurance in the event of excessive individual costs.

132. This assessment remains valid today, noting:

- Increased private savings dedicated to funding the private costs of aged care is not efficient because some older people will save too much and others not enough
- Private savings would redistribute resources across a person's life, but would not allow pooling of the costs of aged care services across the population
- Voluntary insurance is unlikely to work other than at the margins because of problems on both the supply and demand side of the market. This has been the international experience, noting also that the introduction in 2014 of annual and lifetime caps on care contributions in Australia has not prompted a supply response.

133. Many older Australians have built up wealth over a working lifetime, mostly in the form of (capital gains tax free) home ownership. This wealth could be drawn upon to increase contributions towards care-related costs in aged care. Contributions currently represent only 5% and 6% of care costs in residential and home care. A modest increase in contributions would have a beneficial impact on sustainability while still preserving substantial inheritances.

134. Because most people's wealth is represented in home ownership, increased private contributions would need to be supported by financial instruments such as equity release. Equity release products offered by the private sector have not been favourably received by older people. Accordingly, the Productivity Commission recommended the

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introduction of a government-backed equity release scheme in order to increase community confidence in using equity release for aged care.

135. The Government subsequently expanded the scope and access to the Pension Loan Scheme to allow home ownership wealth to be used flexibly to support retirement living, as well as aged care costs such as accommodation (excluding RADs), living expenses and personal and nursing costs and home care costs, without the forced sale of the home.
136. The Government should consider the costs and benefits of applying more concessional interest rates when the Pension Loan Scheme is used for aged care costs as a means of encouraging greater use of this facility, in conjunction with measures to increase contributions by older people and to increase consumer choice and control.
137. The current exclusion of the full value of former family home from the residential aged care means test is regressive by counting the same dollar value of the former home as assessable under the means test (\$171,000) regardless of the value of the home. In effect, the aged care system is subsidising inheritances. The Productivity Commission reported in a research paper¹⁷ that the value of bequests received in Australia in 2013, before the recent period of home price increases, was \$24 billion.

J. SHOULD THE PRINCIPLES UNDERLYING THE GOVERNMENT'S CONTRIBUTION TO THE FINANCING ARRANGEMENTS FOR AGED CARE BE ALIGNED WITH RETIREMENT INCOME POLICY OR ARE THEY BETTER ALIGNED WITH THE HEALTH FINANCING PRINCIPLES? MIGHT IT BE APPROPRIATE FOR DIFFERENT SETS OF PRINCIPLES TO APPLY TO DIFFERENT TYPES OF COSTS EG ACCOMMODATION V CARE?

138. The current aged care system in Australia draws on both retirement income policy and health financing policy, distinguishing features of which being that retirement income policy targets taxpayer assistance to those with lesser means whereas health financing policy has a significant, but by no means complete, focus on social insurance. As mentioned in response to Question B, elements of the aged care system (the capping of everyday living expenses in particular), seem to be influenced by welfare policy.
139. There are grounds for applying both retirement income and health funding principles to aged care, depending on the components of aged care.
140. **Personal and nursing care and allied health:** There is a case for considering personal and nursing care and allied health costs under the Medicare principles that apply to health services generally. However, it is noteworthy that under Medicare, many aspects of health care services involve gap payments or are funded under private (subsidised) health insurance arrangements, i.e. taxpayer funded social insurance for health costs does not apply universally. Accordingly, applying health funding policy to aged care


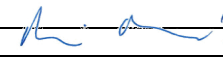
¹⁷ Productivity Commission Research Paper *Housing Decisions of Older Australians* December 2015

would not preclude increased private contributions for personal and nursing care by those who can afford to pay.

