Statement of Professor Henry Cutler

Name: Professor Henry Cutler

Date of birth: [redacted]

Address: [redacted]

Occupation: Health economist

Date: 21 July 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. This statement is true and correct to the best of my knowledge and belief.

2. Where direct speech is referred to in this statement, it is provided in words or words to the effect of those, which to the best of my recollection, were used at the time.

3. The views I express in this statement are my own based on my education, training and experience. They are not intended to represent any views of my employer.

Professional background

4. I am currently the Director of the Macquarie University Centre for the Health Economy (MUCHE). I have been in this role since 2015. I am an experienced health economist, having completed a PhD (Economics) at UNSW in 2009, M.Ec (Hons) at USYD in 2002 and B.Bus (Ec) at UTS in 1997.

5. Prior to working at MUCHE, I worked for KPMG as Director and national lead of health economics.

6. MUCHE is a strategic university initiative developed to undertake innovative research on health and aged care systems. It seeks to develop and promote ideas that influence views held by the academic community, policymakers, and the public.

7. MUCHE undertakes research funded by competitive academic grants and by government and non-government organisations. We investigate the Health Economy at the macro level, focused on the interdependencies of these systems with each other and the broader economy. This includes investigating factors beyond the health and human services sectors that impact the health and wellbeing of populations.

8. MUCHE has 14 health economics researchers, two support staff and four PhD students. Our four key strategic research themes include aged care, mental health, health technology, and integrated care.
9. Over the last five years, our focus on external engagement and applied research has allowed us to work with 30 external organisations and complete 23 research projects. We have advised eight government departments or agencies, and have been interviewed, quoted, or have provided opinion pieces to mainstream media on health and aged care policy issues over 40 times.

10. We have become a reliable reference point for decision makers. Our research has been quoted by the Productivity Commission and used by the Australian Government Senate Select Committee into the Scrutiny of Government Budget Measures. We are contracted by the Department of Health to evaluate pharmaceuticals and medical devices, to help the Australian Government decide whether they should be listed on the Pharmaceutical Benefits Scheme and Medicare Benefits Scheme respectively.

11. We have pushed the academic debate forward with nearly 60 journal publications. Our research has been communicated through 29 industry events and executive round tables. Our external seminar series has attracted internationally renowned academics to Macquarie University, showcasing our desire to better inform decision makers and the broader academic community with innovative research from all corners of the world.

12. We actively collaborate with our Macquarie University academic partners within the Macquarie Business School, Faculty of Medicine, Health and Human Sciences and Faculty of Science and Engineering. We collaborate with research hubs and centres. These include partners within the Australian Hearing Hub, the Australian Institute of Health Innovation, the Centre for Emotional Health, along with several NHMRC Centres for Research Excellence. Our collaborations also extend to world leading universities in Europe and Asia.

13. We partner with government and non-government organisations that require research to solve complex problems within public policy debate. These include federal and state health departments and treasury, government agencies, royal commissions and local health districts. Our research is also used by large international organisations and local not-for profit organisations, to help develop and implement their strategy for success.

14. I report to the Executive Dean of the Macquarie Business School. As the Director of MUCHE, my role is to set the strategic research direction of MUCHE and lead the team towards our vision, manage teams, undertake quality assurance of research, develop and maintain external relationships with government and non-government organisations.

15. I am also responsible for hosting Thought Leadership events, presenting research at domestic and international conferences, mentoring research staff, winning competitive grants, undertaking media and community engagement, participating in internal and external committees, supervising PhD students, leading innovative cross disciplinary research, and undertaking peer review.

My experience working in aged care

16. I have undertaken research for Alzheimer's Australia on evaluating dementia care policy, made recommendations to the Australian Nursing Federation to improve the sustainability of the RAC workforce, evaluated the cost effectiveness of healthy ageing.
strategies for Medibank Private, helped ACAA and LASA interpret Productivity Commission recommendations and LLLB reforms, and undertaken other research for several large aged care providers, including the Salvation Army, Australian Unity and Estia Health.

17. I led the development of two reports for the Aged Care Financing Authority on the potential impact of aged care financing arrangements under the Living Longer Living Better (LLLB) reform package on access to quality care, sustainability, industry viability and the aged care workforce. This required developing a model to estimate the decisions potential residents would make when choosing between a RAD, DAP or combination of both, within the context of impacts on co-contributions to care, taxation, and age pension income.

18. I have also delivered Transitional Business Advisory Services to aged care providers on behalf of the Department of Social Services, which included helping providers appropriately price rooms based on their estimated capital cost, and required return on investment.

19. I led a research project for one large aged care provider to estimate the relationship between housing price movements and accommodation pricing. This required detailed econometric analysis, and forecasting residential asset values over five years.

20. I am currently leading a project to determine whether older Australians make optimal payment decisions when entering residential aged care. This includes evaluating the extent to which people entering residential aged care are making sub-optimal payment decisions from an income and wealth perspective; determining which factors (e.g., financial literacy, socioeconomic characteristics, care circumstance), contribute to non-optimal payment decisions; and identifying potential interventions to help people make optimal payment decisions that maximize their financial wellbeing.

21. I am also currently leading a project on behalf of ACFA to evaluate the role of RADs in residential age care.

Financial state of the aged care sector

Are aged care providers adequately funded to provide quality care?

22. Care quality among residential aged care providers varies considerably. While the Aged Care Safety and Quality Commission have found several facilities that require areas for improvement, are non-compliant, or have been sanctioned, this is a small proportion of residential aged care facilities. This suggests that most residential aged care facilities meet the minimum quality threshold set by the accreditation framework under the current funding arrangement, most of the time.

23. If society accepts this quality threshold, and the accreditation framework measures the true level of quality among residential aged care providers, then these accreditation outcomes suggest providers are adequately funded, at least in the short term. However, findings from the Royal Commission suggests that society wants the quality of care delivered within residential aged care to be improved. Prior reviews have also suggested
that the accreditation and monitoring framework has not adequately captured poor quality within the residential aged care sector.¹

24. Financial metrics suggest that the current levels of quality may not be sustainable in the future. Nearly half of all providers make a financial loss each year, although these are not necessarily the same providers each year. The Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) margin has decreased from 10.6 per cent in 2012-13 to 8.8 per cent in 2017-18.² More recent data suggest the EBITDA margin has continued to decline.³ The decline in recent financial performance has been experienced by the entire residential aged care sector, although not equally with not-for-profits experiencing the biggest impact.

