ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION IN RELATION TO THE FUNDING, FINANCING AND PRUDENTIAL REGULATION OF THE AGED CARE SYSTEM

INTRODUCTION

1. This submission to the Royal Commission into Aged Care Quality and Safety (the Commission) by the Australian Nursing and Midwifery Federation (ANMF) is made in response to the Commission's invitation for submissions to the upcoming hearing on funding, financing, and prudential regulation of the aged care system (14-18 September 2020) in response to the a series of confidential reports and associated documents/appendices provided to the ANMF.

2. The ANMF has previously provided numerous submissions and a significant amount of evidence to the Commission. That material has been responsive to the themes and topics identified by the Commission itself in the course of its work. To date, the ANMF has contributed substantial submissions and witness evidence and participated in round table discussions, workshops and hearings in respect of almost all the topics of the Commission's inquiries on issues ranging across residential and in-home aged care, clinical care, dementia, person-centred care, advance care planning, palliative services, flexibility of aged care, aged care in regional, rural and remote areas, regulation, safety and quality, younger people and diverse community members in aged care, workforce, interfaces between the healthcare system and aged care and aged care program redesign. In our 'final public submission', we detailed our key recommendations that we submit are vital to addressing the significant issues brought to light throughout the Commission's proceedings and that we believe the Commission should themselves recommend to realise safe, quality care that all Australians deserve as they grow older.[1] In summary, these recommendations centred on;

    i. mandated minimum staffing levels and skills mix;
    ii. legislated requirements for clinical governance, leadership, and expertise;
    iii. legislated transparency and accountability measures;
    iv. ensure workforce capacity and capability, and;
    v. registration for unregulated carers.

3. Additional recommendations also pertained to key regulatory matters in relation to quality and safety in aged care, aged care quality standards and indicators, serious incident response schemes, reportable conduct schemes, regulation and use of chemical and physical restraint, caring for diverse populations, dementia care and palliative care, restorative care and reablement, interfaces with health, disability, and social services sectors, and nutrition and diet.

[1] ANM.0022.0001.0003

4. The present hearing and our submission focusses on funding, financing, and prudential regulation of the aged care system which is more or less related to many of the above topics and recommendations covered above. Our present submission is focussed primarily on the following themes:
    i. Lack of transparency and accountability
        a) Primarily the ANMF finds the reports listed below contribute significant evidence towards issues of the need for transparency and accountability in the provision of aged care services and the use of funds to deliver those services. We focus particularly where aged care providers may operate under complex structures/group entities and where there is opaque use of RADs and lack of governance in regard to financial flows between related entities.
    ii. Financing of the aged care sector
        a) Here, the ANMF provides comment on the issues raised in regard to the financing of aged care, including the identification of a national efficient price for the delivery of services, a required rate of return for providers and potential methods of price regulation.
    iii. The relationship between aged care provider ownership status, size, and the quality of care outcomes
        a) Here, we focus on the apparent inverse relationship between the quality of care, and outcomes that are being delivered to residents and provider type. Evidence provided in the reports suggests for-profit providers are more likely to deliver poor quality outcomes but are most likely to be profitable.
    iv. The measurement of care quality
        a) Here, we focus on the concerning issues within the reports that highlight the ways in which quality of care is currently measured, the care indicators available, and how the collection and reporting of these measures can be improved ideally through the use of relevant evidence-based quality measures including those that account for staffing and skills mix.
    v. Proposed reform measures for the aged care sector.
        a) The ANMF provides comment on particular reform scenarios suggested throughout the reports, including broad in-principle support for those strategies which will enable the realisation of the implementation of mandated staffing levels and skill mix, and other supports which will ensure the safe and quality delivery of care to the people who engage aged care services.

5. The remainder of the present submission is divided into subsections each concerning our considered responses to each of the reports. The following reports are discussed:

    i. Report on the profitability and viability of the Australian aged care industry, BDO
    ii. Financial analysis relating to aged care providers for assessment of prudential risk, BDO
    iii. The profitability of aged care, Frontier Economics
    iv. The cost of residential aged care, the University of Queensland
    v. The required return for aged care service providers, Frontier Economics
    vi. Price regulation approaches for aged care, Flavio Menezes
    vii. Aged care reform: projecting future impacts, Deloitte Access Economics

i. Report on the profitability and viability of the Australian aged care industry, BDO

6. The Royal Commission engaged BDO to provide an independent analysis of the finances of the aged care sector (approved providers, residential aged care, and home care), including an assessment of profitability and financial viability, to inform the Commissioners' development of recommendations. BDO also explored whether there are relationships between financial indicators and available care indicators.