141. It is also relevant that a form of social insurance already applies in aged care through the annual and lifetime caps on co-contributions towards home care costs and the cost of personal and nursing care in residential care. This does not mean that the current caps should not be reviewed to ensure their effectiveness is delivering a social insurance dimension to aged care policy.
142. **Everyday living expenses:** With regard to everyday living expenses, there is a case for applying retirement income policy, i.e. publicly funded support should be reserved for those with lesser means. However, the current cap on fees for everyday living expenses (85% of the single pension) is inconsistent with this policy.
143. The logic of restricting all older people to contributing 85% of the single age pension towards their everyday living expenses when such restrictions have never applied at any other point during their lives is hard to fathom. Individuals and families should be able to contribute what they wish given their preferences and life experiences.
144. If government is concerned – as it should be – that 85% of the single pension is insufficient to achieve quality of life outcomes for supported residents, the government should benchmark prices/subsidies to what is paid by non-supported residents and top-up the 85% of the pension accordingly.
145. **Accommodation:** Applying the above principles would mean that accommodation costs should also be borne by the individual, the expectation that applies during an adult's life cycle. Eligibility for accommodation support should be based on means, irrespective of age.
146. **NDIS:** In applying these principles, there is a case for drawing a distinction between aged care and NDIS-funded services for people living with disabilities. The latter receive support to allow their participation as much as possible in mainstream society over a lifetime and to lead a better life. Older Australians have had a lifetime of engagement with society, the economy and the workforce which, to varying degrees, has allowed the accumulation of wealth to help support them manage age-related frailty in their preferred living arrangements.

K. SHOULD PEOPLE CONTRIBUTE TO SAVINGS FUNDS DIRECTED TOWARDS THE AGED CARE SERVICES THEY WILL CONSUMER WHEN THEY AGE?

147. Savings funds would have had to have been introduced several decades ago to be of benefit in addressing the aged care costs of the post war generation. Moreover, a criticism of savings funds is that they can lead to over saving or under saving, and do not allow pooling of some or all of the cost of aged care across the population.

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L. WHAT INTERNATIONAL MODELS (IN WHOLE OR IN PART) WOULD SERVE AS USEFUL PRECEDENTS FOR FINANCING AGED CARE IN AUSTRALIA?

a. What, if any, adaptations to the international model(s) identified in response to Question I above would be necessary for the Australian context?

148. Australia's combination of taxation, retirement income, welfare, health, housing and aged care policies have developed independently of other countries within a federal system of Government, and hence have many unique and inter-related features. The scope for making structural changes to aged care financing policies is constrained by these policy inter-relationships, and would introduce policy and transitional complexities. On balance, it is not apparent that overseas financing models for long term care and social services have much relevance in the context of Australia's political economy.
149. These differences are starkly reflected in comparisons of taxes as a share of GDP.
150. A wide range of potential reforms to the aged care sector applicable in an Australian context have already been canvassed by many reviews and reports.
151. The above does not diminish the importance of designing an aged care system with the flexibility and incentives to pursue international best practice in service delivery, and to contribute to advancing the frontier of best practice and optimum use of technology. It also does not diminish the need to have best practice quality regulatory arrangements and performance rating disclosure.


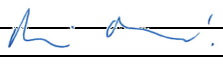
M. WHAT ARE THE CURRENT REVENUE RAISING ARRANGEMENTS (EG BASIC DAILY FEE, MEANS TESTED CONTRIBUTIONS TO THE CARE PAYMENT, EXTRA AND ADDITIONAL FEES, RADS AND DAPS) BUILT INTO THE AGED CARE SYSTEM?

a. Are they adequate or are they excessive?

152. This question was addressed in responses to Questions A and B.

b. Are the current means testing arrangements equitable/ fair and efficient?

153. The fairness and efficiency of the current means testing arrangements were addressed in the *Legislated Review of Aged Care Reform 2017*. Adoption of the following measures, most of which are recommendations of the Review, would improve the fairness and efficiency of the means testing arrangements and the sustainability of aged care services:
- a. Including the full value of the former home in the means test, or the value over a threshold.
 - b. Review the appropriateness of the current annual and lifetime caps on income tested fees, especially if contribution rates are changed.