25. Like quality, financial outcomes are also heterogeneous. For-profit providers and those with 20 or more facilities have the highest EBITDA margins. The ACFA suggests that lower margins for not-for-profits may result from different business models and alternative funding sources. While this is true, it is uncertain whether these business models are sustainable, particularly in times of economic hardship where other services offered by not-for-profits (e.g., helping those unemployed from the Covid-19 response) may take precedence. At the very least, there will be more significant pressure to reallocate some funds away from residential aged care in times of economic hardship if these services are currently being cross subsidised.

26. There has also been a potential lack of underinvestment in new facilities. While demand for residential aged care is currently linear, projections suggest an increase in the growth of residential aged care demand in 2030, when the baby boomers hit 85, which is about the average age where someone enters residential care. Residential aged care providers must develop good quality facilities if they are to provide good quality care that meets consumer preferences.

27. The amount of funding given to residential aged care providers and the way funding is delivered can impact care quality.⁴ A study that investigated the relationship between prices and quality across 7,400 German nursing homes found higher prices significantly increased a quality index comprised of seven risk factors drawn from report cards.⁵,⁶ US studies have found increased Medicaid reimbursement led to higher professional staff intensity, although this did not translate to improved quality.⁷ Another US study found a

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¹ Senate Community Affairs Reference Committee. Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced. Canberra: Commonwealth of Australia, 2019.
² Aged Care Financing Authority (ACFA) 2019, Seventh Report on the funding and financing of the aged care sector, Australian Government, Canberra
³ StuartBrown 2020, Aged care financial performance survey, Nine months ended March 2020, StuartBrown, Sydney
⁶ This study accounted for potential endogeneity given that higher quality could have increased higher prices.
reduction in Medicare cost reimbursement for short stay residents led to increased pressure sores and urinary tract infections due to reduced staffing. Improved US nursing home profit margins have also led to increased total staff hours per resident, but only when quality report cards were available.

28. If the Royal Commission recommends significant changes to residential aged care that aligns with prior aged care review recommendations, this will substantially increase provider costs if implemented. The residential aged care sector will be underfunded using current funding arrangements. Improved quality will require improving workforce skills and experience to allow the development and administration of new models of care. Labour costs have recently grown faster than revenue, and will increase further as organisations compete with other providers within aged care and NDIS funded services.

29. There is also a potential need to introduce more expensive technology to improve care quality. Experience in the healthcare sector suggests that while improved technology has improved health outcomes, it has also substantially driven growth in healthcare costs. If new technology in the aged care sector is cost effective, then it should be introduced, even if more costly. This premise is used for assessing whether pharmaceuticals should be listed on the pharmaceutical benefits scheme (PBS). Aged care funding must account for this technology expenditure growth, which it currently does not.

30. While increased funding is necessary to increase residential aged care quality substantially, it will not be sufficient. Because quality is poorly observed above a minimum threshold dictated by accreditation, quality is underprovided above this threshold. Increased funding may increase quality, but it will also be used by some providers to increase margins.

31. Measuring quality above the minimum threshold to allow consumers to choose their provider based on quality will incentive providers to spend the additional funds on improving quality. Increasing funding without measuring quality above the minimum threshold means the Australian Government must rely on provider altruism to ensure most additional funding is allocated to improving quality and not margins, which is difficult to observe and measure.

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10 Royal Commission into Aged Care Quality and Safety, 2019, A history of aged care reviews, Background Paper 8, Commonwealth of Australia, Canberra.
Identify and explain the key financial challenges that aged care providers experience under the current aged care system

32. A key financial challenge for residential aged care providers is the political and government risk faced by providers associated with key changes to legislation or government decisions that impact revenue and costs.

33. These risks have been significant over the last decade, first through the LLLB reforms and subsequently through findings from various aged care reviews and the establishment of the Royal Commission into Aged Care Quality and Safety. Unexpected changes to ACFI prices by the Australian Government have not only impacted the financial performance of residential aged care providers,12 but demonstrated to investors that returns are not easily forecasted.

34. More financial certainty for providers and investors should be built into the funding system. While forward estimates within the Budget provide some information on the potential allocation of funds over the forward estimates, this is non binding and likely to change each year. It does not remove the political risk from changes in Australian Government attitudes towards aged care funding. More financial certainty would be achieved by using an independent agency to determine aged care prices (a more detailed discussion on this point is provided further in this witness statement).

Are there features of the aged care system that impact on aged care services being delivered in a cost-efficient manner?

35. One barrier for efficiency is the limited competition within residential aged care, resulting from the ACAR and NACPR. This has kept occupancy rates at high levels and reduced the need for providers to find efficiency improvements. The reduced need is exacerbated by the inability of consumers to assess care quality across providers due to limited quality information and constraints on the ability of consumers to choose a provider based on quality. This has limited the incentive to improve quality and innovate and allowed relatively inefficient providers that produce poor quality to remain viable.

36. The ACAR and NACPR has also limited the ability of providers to seek economies of scale. It restricts the ability of providers to operate their optimum size relative to their own market conditions. An ideal aged care system would not restrict this decision, instead allowing providers to choose the size of their facility (i.e., the number of subsidised beds) to respond best to their market conditions.

37. There has also been limited focus on the cost effectiveness of care within the residential aged care sector. This limits the ability of providers and the Australian Government to determine whether the outcomes from a new care program or service are worth the cost. The proposed Aged Care Centre for Growth and Translation is one example of the limited focus on cost effectiveness. While still being formed, the Centre objectives are to stimulate growth and translational research through better models of care, improved

workforce capability, improved care quality and improved productivity. There is no reference to ensuring any outcome will be evaluated for their cost effectiveness.13

38. Given the Australian Government will commit $34 million to establish the Centre, and it will cost the residential aged care sector much more to implement new workforce models (of which the Australian Government will cover most of that cost through care payments), funding should be spent in a cost effective manner. This occurs in other Australian Government health care sectors, such as pharmaceuticals. There, the Australian Government has legislated that a cost effectiveness analysis be undertaken and advice received from the Pharmaceutical Benefits Advisory Committee (PBAC) before a decision on whether to list a pharmaceutical on the PBS is made. This ensures that scarce government funding maximises health outcomes. An ideal aged care system would systematically develop and assess models of care and technology for their cost effectiveness before being implemented.