Group structures

7. Group structures and the transparency of financial activities regarding aged care providers' use of group structures was examined. Group structures are legal but often opaque financial practices used by providers to maximise return and minimise risk. Utilisation of group structures within aged care reduces transparency of financial practices in the sector. Refundable Accommodation Deposits (RADs) paid by residents can be transferred to other entities also owned by the provider via related party loans and used to fund e.g. capital purchases. If a provider then becomes insolvent, as the underwriter, the Government may need to repay the resident's deposit (to them or their estate), while the purchased properly can remain that of the related entity (i.e. it is not sold to refund the deposit).

8. Group structures may also enable providers to optimise activities by utilising the services of their own related entities to provide services e.g. management fees. BDO did not locate any information regarding the governance of this process.

Residential aged care

9. Regarding the profitability and viability of residential aged care, the report notes that labour costs account for approximately 70 percent of total expenditure in residential aged care.[2] Commonwealth Government funding for care and accommodation accounts for 68 percent of income (for-profit), 69 percent (not for-profit), and 52 percent (State Government) respectively. State Governments provide 20 percent of the funding for Government owned providers, but less than 1 percent of the total income of for-profit and not-for-profit providers.

10. For-profit providers receive around $16 more care income per subsidy day than not for-profits ($237 versus $221 per subsidy day); 79 percent ($12) of this comprises a higher Commonwealth Subsidy and Supplement component. The report suggests that the declining number of providers overall may be related to the increasing market share of the largest for-profit providers. Larger providers appear to be more profitable.

11. A large proportion of RADs (86 percent in FY2018) appear to be invested in assets including property, plant, and equipment rather than care.

[2] Here, the report does not specifically define what costs are counted as 'labour costs' however Appendix A provide a range of definitions that incorporate types of labour costs including; care – labour costs, accommodation – labour costs, hotel – labour costs, and administration – labour costs (which includes salaries and superannuation paid to executives, managers and senior management employees, bonuses, and incentive payments and commissions.

Home care

12. The report notes that the viability of home care services is unknown due to the absence of balance sheet information from the Government's financial reporting collection.

Finances and care indicators

13. The report stated that significant variance was found between providers in terms of care indicators with overall, few and statistically weak correlations noted between care indicators and financial metrics:

    i. A weak relationship was identified between income and care indicators for people with higher care needs that attract higher payments.
    ii. A weaker relationship was identified between care expenses and care indicators.

14. Overall, the report highlighted that there appeared to be no direct relationship between care needs and care expenditure (i.e. changes in care needs do not seem to result in any change in expenditure). Further, the report notes that it could be argued that an increase in expenditure to increase the number of staff performing care duties may not necessarily improve quality of care if those staff are not well trained, if there are not effective management and governance processes, or if there is not an organisational culture that encourages performance and quality.

15. The correlation between care needs and expenses (while still low) was found to be stronger among not-for-profit providers than for-profit providers (i.e. greater relationship between care needs and expenses). Correlation between care needs and expenses is lower for Government than not for-profits, but the data is more dispersed and appears to indicate high levels of expenditure per resident.

General conclusions

16. The report found that the current model of profitability and viability in the Australian aged care sector appears to favour more sophisticated providers that have the financial acumen to manage diverse portfolios with capital structures (e.g. large providers with many related entities). Complex structures (while opaque) may enable providers to maximise returns and potentially reduce reliance on Government funding (i.e. opaque financial practices maximise profits). A concern here is that these complex, opaque structures may weaken the link between drivers of return on investment and the quality of care (i.e. quality care is not incentivised/prioritised if there are other more profitable avenues to maximising returns).

17. The BDO supports the use of group structures as a reasonable approach to return maximisation, however warn that opacity and lack of governance may increase risk of loan recoverability and clear understandings of return. The BDO also cautioned against implementing any new policies regarding utilisation of group structures and highlight the availability of insufficient data to determine the policy impact, which may be negative.

18. The BDO recommend improvements in transparency to underpin better informed decision making in relation to policy and investment. Greater transparency is recommended across a number of specific areas (see page 7-8 of the report). Overall, enhanced reporting,

particularly for home care providers is urgently called for by the report. The ANMF very strongly supports calls to urgently improve the transparency of reporting – particularly regarding related entities/complex group structures – as this would enable a greater extent of analysis and decision making. These requirements for legislation for enhanced transparency and accountability is required across the entirety of the aged care sector from home care, to residential aged care and respite care.

ii. Financial analysis relating to aged care providers for assessment of prudential risk, BDO

19. The Commission engaged BDO's Andrew Fielding to identify around six approved aged care providers (residential and in-home care) that appeared to meet one or more pre-specified selection criteria. Overall, information for 870 residential care providers and 918 home care providers for FY2019 with entity level data available for 761 providers was examined. The selected providers account for less than one percent of all providers within the dataset.

20. The pre-specified selection criteria for the analysis appeared to apply to the majority of providers as the report noted that most providers appeared to meet one or more of the selection criteria. Significant liabilities in the form of Refundable Accommodation Deposits (RADs) appeared to be a common feature of many providers and the report highlighted that RAD liabilities of over $10m were identified for 413 providers and that 81 providers appeared to possess RAD liabilities that accounted for greater than 1,000 percent of their reported net assets.