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- c. Require providers to charge the basic care fee in home care, and make the value of the basic care fee proportionate to the value of the home care package.
- d. Introduce mandatory consumer contributions for services under the CHSP consistent with the fee regime applied for home care packages.
- e. Review the equity of the “protected person” policy which allows a significant proportion of residents to qualify for an accommodation supplement irrespective of wealth.

c. Should people be required to contribute more to the cost of the aged care services they consume and if so by what mechanism or mechanisms?

- 154. Means testing arrangements already require those with means to contribute to their residential care accommodation costs, except where the former home is occupied by a partner or dependent person.
- 155. All residents are required to pay for their everyday living costs at a flat rate determined by the Government.
- 156. Home care recipients are responsible for their accommodation costs and everyday living expenses.
- 157. Both home care and residential care recipients contribute minimally towards their personal and nursing care costs – 5% and 6% respectively in 2017-18¹⁸. There is a case on sustainability grounds for increasing the current contributions. Savings would accrue to the Budget and provide greater scope to support those with lesser means.
- 158. Financing and user contribution issues were addressed under Questions I and J, including use of the Pension Loan Scheme to facilitate increased co-contributions in conjunction with greater choice and control.

d. Is there scope in the home care setting for levying co-contributions by reference to the amount actually expended from funding which is available for care of a particular individual, rather than to the amount of the funding entitlement?

- 159. Implementation of this measure under current payment in advance arrangements would introduce unnecessary complexity into the system. Moreover, under current arrangements, any underspend of private contributions is returned to the package holder or their estate on leaving the package.
- 160. A better option would be for government payments and care recipient contributions to be made in arrears based on services delivered, as discussed under (e) and (f) below.

¹⁸ Aged Care Financing Authority *Seventh Annual Report on the Funding and Financing of the Aged Care Industry* July 2019

e. Should payments of home care funding be made in arrears, and why?

161. Payment of aged care subsidies should be in arrears based on services delivered. This is normal business practice, and would avoid the administrative costs and prudential risks of providers holding unspent funds. Implementation of payment of subsidies on this basis would need to be phased in. The Aged Care Financing Authority¹⁹ has provided recommendations concerning transition and implementation arrangements.
162. It is noted that the Government has already signalled its intention to introduce the payment of home care subsidies in arrears based on services delivered, though its phased introduction has been delayed because of the financial impact of the COVID-19 pandemic.

f. Should unspent home care package funding entitlements accumulate or be cancelled at the end of each payment period, and why?


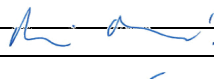
163. Cancelling unspent funds at the end of a payment period is one option for addressing the level of unspent funds held by providers. However, this would limit the capacity, in the absence of pooled funding, for services to be flexed up and down according to need, and may result in scarce resources being used for avoidable reassessments.
164. A more practical approach would be to introduce payment in arrears based on services delivered, together with more robust performance management of assessors and the introduction of a classification system (administered independently of providers) that would increase the number of payment levels and reduce the difference in funding between classification levels.

N. WHAT FUNDING MODELS OR MECHANISMS (EG CASE MIX, BLOCK FUNDING, VOUCHERS, AND CASH ETC) SHOULD BE USED FOR AGED CARE?

Without limiting the matters you wish to address, your statement should cover:

- a. Basic domestic supports**
- b. Basic social supports**
- c. Personal care, nursing, allied health and other care for more complex needs provided in the home, flexible supported accommodation or other community settings**
- d. Personal care, nursing, allied health and other care for more complex needs provided in the setting of residential aged care facilities**

¹⁹ Aged Care Financing Authority *Financial Impact on Home Care Providers as a result of Changes in Payment Arrangements* December 2019

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e. Respite

f. Support services for informal carers

In responding to the above, address the question of what is the appropriate test for determining how much funding is provided to an aged care service provider for the various categories of services they provide?