Financing arrangements

Should the current price caps applying in aged care (e.g. the basic daily fee, and 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”?  

39. Price plays an essential role in the delivery of residential aged care. Theoretical and empirical studies have found that changing the price level and the structure of pricing can significantly impact financial sustainability and the level of quality offered within a market. Market determined prices can result in either an increase or decrease in quality, depending on the sensitivity of consumers to quality. Fixed prices are more likely to increase quality.14

40. The aged care sector has unique characteristics compared to a ‘typical’ market. While prices in many markets exclude those who cannot afford to participate (e.g., luxury cars), the role of the Australian Government, and the expectations of Australian society, is to ensure those who need residential aged care can receive it at a minimum level of quality.

41. Ensuring those in need can access aged care is a fundamental principle of equity, and is ensconced within other government funded programs, such as public hospitals, primary care and pharmaceuticals. This means prices should not exclude people from receiving residential aged care based on need.

42. Multiple characteristics within the residential aged care sector suggest the market is not competitive. Quality information is poorly observed and there are high barriers to entry due to the ACAR and NACPR. These have manifested in high occupancy rates and

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13 Department of Health 2020, Request for proposal for the provision of services to develop a model: Stage 1, Aged Care Centre for Growth and Translational Research (CGTR), Australian Government, Canberra
limited competition among providers, resulting in market power for providers and limited choice for consumers.

43. Consumers are also vulnerable to price exploitation, given their frailty and unfamiliarity with consuming residential aged care. They are confronted by a complex aged care system that is difficult to navigate and understand. Some must make decisions with limited time and under distress, reducing the capacity for consumers to ‘shop around’. They have limited information on care quality to form a view on whether prices represent value for money. Entering aged care is typically a one-off event for most people, so information from prior transactions cannot be used to determine value.

44. Provider market power within residential aged care is reflected within market outcomes. There is no price competition around the basic daily fee, with providers charging the maximum 85 per cent of the single person rate of the basic age pension. The average price agreed between providers and residents has also increased by 33 per cent, from $296,000 in 2013-14 to $393,000 in 2017-18. While some increase has compensated providers for a reduction in interest rates and been used to improve and build new facilities, the increase also reflects the capacity of providers to extract increased wealth from residents due to rising house prices.

45. The Australian Government understands the potential for price exploitation in the residential aged care market. It uses price caps to reduce the ability of providers to extract excess profits from consumers. The Aged Care Pricing Commissioner was also established as part of the LLLB reform package to reduce the chance of excessive accommodation prices for extra services and accommodation. Some providers were price gouging consumers before the LLLB reforms. Significant accommodation price discrimination was also common, suggesting market power allowed providers to charge based on the value consumers placed on accommodation, not the marginal cost of producing accommodation. This is not reflective of a competitive market.

46. One problem with using price caps in residential aged care is that all providers are beholden to one maximum price, regardless of their cost structure or willingness to offer better quality services and innovative models of care. As price caps are homogenous, care also becomes homogenous across providers because there is little leeway to differentiate.

47. Removing price caps would allow providers to increase their care quality and pursue innovative models of care. This would improve health outcomes for those who can afford the increased prices. Increased care prices can lead to quality improvements because it

15 Data from the Aged Care Financial Performance Survey undertaken by StewartBrown suggests the cost of providing daily living services has been greater than the revenue received from the basic daily fee since 2012. However, this reflects an average estimate and given the heterogeneity in financial performance across providers, many providers are likely to deliver daily living services at less cost that the basic daily fee. This gives them a greater capacity to compete on the daily living fee to attract residents, if desired.


17 Aged Care Financing Authority (ACFA), 2018, Sixth report on the funding and financing of the aged care sector, Commonwealth of Australia, Canberra.
increases the margin for each resident. This creates more intense competition, and under a fixed care price regime like the Aged Care Financing Instrument (ACFI), the only way to compete is through improved competition.

48. However, increased quality resulting from increased prices may not happen to any significant level if occupancy rates remain at current levels. There is little incentive to compete for more consumers. Increased prices are likely to manifest into increased margins for many providers, but the extent will depend on their motivation. Those more altruistic providers are more likely to use increased prices to improve quality, however altruism among providers is almost impossible to measure.

49. There is consequently no guarantee that removing price caps would lead to significantly improved care. Even if removing price caps led to some improved care, this may not be socially optimal. Those consumers who receive increased quality for increased prices may improve their welfare. The extent will depend on the relative change in quality and the impact of quality on wellbeing versus price increases. However, those who pay increased prices but do not receive increased quality will experience a decrease in their welfare, given those funds could have been used elsewhere.

50. Given care quality above the minimum accreditation threshold is not measured well under the NACQIP, neither consumers nor the Australian Government would be able to compare prices to care quality to determine value robustly. There is consequently a significant opportunity for providers to price exploit either consumers, the Australian Government, or both (depending on who pays for the price increase) if price caps were removed.

51. The continued use of price caps for care quality is therefore necessary within residential aged care until care quality is measured better, and competition can moderate price increases. This can only be achieved by introducing a robust quality measurement framework that reports on quality beyond that required for accreditation, funding independent agents to help consumers choose a residential aged care provider based on quality and value, and removing the ACAR and NACPR to promote greater competition. Allowing good quality providers to flourish in the market would increase the overall average level of care quality and reduce the amount of price increase required.