21. Lack of transparency and detail regarding provider use and reporting of RADs particularly in regard to their utilisation through complex related entity structures is concerning and impedes accurate assessment of the level of prudential risk for stakeholders (e.g. providers, consumers, and government) within the aged care sector. This appears to be particularly the case for for-profit providers that possess large RAD liabilities that are hard to evaluate in terms of recoverability and risk. A key concern that has particular relevance during and following the COVID-19 pandemic, is that where consumers may choose to pull out of aged care and require reimbursement of their RAD, providers that have moved RADs along via complex related entity structures may not possess the necessary liquidity to repay the deposit putting themselves, the consumer, and the Government at risk.

22. The report explains that due to the lack of clear information regarding the reporting and use of RADs and because RAD liabilities are treated as "current liabilities" that can be used by providers for various purposes (e.g. to increase or decrease current assets and/or liabilities) the actual prudential risk evident within the sector cannot easily be determined. The report highlighted that the varied applications of RADs by providers creates potential difficulties when setting benchmarks for financial ratios that use balance sheet items and when comparing results between providers that use RADs for different purposes.

23. Further, the report highlights several additional areas where limited or unclear data was noted:

    i. Details of group structures/complex related entity structures

ii. What intangible asset balances are for and how they have been calculated
iii. The terms, documentation, recoverability/collectability, and security etc regarding related party loans (information limited only to whether the loans are current or non-current assets or liabilities).

24. The report noted that the data provided to the BDO for analysis did not contain information regarding whether or not particular providers were members of a group with complex related entity structures and that publicly available information was required to identify this. Utilisation of complex related entity structures is one way that providers are known to use RADs which creates difficulty in terms of assessing provider liquidity, prudential risk, and the ability of providers to reimburse RADs to residents/clients. Due to the absence of supporting data regarding the collectability of loans made to related entities, the report noted that it would be reasonable to assume that some providers loan a large proportion of their RAD liabilities to related entities. These loaned liabilities are difficult to account for and challenging to assess how readily collectable they are in the event the provider was required to reimburse them. The concern here is that because RADs are guaranteed by the Commonwealth Government, if RAD liabilities are loaned to related entities for the purchase of capital (e.g. real estate) and not able to be paid back (i.e. if the provider becomes insolvent), the Government may be forced to guarantee the 'lost' RAD liabilities.

25. Based on the limited available information, the report concluded that many providers appear to have low liquidity relative to their RAD liabilities; 37 percent of providers had less than 35 percent of their RAD liabilities (totalling $17.4bn) in highly liquid assets. This figure appears to be even higher among for-profit providers, with 68% having less than 35% of their RAD liabilities covered by liquid assets.

26. Following analysis and adjustment regarding RADs, the report noted that around 56 percent of providers may appear to be in financial distress (current liquidity ratios of less than one) and that for-profit providers in particular appeared to have significantly lower current ratios than others. Further, 36 percent of providers in FY2019 would appear not to satisfy a potential threshold of 20 percent in terms of capital adequacy.

27. Overall, the report highlighted that the available data was not detailed enough to conduct a thorough analysis of individual providers, particularly regarding how these providers use RAD funds and what assets remain on balance sheets to repay RAD liabilities. The report suggests that it is not possible to give definitive guidance regarding the risks associated with the use of RADs by aged care providers based on the data provided and that detailed review of individual providers and additional financial information would be necessary to fully understand the nature of industry use of RADs, risks, and assets remaining available for meeting RAD liabilities and client/resident risks. Because the utilisation of RADs, particularly via complex related entities, is apparently a significant but also very opaquely reported issue where a huge amount of resident and/or family member money is held and potentially moved around and lent on by providers, the ANMF submits that this is an area where transparent reporting is required. The ANMF strongly recommends that if RADs are retained in substantially their current form there must be clear, legislated requirements for providers of aged care to report on the use of RAD funds and how RAD liabilities are to be repaid.

iii. The profitability of aged care, Frontier Economics

28. The Commission asked Frontier Economics to prepare a report on returns in the aged care

sector. This report uses secondary sources of information to report on the financial returns earned by providers of aged care services in Australia over the course of the last five years.

29. The first section of the report looks to determine the best measures by which the financial returns of approved aged care providers can be determined. The report acknowledges Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA), and Earnings Before Interest and Tax (EBIT) as the most appropriate measures by which a reasonable comparison of provider can be made, when expressed as a proportion of revenue or residents.