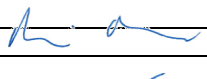
g. Is using an individualised care plan to generate an individualised budget, or a casemix based funding model, or something else, appropriate? Does your answer differ between residential aged care and home care services? If so, why?

h. If the better model is an individualised care plan and budget model (e.g. 'reasonable and necessary' test), what are the key features that model should have and what is needed for its successful implementation?

i. If the better model is a casemix model, what are the key features that model should have and what is needed for its successful implementation?


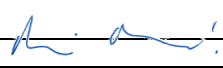
165. The selection of funding models and mechanisms requires a balancing of many inter-related policy issues, and the balance can vary for different elements of the system. Policy issues include:

- The degree of consumer choice and control over services, setting and service provider. Achieving choice and control, which can be achieved in different ways, should be the starting point in program design
- Allied to the point above, the level of service delivery competition desired in the system
- The extent to which the primary funder (government) wishes to have control over the purposes for which public funding is used, e.g. a focus on reablement
- The level of Budget control sought by the primary funder (government)
- The economics of service delivery, and in particular how individual needs can be most cost effectively delivered
- The economics of service delivery in certain circumstances:
 - congregate living v each older person's home,
 - thin markets with insufficient demand to support competition in service delivery and economies of scale
- Administrative simplicity/difficulty/costs under different funding mechanisms
- The extent to which aged care funding is directed to supporting informal carers

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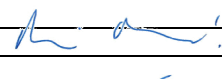
- The extent to which funding mechanisms need to be tailored to better support communities with distinctive cultural characteristics which affect service delivery, such as Indigenous communities
- The extent to which service delivery in certain circumstances involves a partnership with other jurisdictions, e.g. to achieve economies of scale
- The extent to which better outcomes can be achieved through specialist in-reach services.

166. Catholic Health Australia's [submission](#) in response to Consultation Paper 1 issued by the Royal Commission attempted to balance many of these considerations, including by canvassing a variation on the aged care program design presented in Consultation Paper 1.
167. The following sets out some additional reflections to those in CHA's submission:
168. **Entry level support:** There is a case on grounds of administrative simplicity and cost for assistance with basic domestic supports for age pensioners (referred to in Consultation Paper 1 as entry level services) being provided as a debit card based standard payment (scaled to means), subject to a needs assessment. The aged pension assumes a high degree of self-provision during an extended retirement period. It does not take into account when age related frailty means that self-provision capability diminishes. Age pensioners would then have flexibility to purchase specified services as needed from preferred providers.
169. However, this approach would need to be balanced against demand and cost if the assistance is to be provided on an entitlement basis. The approach may also not lend itself to the implementation of effective reablement strategies. It may also be the case for many older people that the need for basic assistance with domestic activities will coincide with the need for personal care and support, which raises questions about the practicality of separating the funding streams.
170. An attractive feature of a standard payment for aged pensioners that applies regardless of setting is that it would allow older people using residential aged care to purchase additional services to match such services purchased by non-supported residents. But there are other strategies for addressing this issue, such as a subsidy top-up of the basic daily fee.
171. **Funding following the consumer in CHSP:** As noted earlier in this Statement, there is a case on administrative cost grounds, while still achieving greater consumer choice and control, for providing lower level CHSP-type care and support on a 'funding following the consumer' basis, with individual budgets only applying for higher level packages (to be defined) which cater for personal support and nursing care needs as an alternative to residential care. Funding could either be on a capitation basis or linked to a classification system, but pooled under both arrangements.
172. Both the above approach and the alternative of individual budgets across all home-based aged care would entail a significant restructuring and rationalisation of the CHSP

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sector, currently characterised by almost 1,500 providers each with a contract with the Department of Health to deliver a specified list of services. It would also require elimination of the home care package waiting list, noting that many on the queue are also currently receiving CHSP.