52. This conclusion does not exclude the possibility that current price caps are inappropriately set, which is the case if the Royal Commission recommends changes to the residential aged care sector in line with prior aged care reviews. Increasing price caps beyond their current levels will allow providers some flexibility in offering better quality care, but also reduce the potential extent of price exploitation within the market compared to allowing providers to set prices on their own. The extent of any price cap increase should consider the level of increased quality required by providers. Increased

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19 Cutler H, Partington A, 2020, Power to the people. Improving residential aged care quality through better consumer choice, Submission to the Royal Commission into Aged Care Quality and Safety
price caps should be accompanied by the same policy changes that reduce the ability for providers to price exploit.

**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 incumbency advantage that current providers have?**

53. The residential aged care sector operates within a market given aged care services are exchanged. This is facilitated through prices, where maximum prices are set by the Australian Government for daily living expenses, care and accommodation. There are no restrictions on providers to trade below these maximum prices.

54. The residential aged care market contains special characteristics compared to preconditions for an efficient market. Without regulation, the residential aged care market would not maximise social welfare. This is because residential aged care generates positive externalities not priced into the market, perfect competition does not exist, and there are large information asymmetries leading to provider market power and consumer uncertainty when purchasing services.

55. Most markets exhibit market failure. Government intervention is justified in residential aged care because it can shift the market towards a more efficient equilibrium by accounting for its special characteristics. The extent to which this occurs relies on Australian Government policy. Efficiency in the residential aged care market is constrained by the high levels of information asymmetry between the provider and consumer on care quality. This creates uncertainty for consumers about the types and quality of services they will receive.

56. While the NACQIP was made mandatory by the Australian Government in 2019, its reliance on a limited set of clinical indicators means it cannot reduce a substantial amount of information asymmetry. Other characteristics that impact wellbeing, or consumers believe are important, are not reported. The two additional clinical indicators being explored by the Australian Government, including falls and fractures, and medication management will not fix this problem.

57. The residential aged care market will only move closer to a more efficient equilibrium if the NACQIP is overhauled. This includes reporting on other service characteristics that impact wellbeing and consumers believe are important. Indicators must be risk adjusted to account for variation in the composition of residents within facilities.

58. The Australian Government must also increase the ability of consumers to acquire quality information and process that information. This is particularly the case given many consumers will process quality information under times of stress, when their health may have deteriorated rapidly and entry into residential aged care is urgent.

59. A composite indicator, like a star rating system, should be developed for the Australian residential care sector. This would provide a holistic view of provider quality and allow consumers to rank providers in their local market. Individual quality indicators and
provider characteristics should also accompany the composite indicator to allow consumers to match their preferences to providers better.

60. While some consumers will use quality information when choosing between a provider, others will struggle to interpret the quality information relative to their own needs and preferences. The Australian Government should fund independent agents to help consumers choose a provider within their local area based on quality. Responsibilities of an agent could include monitoring and interpreting information on quality presented through an overhauled NACQIP, supplemented with additional information sourced from audit reports and serious risks found within providers. The agent would seek to understand care preferences, identify special needs, and best match these with local providers.

**Should an independent authority, or alternatively the government, set levels of funding based on actual cost data?**

61. There must be some funding certainty over the long term for the residential aged care sector to attract investment. Unexpected variation in funding creates investment risk, which means more return is required to attract investment. Reduced funding uncertainty will lead to lower required rates of return and increased investment in the residential aged care sector.

62. Historically, Australian Government decisions to reduce funding have financially impacted the sector. ACFA suggests the recent poor financial performance experienced by residential aged care providers is related to an Australian Government decision to freeze indexation rates for ACFI prices in 2016.20

63. The Australian Government would also like some level of certainty around its funding obligations to the aged care sector. However, this does not require the Australian Government to set funding levels. Currently, there are no caps on aged care funding, with expenditure managed through various ways. These include setting access criteria, setting ACFI prices, setting means testing criteria, limiting the number of Home Care packages and limiting the number of subsidised beds through the NACPR. Funding is also uncapped for other health and human services, including for medical services through the Medicare Benefits Schedule (MBS), which is the largest budget item in the health portfolio.

64. The Treasury is responsible for determining how government revenue is allocated across portfolios. However, funding levels are a combination of price and quality, and there are good reasons why price should be set by an independent authority. It would remove some volatility to provider revenue associated with potential Australian Government policy change on ACFI prices. It would also ensure price setting is undertaken more transparently, based on the needs of consumers and providers rather than of the Australian Government to balance budgets. Removing the Australian

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Government influence on prices would remove some political risk within residential aged care investments and attract more investors to the sector.

65. The model for independently setting prices could take several forms. The Independent Hospital Pricing Authority (IHPA) sets the national efficient price (NEP) and national efficient cost (NEC) after collecting cost data from public hospitals. While the Australian Government pays the NEP, state governments are still free to price public hospital services, so a public hospital may not necessarily receive the NEP for their care. This can reduce the incentive to become more efficient.

66. The NSW Independent Pricing and Regulatory Tribunal (IPART) has set prices for nearly 30 years for essential government monopoly services, including energy, water, transport and local government. IPART works independently from the NSW government as an economic regulator. It either sets the maximum price or establishes the methodology to fix the maximum price. It engages with consumers, undertakes rigorous research and analysis, and is not subject to Ministerial control in making price determinations or recommendations.21

67. Instead, IPART price determinations are transparent. The methodology for setting maximum prices has been established through legislation, to include the economic cost of production, past, current and future expenditures, economic parameters (discount rates and inflation), appropriate rates of return, asset valuations, the need to promote competition, demand management, least cost planning, and environmental protection. In determining prices, IPART also considers the protection of consumers from price gouging and poor quality, efficiency, the impact of pricing policies on borrowing and investment opportunities, the social impact of pricing determinations and the resulting standards of service (quality, reliability and safety).22

68. An independent pricing authority should also be used in aged care to set maximum prices for daily living expenses, care and accommodation. Like IPART, the independent economic pricing authority should not be subject to Ministerial control and would set prices based on the same types of considerations used by IPART. The price setting methodology should also consider population ageing, changing aged care preferences, changes to frailty and technology change.

69. An independent pricing authority would reduce the ability of the Australian Government to control aged care expenditure. This could be perceived as a significant budget risk considering it spent $12.2 billion on aged care in 2017-18 (of which most was associated with care). It may be politically challenging to implement without the Australian Government having some ability to control unexpected large increases in expenditure.