30. Frontier economics does however state that several changes are required in the way which providers record their financial accounts. These changes largely involve the way in which RADs are recorded. The report states that as of 30 June 2019, the balance sheet of residential aged care providers maintained the value of RADs to be $30,183,000,000 ($30.1bn). A figure which is noted to represent 7 percent of liabilities within the sector. However the commitment to RADs as a liability may vary by provider with a greater commitment to RADs (as a portion of liabilities) witnessed in some facilities, and less in others. The extent to which residents choose to pay for accommodation by means of a RAD (as opposed to a daily accommodation payment (DAP) appears to vary by provider type. The report indicates that as of May 2020, 30 percent of individuals preferred to pay for their accommodation using RADs in the not-for-profit sector, 44 percent in the for-profit sector and 35 percent in the government sector.

31. As indicated within the report, it appears that RADs can function as both a source of revenue and a source of capital. It follows that, where providers do not have access to RADs they would be required to find alternate sources of revenue and capital. In this scenario DAPs would likely be the alternative form of revenue and corporate bonds or debt the alternate form of capital. Through means stated in the report, issues in comparing the profits of providers then become apparent where a provider who is more heavily invested in RADs may demonstrate lower dollar earnings but still provide the same return to equity as another provider which may be less invested in RADs. A comparison between these two providers may then incorrectly conclude that the second provider is more profitable than the first.

32. In acknowledgment of the above challenges presented by the role of RADs in analysing the financial data of providers, Frontier Economics suggests that for EBIT and EBITDA methods of analysis to be most effectively applied, adjustments to the financial accounts of providers is required. The report suggests that:

    i. RADs be treated as non-current liabilities
    ii. The implicit interest paid on the RAD debt as an expense be included
    iii. The implied interest on RADs be included as revenue.

33. In concluding remarks regarding the challenges presented by RADs, the report states that if in analysing financial returns the above adjustments are not made; the analysis will be limited to observing changes that occur over short periods of time, and confined to sectors that have similar capital structures and sources of revenue. It is clear then in this sense that the way in which RADs are being accounted for in financial reporting is not reflective of the diverse and varied nature of providers operating throughout aged care.

34. Further to the above, the report echoes sentiment made within the BDO report and states that all financial data should be treated with caution. Several reasons are provided as to why

this might be the case, but the primary concern is related to financial flows that occur between related entities. To reiterate, these financial flows may be facilitated through:

i. Lease payments by an approved provider to a related entity which owns the property asset
ii. A loan by an approved provider to a related entity of RADs and the payment of the interest on that loan from the related entity to the approved provider
iii. A loan by a related entity to an approved provider and the payment of interest on that loan from the approved provider to the related entity
iv. The payment of management fees or other expenses by the approved provider to a related entity.

35. It is then also noted that even where accurate representation of profits can be assumed as being fairly represented; the portion of profits generated (and recorded) for a provider may not be accurately represented due to the portion of non-aged care activities undertaken by that provider.

36. It is the view of the ANMF that the above analysis as presented by Frontier Economics contributes to the evidence that indicates there is a significant lack of transparency in financial reporting throughout the sector. Where RADs contribute such a large contribution to the financial activity of a provider, the way in which they are utilised, and to whose benefit should be clearly stated and discernible from publicly available information. It is apparent that this is currently not the case. Further, the above analysis suggests the use of group entities, although legal, potentially contribute to the facilitation of business practice that is profit orientated at the expense of residents, and the quality of care which they receive. The ANMF strongly recommends that the way in which funds are gained and utilised should be clear from providers' reporting, and that all providers should be held accountable via legislation, particularly where available funds are intended to support delivery of care to the resident and where significant sums of money are held in trust by providers with very little requirement to report.

37. The second half of the Frontier Economics profitability report provides an analysis of average returns to aged care over the last five years by making assumptions that account for the apparent challenges noted above.

38. The ANMF acknowledge Frontier Economics statement in regard to the findings of this analysis:

> *"we have formed the opinion that certain adjustments need to be made to the reported accounting data before useful analysis can be undertaken. The reported accounting data might be satisfactory for comparisons over relatively short periods of time (for example, a few years) for the same entity or group of entities. However, reported financial data are not very useful for comparisons across entities that differ in their capital structure, kind of care or location."*

39. As has been widely acknowledged throughout the Commission, and is evident throughout these reports, the aged care sector is varied, diverse and complicated, and so the ANMF notes that the findings of average returns to the sector as identified by Frontier Economics may not be truly representative of the real profits attained by providers in the sector. For the purpose of analysis however it is acceptable to the ANMF that the following statement is supported in principle, being that, at an aggregate level the findings are in line with what

economic theory might suggest, and that given the relative ease and access into and out of the sector, returns are likely close to the cost of capital in the long term.