173. **Respite services:** For administrative simplicity, there is a case for respite and group social supports for people living in the community to continue to be grant funded, with an appropriate means tested co-contribution, on the basis that these services tend to be group activities rather than consumed individually. There are also different forms of respite and social supports with different unit costs, adding complexity to reflecting these costs in an individual budget.
174. Residential respite funding should be aligned with the proposed new AN-ACC funding model for residential aged care.
175. **Block funding:** Block funding is relevant in the case of small providers in thin markets where economies of scale are not present and where small changes in occupancy can have inordinate budgeting consequences.
176. CHA's submission in response to Consultation Paper 1 also commented on the use of individualised care plans to generate individual budgets based on the NDIS's "reasonable and necessary" criterion. This approach is not favoured for aged care because of the following:
 - It would be administratively very costly, including significant workforce implications. Home-based care recipients are already more than double the number of NDIS clients and, more importantly, significant growth in the number of people potentially needing aged care is projected. By 2054-55, the 65-84 cohort is projected to be around 7 million, and the 85 and over cohort is projected to be around 2 million people (together around 23% of Australia's population).
 - As identified in the recent Review of the [National Disability Insurance Scheme Act](#), the subjective nature of the "reasonable and necessary" criterion, and the improbability that it would be applied consistently if applied to a much larger number of older people, creates the potential for a significant number of disputation/review requests.
 - Although the NDIS uses individually costed care plans prepared by independent contracted parties (Local Area Coordinators), in practice, budget approval by the NDIA has regard to reference levels akin to classification levels, but without the rigour of a cost-effectively administered classification and assessment system – resident classifications under the AN-ACC are taking less than one hour.
 - There are administrative and care continuity advantages in basing program design on encouraging a close and ongoing relationship between the chosen provider and the older person whereby the provider is responsible for preparing and reviewing a care plan in partnership with the older person/family, with external support arrangements for those older people who would benefit from such third party support. That is, there is separation of assessment for funding

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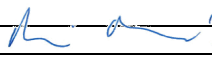
purposes and assessment for developing and reviewing care plans. Care planning and coordination is an integral part of service delivery.

- A more sustainable funding model for home-based care would be to reference funding to what it would cost to provide care in a congregate living environment, rather than fund each person according to 'whatever it takes' to meet all their assessed needs, irrespective of setting.

177. Overall, an appropriately designed classification-based funding system would be a more cost effective model, yet still provide consumer choice and control. Appropriately designed, it could also reduce reassessments, noting that older people's needs are likely to change significantly over a relatively short time period compared with most NDIS clients.

O. HOW SHOULD FUNDING MODELS ACCOUNT FOR CHANGING COST INPUTS OF AGED CARE PROVIDERS?

178. Given the current price capped arrangements for the provision of personal and nursing care and everyday living expenses in residential aged care, a funding model should be informed by cost inputs and financial performance outcomes identified through regular cost studies whose methodology takes into account total costs and revenues and accepted quality of care and quality of life outcomes.
179. In order to capture an expectation of productivity gains through use of technology and innovation in service delivery, it would be necessary that delivery of services in most cases is taking place in a competitive market. The alternative of including a productivity dividend in indexation arrangements has proven problematic due to the difficulty in identifying an indexation formula that consistently, accurately and fairly reflects productivity trends in the sector.
180. For home-based care, it is not sustainable to base a funding model on the premise that every older person will have all their care and support needs met through government subsidies. The delivery of home-based care will be more expensive than to deliver the same level of care in a congregate living setting, such as residential aged care. As well, unlike people assisted under the NDIS, the aged care funding model should take into account that older people have had a lifetime of engagement with society, the economy and the workforce to accumulate wealth to help support themselves in their preferred living arrangement, and often have better access to informal care and other supports.
181. Accordingly, the government subsidy for personal and nursing care for those who choose to live in a non-residential aged care setting should be no more than the subsidy/price set for an older person with an equivalent needs classification living in an aged care home. The government subsidy for people choosing to live in a non-residential aged care setting should be seen as a contribution towards their care costs, rather than providing funding for 24/7 care.