70. Some Australian Government control could be achieved by placing a cap on an annual increase in aged care expenditure, effectively allowing the independent agent to set prices within a budget envelope. For example, the Heads of Agreement between the

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22 Ibid.
Commonwealth and the States and Territories on public hospital funding and health reform (the HoA) establishes a five year agreement between the Australian Government and jurisdictions on public hospital funding. This includes a state based soft cap and national funding cap of no more than 6.5 per cent growth in public hospital funding. Funding beyond a 6.5 per cent growth is still possible for states if total funding is under the national funding cap.

This arrangement would still expose the residential aged care sector to changes in Australian Government policy on aged care funding (given it would set the cap). However, an agreed transparent process to establish maximum prices and an agreed funding growth trajectory would reduce funding uncertainty. An independent agent setting prices would also help balance the uneven political power that currently exists between providers and the Australian Government when setting ACFI prices.

**Should funding levels be set at benchmark efficient levels or merely average levels?**

Using costs to set price is preferred to some arbitrary price setting undertaken by the Australian Government, which occurs using ACFI. However, cost data is retrospective. While this can incentivise innovation that reduces cost, it can reduce the incentive to innovate if costs increase without being compensated trough price. Price increases will only occur if other providers adopt the innovation, price is updated to reflect average cost changes, and cost data accurately reflects costs.

As more providers adopt an innovation, there may be less incentive to adopt for other providers. Price will increase to compensate innovation costs, but providers that have not adopted the innovation will also receive a price increase. This could entrench inefficient practices in some providers.

An increase in consumers from innovation may also compensate a provider. However, consumers must be able to recognise the value innovation brings. Again, robust quality information that is easily understood by consumers is required. Providers must also have some capacity to accommodate more consumers, which is limited due to high occupancy rates.

It is recognised that Diagnosis Related Groups (DRG) prices based on average costs may reduce the incentive to introduce costly innovation in hospitals. However, many countries have adopted different mechanisms to accommodate costly innovation. Short term mechanisms include providing separate payments outside the DRG system, supplementary payments within the DRG system, and special funding for cost outliers. Long run mechanisms include changes to the patient classification system and adjustments to the hospital payment rate. Some of these mechanisms introduce the potential for reduced efficiency without parallel use of other mechanisms, such as cost

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24 Scheller-Kreinsen D, Quentin W, Busse R, DRG-Based Hospital Payment Systems and Technological Innovation in European Countries, Value in Health, Vol. 14, pp. 1166-72
effectiveness analysis. More research is required on whether these mechanisms encourage cost effective innovation adoption.

76. Deciding on whether to use an average cost or benchmark efficient level cost requires making some trade-offs across pricing objectives. While using average costs would mean some providers make greater returns compared to efficient costs, this incentives investment in providers than are performing efficiently. This would push the sector towards greater efficiency on average, so long as efficient providers can flourish in the market. However, using an average price may also reduce the incentive for some providers to increase their efficiency if their returns are deemed sufficient.

77. While an efficient price seems appealing, given it should motivate all providers to become efficient, it would be difficult to implement in the residential aged care sector. Efficiency is only one objective when setting prices. Prices should be set in a transparent way to engender trust within the price setting process. An efficient price may result in more providers unable to cover their costs compared to using an average price, exposing the sector to greater financial pressure and potential closures.

78. It would also be challenging to settle on a definition of efficiency within the context of the residential aged care sector. Most providers are likely to argue that their circumstance is special. Data collection would need to improve significantly. This would require investment in data collection processes and infrastructure within residential aged care providers. It would take time for the data quality to mature. In addition to detailed cost data, developing an efficient price would require collecting detailed outcome data, and resident characteristics to risk adjust outcomes.

In the long term, what would be are the optimal financing arrangement or arrangements to support the economic sustainability of the aged care system?

79. An optimal financing arrangement would seek to achieve efficiency, equity, and sustainability to maximise social welfare subject to a government budget constraint. This requires taking into consideration the impacts of alternative financing arrangements on labour market outcomes. Determining an optimal financing arrangement typically requires determining an optimal trade-off between efficiency and equity.

80. Efficiency can be measured through administrative costs, which differ across alternative financial arrangements. These typically relate to the cost of administering the financial arrangement and the economic cost associated with distorting markets from applying some revenue collection tool (e.g., tax, levy, or compulsory contributions).

81. Collecting revenue from taxes on an ongoing basis and redistributing this to aged care providers requires government resources to develop and enforce tax legislation, and collect tax revenue. However, the marginal cost of collecting additional revenue to cover

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25 Efficiency can be broadly defined as collecting and distributing revenue for the least cost possible. Equity can be broadly defined as people with similar financial means facing the same cost burden (horizontal equity) and those with greater means facing a greater cost burden (vertical equity). Sustainability can be defined as a financing arrangement that allows the residential aged care sector to meet consumer demand in perpetuity.

aged care expenditure would be small given the relatively small share of aged care expenditure relative to total government expenditure.

82. There is also a broader economic cost from taxation. This comes from the distorting impacts taxation has on labour markets through income tax, and other markets through other taxes, such as the Goods and Services Tax (GST). The size of the distortion and the economic cost depends on which tax is used to ‘fund’ aged care. Currently, aged care is funded through general tax revenue.

83. As there is no ‘earmarked’ taxation for aged care, the economic distortion is across all taxed markets. There is no reason why taxes should be earmarked to aged care from a welfare perspective, however, creating an earmarked taxation would shift the current economic distortion from all taxed markets to one taxed market. Alternative earmarked taxes would have different economic costs. For example, funding aged care using a levy attached to income only would distort the labour market, while funding aged care using an increase in GST would distort markets for consumer goods and services, given the behaviour of consumers and businesses will change.

84. Compulsory contributions to a social insurance model would have similar administration costs to collecting revenue from taxes. Not only would it require either public or private sector resources to establish and enforce contribution rules, it would also distort the market as the compulsory contribution would act like a tax. The economic cost would be concentrated within the labour market if compulsory contributions were based on the amount of income an individual receives.