40. Frontier Economics find that at an aggregate level, when not accounting for different structures of ownership (for-profit, not-for-profit and government) within aged care, returns in residential care were modest on average but significant enough to induce investment. The report notes average returns in residential aged care were reasonably constant in FY2015, FY2016 and FY2017, and that significant investment in infrastructure during this time is a likely indication that providers within each segment did recover their cost of capital. Further analysis then segments the return to the sector by ownership type. It is these findings that then suggest for-profit providers were more likely to recover their cost of funds, making a higher return than not for-profits; and not for-profits making a higher return than government operators. In response to these findings, the ANMF highlights the inverse relationship between the likelihood to recover costs, and the quality of care delivered by the provider. In this regard the ANMF draws attention to the findings of the University of Queensland report (discussed in detail below), which draws a distinct connection between for-profit ownership and the delivery of relatively lower quality care.

iv. The cost of residential aged care, The University of Queensland

41. The University of Queensland (UQ) was commissioned by the Royal Commission into Aged Care Quality and Safety to conduct and report on an analysis to:

    i. Estimate the efficient cost of delivering residential aged care for the range of output quantities and care qualities observed historically, accounting for the degree of care required by residents and other relevant factors that impact on service delivery costs.
    ii. Assess the historical level and distribution of inefficiency across service providers, using the estimates.
    iii. Determine the efficient costs required to achieve the different care qualities for all aged care facilities, using the estimation model(s).

42. The study noted that it used a comprehensive set of seven quality indicators, ranging from clinical outcomes of residents, process quality standards and service experience indicators.

The rating system doesn't incorporate all important factors for determining quality (e.g. staffing)

43. The composite quality index developed specifically for the project comprised several quality indicators (consumer experience ratings, reported issues, accreditation standards not met, and prescription of four high-risk medicines; sedatives, antipsychotics, opioids and antibiotics). We note that these quality indicators are dissimilar to those used by the United States Centers for Medicare and Medicaid Services (CMS) Rating System for nursing homes (the CMS Five-Star Quality Rating System or 'CMS Compare') which are; health inspections, quality measures (15 different physical and clinical measures for nursing home residents), and staffing (the number of hours of care provided on average to each resident each day by nursing staff). Congruent with what CMS highlights in relation to rating systems for nursing homes in a general sense, no rating system can address all the important considerations underpinning decision-making regarding the selection of a particular home. Considerations regarding the need or preference for specialty care (e.g. dementia, rehabilitation, or culturally appropriate care), or ease of family visitation are not incorporated into CMS

compare nor the UQ report.

There is limited direct evidence available to determine the quality of care provided within Australian nursing homes

44. Concerningly, the UQ report highlighted that there were insufficient direct measures of the quality of care recorded for facilities examined, indicating that stakeholders including consumers (e.g. older people and their loved ones), staff, providers, and governments have little to go on when determining the specific or relative quality of care that residents receive within Australian nursing homes.

45. The ANMF strongly recommends that there must be greater collection, reporting, and use of relevant and evidence-based quality measures in nursing homes so that stakeholders including consumers, staff, providers, governments and government agencies have the best available, relevant evidence regarding the quality of care delivered by Australian aged care providers. Staffing levels and skills mix are evidence-based indicators of care quality and better resident outcomes. As we have highlighted in our previous submissions that address the CMS Rating System, it is also important to understand that rating systems are neither designed to nor capable of determining safe, quality staffing levels or ensuring that providers meet any particular standard of staffing numbers and skills mix. Rating systems may facilitate better consumer decision making and sector transparency, but do not themselves underpin staffing improvements and the delivery of safe, quality aged care.

International and national quality and safety indicators for aged care

46. The ANMF has also examined the Commission's eighth Research Paper on international and national quality and safety indicators for aged care.[3] This paper reviewed national and international Quality and Safety Indicators and where applicable, a comparison was made between these indicators and Australian Aged Care providers. Overall 305 largely heterogenous indicators were identified across nine domains of physical and psychosocial function, health-related areas (inclusive of medication-related indicators), social well-being, and safety and quality of life. Canada, Netherlands and Sweden also provided home care indicators. For comparison, 134 quality and safety indicators were identified. These covered 12 domains (inclusive of home-care indicators):

i. medication-related
ii. pressure injury
iii. falls/fractures
iv. weight loss, malnutrition
v. bowel/bladder/incontinence
vi. depressive symptoms/depression
vii. pain
viii. care plans/medication review
ix. hospitalisations

[3] The Registry of Senior Australians (ROSA) Research Team at the South Australian Health and Medical Research Institute (SAHMRI). International and National Quality and Safety Indicators for Aged Care. 2020. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/research_paper_8_-_international_and_national_quality_and_safety_indicators_for_aged_care.pdf

x. infections
xi. cognition
xii. mortality

47. A comparison of Australia's performance against national/international indicators found that low end performance was observed for utilisation of care plans and mediation reviews and significant unplanned weight loss. Mixed performance was observed for antipsychotic or anti-anxiety/anti-hypnotic medication use and pressure injuries (stage II-IV). High performance was observed for re-hospitalisations and emergency department presentations within 30 days of discharge.