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P. AS TO THE COST OF CAPITAL AND REQUIRED RATE OF RETURN ON CAPITAL FOR AGED CARE SERVICE PROVIDERS :

a. Should the funding of aged care meet providers' cost of capital?

182. Investment decisions are expected to generate a rate of return that at least exceeds an entity's cost of capital to the fund the investment, as well as the entity's hurdle rate for proceeding with one investment over another. The cost of capital will vary across entities depending, inter alia, on their balance of equity to debt, including an entity's risk profile. This is further complicated for aged care investments through the use of RADs as a source of capital. A project's projected balance of DAPs and RADs will impact costs of capital and hurdle rates.


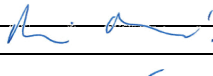
b. Does the cost of equity capital materially vary depending upon the scale, business model, constitution (for profit, public listed for profit, not for profit) and capital structure of the provider?

183. The cost of equity capital, or returns on equity, can be expected to vary across for-profit, listed for-profit and not-for-profit entities, reflecting the different motivations of investors, risk appetite, and propensity to seek out other investments in order to maximise returns.

c. Should the cost of capital for aged care service providers be estimated from a weighted average cost of capital including both equity and debt capital?

184. The Weighted Cost of Capital Approach (WACC) is used extensively in the commercial sector to benchmark projects against alternative investments, both within an industry sector and outside the sector.
185. Every entity's WACC and hurdle rates will be different depending on the risk profile of the entity, the source of their funding (including mix of RADs and DAPs), and the equity/debt mix. A not-for-profit WACC might be a product of a mix of cash investments and debt. An ASX entity might raise equity or hybrid equity instruments as well, depending on their risk rating.
186. It is often considered that the WACC approach may not adequately reflect the circumstances of not-for-profit organisations because their financing structures and basis of operations are not solely driven by financial considerations, hence their purpose and mission cannot be measured by reference to financial parameters alone.
187. Given the above, it is generally considered that it is not possible to determine a homogenous WACC for analysis purposes across a sector such as the aged care sector with its diversity of entity types.

Q. WHAT ROLE DO RADs PLAY IN AGED CARE FINANCING AND HOW WOULD THE CAPITAL MARKETS REACT TO ANY CHANGE IN THE REGULATION OF RADs, INCLUDING PROPOSALS FOR THEIR ABOLITION?

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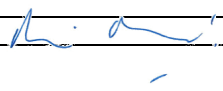
188. Refundable Accommodation Deposits (RADs) held by aged care providers currently total \$30 billion, and are the main source of low cost capital for the development of new residential aged care facilities and for renewing old stock – a form of equity for which no dividends are payable and a form of interest free debt from which interest may be earned from time to time. In 2018-19, RADs made up 75% of the capital funding of the sector.
189. In the absence of RADs, the sector would have to become reliant on more expensive debt from financial institutions and equity (either investors or retained earnings) to finance their operations. It is often remarked that two-thirds of residential aged care providers operating under current funding and regulatory arrangements are already “unbankable”, meaning that they would have difficulty attracting either institutional finance or investor finance.
190. In short, RADs and their predecessor accommodation bonds have allowed aged care services to be provided at lower capital cost than would be the case if financing were required to be accessed on normal commercial capital financing arrangements.
191. As the primary funder of aged care, the government has also been a beneficiary of this source of low cost capital for the residential aged care sector.
192. The removal of RADs would require the sector to be able to meet normal commercial financing terms such as Loan to Value Ratios, which would require providers to be achieving commercial rates of return and, mostly in the case of for-profit providers, to have stronger balance sheets. Hence the removal of RADs would have to be carefully phased-in if business failures due to liquidity pressures are to be avoided, and will require adaptations to the current accommodation-related funding arrangements for supported residents to reflect the higher costs of capital.

Signed: _____

Date: 11 April 2020

Witness: _____

Date: 11 April 2020

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