85. Administration costs from collecting taxes or using a social insurance model may not different much. However, it may differ from an economic distortion perspective, given the former seeks revenue from a broad tax base while the latter may seek revenue from one specific tax base. The difference in economic cost from lost efficiency from the market distortion will depend on the price elasticity of demand and supply. Generally, it is better to tax markets where price elasticity is low to minimise the economic distortion.

86. The difference between collecting taxes and a social insurance model may also not differ much from an equity perspective. If the population age structure is relatively stable, and hence future expenditure is also relatively stable, then taxing workers to cover the cost of aged care in the current period is the same as collecting compulsory contributions for a social insurance model to cover future aged care costs. The only difference is that young workers are required to contribute more when transitioning from current arrangements to a social insurance model. This inequity could be smoothed over by allowing the social insurance model to borrow from the government.27

87. However, the Australian population is not stable. The Australian Government predicts that its aged care expenditure will increase from $620 in 2014-15 to $2,000 in real, per person terms, primarily due to population ageing.28 Equity outcomes between collecting taxes and a social insurance model will differ. Under a tax model, the current generation

will pay less for aged care than what it will use. There is more scope under a social insurance model to match contributions with expected use.

88. While this sounds appealing, matching contributions to expected use is a departure from our broader tax system. We do not ask individuals to contribute to their future healthcare costs, nor to future social payments. Both are funded by general tax revenue. A social insurance model would also incentivise people to reduce their contributions if aged care funds were subsequently allocated based on need (as is currently the case). This reduces the incentive to work if contributions are based on income. It would also not ameliorate the need for tax collected contributions given many lower income people and those out of work would not have the capacity to contribute. There is currently no strong argument to suggest a social insurance model would deliver better outcomes than current tax arrangements for aged care.

89. Other financing arrangements would have alternative administration costs and equity outcomes that are unlikely to improve on current tax arrangements significantly. For example, the Productivity Commission recently reviewed the superannuation sector and found significant problems with efficiency due to excessive and unwarranted fees, poor returns for some members, inadequate competition, governance and regulation, and little scale economies.

90. The private health insurance sector also has significant administration costs, with around $2.2 billion spent on health insurance business expenses and claims handling in 2018-19. This equated to nearly 11 per cent of fund benefits paid. Competition in the private health insurance sector is also limited, as evident through low transfers of members between funds, low product differentiation, and lack of new entrants into the market.

_**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?**_

91. Principles to assess the performance of Australia’s retirement income system include adequacy, equity, sustainability and cohesion. This is based on three pillars, including means testing to receive the Aged pension, compulsory contributions to savings and voluntary savings.

92. Healthcare is mostly financed through general tax revenue. The Australian taxation system is guided by efficiency and equity principles (like those outlined in response to the previous question). Healthcare is also financed through private health insurance and

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32 Private Health Insurance Administration Council, 2013, Competition in the Australian Private Health Insurance Market, Australian Government, Sydney
33 The Treasury 2019, Retirement income review, Consultation paper, Australian Government, Canberra
patient copayments. Both have an element of means testing. The private health insurance rebate is means tested, while access to a pensioner concession card depends on whether the person receives other government benefits that are means tested, such as the age pension.

93. Given retirement income policy and health financing principles overlap, the government’s contribution to the financing arrangements for aged care should not be aligned with one or the other, but both.

94. One primary difference between retirement income policy and health financing principles relates to compulsory savings. Retirement income policy requires individuals to save (in part) for their retirement consumption based on their income, through compulsory superannuation contributions. Compulsory savings are not required for future healthcare expenditure.

95. Having individuals save for future hypothecated aged care expenditures is unlikely to be efficient compared to other financing arrangements, such as collecting taxes or social insurance models. It would be difficult for individuals to determine how much savings would be required to cover their aged care needs in the future. Uncertainties include the need to use aged care, the type of aged care preferred, and the period of use.

96. Many people would underinvest when saving for aged care, particularly those with low incomes. The Australian Government would need to cover the expenditure gap if equity principles were maintained. Many people may also overinvest, reducing consumption in the present for expected aged care consumption in the future, which may never occur, or may occur to a lesser extent than anticipated. While under and over investment also occurs in superannuation, it seems easier to predict how much income is required in retirement. The use of funds from superannuation are also not restricted, which means they can be used to cover unanticipated costs across multiple expenditure domains.

97. The literature points towards potential inefficiencies associated with medical savings accounts (MSAs). These accounts seek to encourage young people to save for their future healthcare expenditure. As MSAs do not pool risk but the future need for aged care is somewhat random, they do not capture the efficiencies gained by sharing risk across a population that is a characteristic of private health insurance. Proponents note that MSAs should induce people to take more responsibility for their healthcare, reduce the moral hazard problem associated with healthcare, and reduce the overall costs of healthcare. While there is some debate on the usefulness of MSAs, research across four countries (China, Singapore, South Africa and the US), suggest they do not increase efficiency, lead to inequitable access to healthcare, and offer little financial protection from healthcare costs.

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34 There is other private funding, such as funding from workers compensation schemes and accident insurance schemes.


Should people contribute to savings funds directed towards the aged care services they will consume when they age?

a. Should such contributions be compulsory?

b. How would such an approach affect those who are less able to make contributions to such savings funds?

c. What role could government play in overcoming any consequences identified in (12)(b) above?

98. See the response to the previous question.

What are the current revenue raising arrangements (e.g. basic daily fee, means tested contributions to the care payment, extra and additional services fees, RADs and DAPs) built into the aged care system?

d. Are they adequate or are they excessive?

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

f. 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?

g. 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?

h. Should payments of home care funding be made in arrears?

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

99. Like judging financing arrangements, means testing arrangements should be judged on whether they are efficient, equitable and lead to more sustainable aged care financing. Means testing could be considered efficient from an administrative cost perspective, given contributions from consumers require little Australian Government involvement (although there is still a government administration cost associated with means testing) relative to collecting and redistributing taxes.