48. The ANMF supports the reports suggestion that by using existing administrative data, and at no extra burden to aged care providers, domains for the routine monitoring of aged care quality and safety indicators in Australia could include:

    i. Medication related quality of care, antipsychotic medication use, high sedative load, and antibiotic use.
    ii. Falls and fractures
    iii. Hospital re-admissions
    iv. Hospitalisation for dementia/delirium in individuals with dementia
    v. Pain (chronic opioid use)
    vi. Premature mortality
    vii. Pressure injury
    viii. Utilisation of care plans and medication reviews
    ix. Weight loss/malnutrition

49. The report goes on to suggest that any set of quality and safety indicators should be consistent at the national level, and should use existing data for the development of indicators that are feasible, standardise aged care providers management systems to capture additional elements as part of their ongoing processes of care, focussing on complementing and not repeating data already elsewhere collected, and develop and include high quality instruments to capture domains of care not able to be collected elsewhere (e.g. quality of life, consumers' experience). These recommendations are all supported by the ANMF.

50. Finally, and also supported by the ANMF, the report also recommends that any reform of quality and safety indicators should incorporate the following elements:

    i. Routine monitoring of home care quality and safety.
    ii. Real time data collection
    iii. Establish and include evidence-based target ranges or benchmarks
    iv. Allow for adjustment of case mix
    v. Maintain a provision for public reporting to support transparency and accountability throughout the sector.
    vi. Include reassessment of indicators to ensure relevance
    vii. An independent regulatory body be responsible for oversight of the indicators

51. One of the key issues raised in this reporting appears to be a lack of quality of life and wellbeing measures. With the Royal Commission repeatedly highlighting calls throughout

the sector for the delivery of respectful and dignified care it appears unreasonable that there is no currently feasible method of reporting these outcomes at the population level. This lack of reporting ability has also been acknowledged in the ANMFs response to the UQ report, whereby the research team identified a lack of direct evidence that would enable an appropriate understanding of the provision of quality care in Australian aged care facilities. The ROSA team concludes their analysis of national and international quality and safety indicators by stating that with currently available data, Australia is capable of implementing a well-designed, comprehensive, and effective set of quality and safety indicators. Given this clearly stated capability to do so, there does not appear to be any reason why this reform would not be agreed upon. In implementation of these indicators however, it is imperative that work is undertaken to ensure measures of quality of life and wellbeing are appropriately captured and reported in any scheme of aged care quality and safety indicators..

The provision of high-quality care is not common

52. The UQ report notes that only 11 percent of providers appear to be delivering relatively higher quality care than what could be regarded as the 'standard' or moderate quality delivered by 78 percent of providers. Government-owned and smaller-sized homes appear to provide relatively higher quality care, while a large proportion of the total number (11 percent) providers delivering relatively poorer quality care appear to be owned by for-profit companies.

53. Based on the limited data available to the investigators, 78 percent of providers appear to deliver 'moderate' quality care, while 11 percent deliver relatively poorer quality care and 11 percent deliver relatively higher quality care. Overall, Government-owned and smaller-sized facilities appeared to deliver relatively higher quality care where size of facility appeared to be consistently associated with relatively better quality regardless of ownership/provider type. Concerningly, for-profit providers accounted for a higher proportion of lower-quality nursing homes relative to their prominence within the sector. The relationship between nursing home size and resident and family member satisfaction where smaller size appears to underpin greater satisfaction has also been identified in published studies.[4,5,6,7] These studies also found other positive relationships between measures of amount of exercise/activity of residents, individualized care processes, ownership status, staffing ratios, and staff education levels and inverse relationships with satisfaction for chain affiliation and size of facility.

54. With for-profit aged care providers and larger operators increasing their market share across residential and in-home aged care, the ANMF strongly recommends that greater scrutiny must be placed upon aged care providers - particularly for-profit providers based on the

[4] Spangler D, Blomqvist P, Lindberg Y, Winblad U. Small is beautiful? Explaining resident satisfaction in Swedish nursing home care. BMC Health Serv Res. 2019;19(1):886. doi:10.1186/s12913-019-4694-9, 10.1186/s12913-019-4694-9

[5] Shippee TP, et al. "Family Satisfaction With Nursing Home Care." Research on Aging 39.3 (2017): 418-442. Ovid MEDLINE(R). Web. 12 August. 2020. <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med14&NEWS=N&AN=26534835>.

[6] You K, et al. "Do Nursing Home Chain Size and Proprietary Status Affect Experiences With Care?." Medical Care 54.3 (2016): 229-34. Ovid MEDLINE(R). Web. 12 August. 2020. <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med13&NEWS=N&AN=26765147>.

[7] Marilyn J. Rantz, PhD, RN, FAAN, Lanis Hicks, PhD, Victoria Grando, PhD, RN, Gregory F. Petroski, MS, Richard W. Madsen, PhD, David R. Mehr, MD, MS, Vicki Conn, PhD, RN, Mary Zwygart-Staffacher, PhD, RN, BC, GNP, GCNS, FAAN, Jill Scott, RN, PhD, Marcia Flesner, RN, PhD(c), Jane Bostick, RN, PhD, Rose Porter, RN, PhD, Meridean Maas, RN, PhD, FAAN, Nursing Home Quality, Cost, Staffing, and Staff Mix, The Gerontologist, Volume 44, Issue 1, February 2004, Pages 24–38, https://doi.org/10.1093/geront/44.1.24

indications that for-profit ownership appears to relate to the provision of worse quality care. Further, additional examination of why larger homes appear to provide relatively poorer quality care is necessary to determine what approaches may be necessary to improve care quality. Further funding provided by State and Territory governments that is invested in the provision of care – such as into supporting improved staffing levels and skills mix – may be argued to result in better quality care and better satisfaction of staff with work. The ANMF also highlights that supporting better quality care provision in aged care could also lead to offsets elsewhere including reduced hospitalisations, lower spending on medicines, and the reduction of workplace injuries as a result of better staffing levels.

Higher costs of proving care results in higher quality care

55. The UQ report found that the higher the total cost of providing care (care and non-care combined) and care alone appear to result in the provision of relatively higher quality care. Greater spending on direct care therefore may improve overall care quality. The UQ report suggests that there is an association between total cost of care provision (direct care and non-care costs combined) and the quality of nursing home care; i.e. the greater the cost required to deliver care, the greater quality of care provided. Analysis appears to indicate that for smaller nursing homes (<30 beds) providing relatively better-quality care, the cost of that care is higher than for smaller homes providing relatively poorer and moderate quality care. The cost of providing care in larger homes (>30 beds) is generally lower than in smaller homes and again, appears positively related to quality of care (i.e. higher cost of care seems to result in relatively better-quality care). Overall, the relationship between cost of care and relative quality was noted for direct care costs and quality but not non-care costs and quality. This could indicate that greater spending on direct care costs (e.g. staffing and resources to provide care) results in greater quality of care, but more spending on non-care costs (e.g. accommodation, hotelling) does not. This finding is important, should be examined further, and underpins the ANMF's calls for increased transparency and accountability for the utilisation of funding for the provision of care.

The Australian aged care sector operates relatively cost-efficiently

56. The UQ report found that the Australian aged care sector appears to operate relatively cost-efficiently. Additional spending of $620 million would have been required in FY2018-19 for the sector to deliver relatively higher quality care in relation to the UQ report's analysis. Without any cost inefficiency, analysis suggests that providers would have spent $15.70 billion in FY2018-19. To operate at the relatively higher quality level of the 11 percent of the better rated homes, an additional $620 million would have been required to be spent by the sector in FY2018-19. The UQ report suggests that the Australian aged care sector would appear to operate with relatively high efficiency (average of 0.88 total / direct care 0.91); higher than what is reported in the literature (average of 0.75) and greater than the hospital sector (average of 083). Insufficient evidence was located to suggest that cost inefficiencies exist across non-care areas. An important point to note is that while statistical evidence was noted for the cost efficiency of aged care, the report highlights that the differences between providers are not always large in dollar terms. This, the report notes, is possibly because RAC facilities are largely funded by the Government with a relatively narrow funding range, and that quality depends on many factors other than expenditure (for example, the skills of staff, clinical governance, work processes and organisational culture).

57. Echoing the caveat in the UQ report, the ANMF draws the Commission's attention to the fact that the UQ estimates are for the quality levels found among facilities within the current residential aged care system under current funding levels. Funding levels might need to be much higher than the estimates if the Australian community and the Royal Commission aspire to achieve a higher quality in the future than facilities have achieved historically. The ANMF suggests that this is likely to be necessary as the overall quality of care in the Australian aged care sector would appear to be relatively low (i.e. in line with the University of Wollongong report showing that most Australian facilities would receive only 2 Stars (below average performance) within the US's CMS Compare Rating System,[8] and the ANMF's evidence demonstrating that many residents receive far too little care from a insufficiently sized workforce with generally low skills mix.[9]

58. Where the sector appears to be heavily reliant upon Government funding (i.e. taxpayers' money) and large payments and deposits from residents and their families, it is imperative that providers transparently account for the use of this money to provide safe, quality care and accommodation. The ANMF strongly recommends that there must be greater provider transparency and accountability regarding the use of funds to support the delivery of direct care services that would underpin the provision of higher quality care, particularly if additional funding is to be provided to deliver that care.

Lack of data impedes assessment of the quality of care

59. The report noted limitations regarding data reporting around quality impede assessment regarding the quality of care delivered by Australian nursing home providers. The report concludes that both better financial and workforce reporting standards, and improvements in quality indicator measurement and reporting are required to drive better measurement of quality of care in Australia's residential aged care sector and to increase confidence in the results of UQ's analyses. The ANMF agrees with the report's conclusion that adoption of the Australian National Aged Care Classification (AN-ACC) developed by Professor Eagar's team at the University of Wollongong would contribute to developments regarding measurement of care quality and the needs of residents.