100. While means testing reduces some economic distortion because it potentially avoids the need to increase taxes, it may change the labour and savings behaviours of individuals. Increased means testing could increase the labour supply and savings as people are required to pay more for their aged care. Avoiding an increase in tax rates may also increase the labour supply. However, people may also reduce their labour supply and savings to avoid paying the means tested contributions. It is unclear whether a greater proportion of funding for aged care from means testing would increase efficiency.
101. It is also unclear whether means testing is equitable. Under an egalitarian viewpoint, aged care would be provided according to need and financed according to ability to pay. Under a libertarian viewpoint, aged care would be rationed according to ability and willingness to pay.37 The Australian healthcare system operates under both viewpoints. For example, public hospital services are allocated according to need (mostly), while private hospital services are allocated according to the ability and willingness to pay.

102. There is a strong justification from an equity perspective on why aged care should be provided according to need. Australian society is likely to consider access to aged care according to ability to pay unacceptable. Many people would be unable to access aged care given the large and unexpected cost, resulting in significant declines in welfare for the consumer and family members. Additional positive externalities from aged care would also be reduced.

103. However, an egalitarian viewpoint also dictates that aged care should be financed according to ability to pay. Some argue the justification for this component of equity is weak, so access according to need within an egalitarian viewpoint should be decoupled from the ability to pay.38 This is evident within the Australian healthcare system given that public hospital patients are not means tested.

104. Means testing may be beneficial from a sustainability viewpoint. Assuming a fixed Australian Government subsidy, increased means testing will increase provider revenue, enabling them to produce better quality services that better meet consumer preferences, and generate a greater return on investment. The extent of either will depend on how the additional funding from means testing is allocated, which is a decision for providers to make.

105. However, the Australian Government may be tempted to use funds from increased means testing to reduce current or future aged care subsidies. Assuming the Australian Government subsidy to aged care is flexible, then increased means testing along with a reduced commitment by the Australian Government to subsidise aged care, would effectively substitute Australian Government expenditure. There would be no benefit from increased means testing to consumers or aged care providers.39

106. Determining whether means testing contributes to sustainability therefore depends on the extent to which the Australian Government aged care subsidy is fixed or flexible. While politicians may argue there are limited funds available for increased aged care expenditure, Australia remains a rich country with little net debt as a proportion of GDP compared to other developed countries, even with a substantially increased budget deficit resulting from the Covid-19 response. It is untrue to suggest the Australian Government aged care budget is fixed because of budget pressures. Funding aged care is a political matter of prioritising aged care over other government budget portfolios.

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38 Ibid.
39 There may be benefits generated in other parts of the economy if the expenditure ‘saved’ from increased means testing in the aged care sector is allocated elsewhere, or if results are reduced taxation.
107. If the Australian Government does fix the aged care subsidy, and that Australian society subscribes to the notion that aged care should be financed according to ability to pay, there is an opportunity to increase means testing within aged care. The first place to start should be removing the cap on the value of the principal residence included in the assets test.

108. The cap on the value of the principal residence reduces the ability of the aged care sector to access most savings held by older Australians. It also fails to align with the principle of paying according to ability. Consumers are asked to contribute not on their wealth, but on their decision on how to allocate their savings (e.g., a person that owns $500,000 in cash is asked to pay more than a person who owns a $500,000 home). The potential to increase annual and lifetime caps should also be considered. While these were introduced as a stop loss measure to help consumers avoid catastrophic losses associated with means testing, (effectively the Australian Government insures against large means testing contributions), their levels seem relatively low compared to the capacity for some people to pay for aged care.

109. An increase in means testing should not distort the selection of Home Care versus residential aged care according to need, or stop consumers accessing aged care. In the Australian aged care sector, this may occur if means testing based on assets requires a consumer to pay more than their income allows (i.e., people who are asset rich but income poor) and are unable to draw down the assets upon which they were assessed. An increase in means testing must consider the possibility that assets may be illiquid (e.g., housing where a dependant still resides). A robust and accessible financial product that allows people to draw down on the value of their homes, as recommended by the Productivity Commission, would allow the Australian Government to seek greater means tested contributions from consumers with the capacity to pay. The Pension Loan Scheme (PLS) allows people to access housing wealth, although this should be expanded to allow people not receiving a pension also to access the PLS, given they will be more likely to be means tested.

Funding arrangements

What funding models or mechanisms should be used for aged care? Without limiting the matters you wish to address, please cover:

a. Basic domestic supports

b. Basic social supports

c. Personal care, and nursing, allied health and other care for more complex needs provided in the home, flexible supported accommodation or other community settings

d. Personal care, and nursing, allied health and other care for more complex needs provided in the setting of residential aged care facilities

e. Respite
f. Support services for informal carers

In responding to the above, please address the question, 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?

110. There is no perfect funding model for residential aged care. All funding models have their advantages and disadvantages. Selecting a funding model will require trade-off between complexity and the ability to incentivise good quality care. For example, historical block funding is relatively easy to administer, but it does not incentivise better care quality or efficiency improvements. It will also lead to inequitable access to care if funding fails to reflect population need.

111. Different models are better suited for funding different types of services. Selecting a funding model will require trading off one important criterion for another. For example, MUCHE has extracted funding model criteria from twelve Australian policy documents on public hospital funding, which resulted in 32 potential criteria extracted from with 103 references to these criteria across all publications. Drawing out common themes led to 15 common funding model criteria (see Table 1).

Table 1: Funding model criteria extracted from hospital policy documents

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Accessibility</td>
<td>The funding model allows people to obtain health care at the right place and time irrespective of income, physical location and cultural background.</td>
</tr>
<tr>
<td>Choice</td>
<td>The funding model allows patients to choose the setting (acute versus the community) in which they receive care.</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>The funding model allows the health care system to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.</td>
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<tr>
<td>Data needs</td>
<td>The funding model does not require significant investment in additional data collection and quality improvement.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>The funding model promotes the most appropriate interventions (preventative or responsive), based on established best practice standards, to achieve optimal health outcomes for the patient.</td>
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</tbody>
</table>
CONTINUED STATEMENT OF: Professor Henry Cutler

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>The funding model achieves desired objectives with cost effective use of resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentives</td>
<td>The funding model builds incentives into provider management and clinical operations to improve quality, and avoids perverse incentives.</td>
</tr>
<tr>
<td>Low cost</td>
<td>The cost of implementing and administering the funding model is not overly burdensome on the government budget.</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>The funding model promotes services that are client orientated. Clients are treated with dignity, confidentiality, and encouraged to participate in choices related to their care.</td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>The funding model takes into consideration the complexity of patients, appropriately rewarding those hospitals that serve the sickest patients.</td>
</tr>
<tr>
<td>Risk minimisation</td>
<td>The funding model does not expose local health districts or government to potential unplanned variations in revenue streams for hospital care.</td>
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<tr>
<td>Safety</td>
<td>The funding model promotes the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.</td>
</tr>
<tr>
<td>Simplicity</td>
<td>The funding model is simple to implement and administer for purchasers and providers, regarding data collection and reporting, and forecasting future funding requirements.</td>
</tr>
<tr>
<td>Transparency</td>
<td>The funding model allows for a transparent determination of the allocation of funds across providers.</td>
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112. Choosing a funding model should depend on the complexity of the service being funded. Simple services, such as basic domestic and basic social supports, lend themselves to choosing a funding model with administrative simplicity, although an assessment of need is also necessary, along with means testing to ensure Australian Government funds are not substituting private funding that would otherwise have been used.

113. As basic domestic and social support services are relatively easy to define, a simple fee for service model is appropriate, with different subsidies allocated to different services. This would allow funds to be transparently attached to activity and can incentivise providers to increase their service volume, thereby encouraging low waiting times. However, the assessment of need would be crucial, allowing some flexibility in the allocation of funds across supports, but not allowing providers to over service the delivery of support, or provide inappropriate support.
114. More complex services lend themselves to more complex models. Personal care and nursing, allied health and other care for more complex needs provided in the home, flexible supported accommodation, other community settings or residential aged care facilities should be funded through a capitation based system. The amount of funding allocated to each consumer should be based on the expenditure risk of enrolled consumers. Individual risk is typically determined by allocating consumers into broad risk categories based on a care need assessment.

115. The proposed AN-ACC broadly undertakes this approach, with consumers allocated to a casemix class based on their independently assessed care needs. Using a capitation based funding model ensures funding is allocated based on the care needs of the consumer, but still allows for flexible use of funding by providers to meet local and individual needs. It also incentivises providers to invest in more efficient practices, prevention activities and better quality care, as a reduced need for care results in greater margins for providers.

116. Funding models can also be combined to mitigate disadvantages or introduce further advantages associated with using only one funding model. While this increases the administrative burden, benefits associated with better targeted funding and subsequent improved outcomes can outweigh these costs. However, some funding models are more suitably combined. Pay for performance is typically used alongside other funding models, such as fee for service models. For example, the Practice Incentive Program (PIP) for Australian GPs operates alongside Medicare.

117. While the evidence on the effectiveness of pay for performance models to improve care quality is variable, particularly within a health care setting, this should not exclude the Australian Government from further exploring these models in the context of aged care. Aged care providers are likely to respond to additional funding opportunities. However, it would be remiss for the Australian Government to apply pay for performance models from other countries to the Australian aged care sector given our unique aged care environment and its relationship with other support systems, such as healthcare. Pay for performance models should be trialled among aged care providers, using intervention and control groups. Trials should explore outcomes, size of incentive, the use of rewards versus penalties, and absolute versus relative performance targets, and their cost effectiveness.

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How should funding models account for changing cost inputs of aged care providers?

Funding models should account for changing cost inputs through annual reviews of provider costs. As described previously, costs are not the only factors that should be considered upon review.

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?

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?

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?

d. If so, what debt to equity ratio should apply and should it be different as between segments of the aged care sector?

e. What is the current cost of equity capital, and how would that cost be affected by significant changes to the current arrangements? For example, by removal of caps on supply of places, or greater or less regulation of fees.

The cost of capital for a provider will depend primarily on its risk. Provider risk depends on several factors. This includes the characteristics of the management team, characteristics of the asset portfolio (e.g., single beds versus shared rooms), whether the provider owns a single facility or multiple facilities, the location of facilities given this impacts the expected return on accommodation, and the age and condition of facilities. All providers face the same political risk that impacts investment decisions, as described earlier. Given the heterogeneity of provider risk, the cost of capital will also vary across providers. This gives some providers a competitive advantage as they can access debt cheaper, or attract more equity investment.

Aged care accommodation funding must primarily cover the cost of capital if the aged care sector is to maintain and attract additional investment. While there is no reason why funding should cover the cost of capital for all providers, funding should at least ensure the aged care sector remains sustainable, which means it can meet consumer demand in perpetuity. Importantly, the Australian Government needs to ensure consumers can access care when needed, including in rural and remote locations where the ability to attract appropriate returns on investment, or maintain occupancy rates, are diminished. Given some providers are more efficient at attracting capital, these providers should be allowed to flourish. This can only occur if the ACAR and NACPR are removed.

The weighted average cost of capital (WACC) is an appropriate approach to estimate the required rate of return for a provider. The WACC will reflect the business risks described above, along with the composition of equity and debt. A WACC should be
used regardless of the ownership type. However, ownership status will impact the WACC given for-profit and not-for-profit providers are taxed differently. There will also be differences in the WACC by ownership status, given the composition of debt and equity will vary.

If the WACC is used in determining aged care prices, then using an average debt to equity ratio seems like the natural place to start given its simplicity. However, this will favour organisations that can access low cost debt and equity. This will be large provider groups with a strong management team, healthy balance sheet, and relatively new facilities. This seems worthwhile from an efficiency perspective. However, these providers are not necessarily the same that deliver in regions with low returns on investment, such as rural and remote regions. Prices would need to consider this by applying a price adjustment to ensure continuity of supply. There is also a considerable transition process that would need to be managed carefully given 572 providers (around 63 per cent of facilities) own only one facility.41

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?

118. I am currently leading a research team commissioned by the Department of Health on behalf of the Aged Care Financing Authority that is investigating the role of RADs in residential aged care. It would be premature to answer this question before the research is complete.

Signed: [Signature]
Date: 21/7/20
Witness: [Signature]
Date: 21/7/2020

41 Department of Health 2020, Australian Services List 2019, Australian Government, Canberra