60. The ANMF recommends that these improvements in data reporting should be called for by the Royal Commission as a matter of priority in order to address deficiencies in the collection, reporting, and use of vital data required to underpin the delivery of safe, quality care in Australia's residential aged care sector.

v. The required return for aged care service providers, Frontier Economics

61. Frontier Economics delivered a second report to the Commission that aimed to:

    i. Estimate the weighted-average cost of capital (WACC) for the provision of accommodation in the residential aged care sector.

[8] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

[9] Willis, E., Price, K., Bonner, R., Henderson, J., Gibson, T., Hurley, J., Blackman, I., Toffoli, L and Currie, T. (2016) Meeting residents' care needs: A study of the requirement for nursing and personal care staff. Australian Nursing and Midwifery Federation

ii. Advise on how the WACC may vary under different reform scenarios.
iii. Demonstrate how the WACC may be used as a component of a 'building block' model to determine an appropriate allowance for the return on capital and return of capital (depreciation) for providers of aged care accommodation services.

62. The first section of this report provides a comprehensive overview of how they estimated a Weighted Average Cost of Capital (WACC) through the use of a Capital Asset Pricing Model (CAPM). Frontier Economics explains the WACC as the return owed to shareholders to justify their investment. The example provided states that if a firm maintained $1,000 of capital, with an estimated WACC of 7 percent, then that firm would be required to generate enough revenue that after all other expenses are accounted for, $70 (7 percent of $1,000) remains to be passed onto those who had invested in the initial capital of $1,000. This reimbursement is explained as being required to incentivise investment and growth within the sector. In a scenario where investors are not satisfactorily reimbursed and their investment is not attracted, the sector will not see the provision of capital that is required for the purchase or construction of facilities and equipment, and will subsequently be limited in growth and ability to service increased demand for services.

63. The report determines the WACC through the use of a CAPM which is described to be a standard approach widely administered by Australian regulators when setting allowed revenues for regulated infrastructure assets in Australia. Frontier Economics defines a WACC in this scenario as an estimate of a fair rate of return for the providers of investment capital (into Aged Care) that is reflective of the risk borne by those investors.

64. The second section of the report uses a building block approach and the calculated WACC to determine the required revenues for a provider. By incorporating an estimation for return of capital, return on capital (as determined using the WACC), operating expenses, and corporate taxes, a standard regulatory model for the required revenue of an aged care provider is determined. It is noted in the report that the model presented is similar in construction to standard regulatory building block models, such as those used by the Australian Energy Regulator, with the exception that it considers the value of land assets (as appreciating), and buildings and fixtures (as depreciating assets).

65. The building block model described, and the subsequently determined required revenue, can then be used to allocate a price or revenue cap paid to the provider. This price cap can inform the limit to which a person receiving those accommodation services might be charged (i.e. an annual price per bed year payable to the provider per resident); a limit which is sufficient to ensure a provider is able to cover its operating costs and only receive a fair return on its capital.

66. The ANMF understands that there are complexities around whatever model and approach is used to determine fair return on capital and acknowledges the range of explicit and implicit subsidies the report raises and their potential impact on required revenue. As noted in the report, entities which differ regarding their tax requirements, required rate of shareholder return and financing structures will attract different required rates of return and it is important all contributing factors are identified. The ANMF submits that any approach used to define a required return on capital must ensure the fair and equitable delivery of safe and quality care, be transparently accounted for and reported and take account of the relative security of income flows through Commonwealth funding.

67. Beyond the calculation for a required rate of return, the report also discusses potential outcomes should a range of reforms be implemented. Analysis of these reforms is introduced in incremental scenarios of increased reform and a situation where all reforms are considered is described as follows. The aged care sector would no longer see lump sum RADs permitted and commonwealth capital grants would be discontinued. Further, DAPs would be permitted but capped and residential care subsidies would remain rationed at current levels and allocated through the ACAR. The rationing of residential care places would be phased out and commonwealth support would be provided for an increase in availability of home care places. Finally, the commonwealth would provide incentives that encourage the development of smaller scale congregate living arrangements.

68. Further a variant to the above reforms is discussed, whereby frontier economics explore a scenario where residential care subsidies are allocated to the individual as opposed to the provider. This effectively allocates a package of funding to a resident, which would then follow that resident should they wish to switch provider, and subsequently allowing them a greater level of consumer choice. The ANMF has grave reservations about this scenario and considers that it is akin to entitlement based individualised funding and like proposals that were the subject of criticism in the ANMF Submissions on Program De-design: ANM.0017.0001.0006 AWF.660.00041 and ANM.0019.0001.0001 AWF.665.00020.

69. The ANMF notes that the impact of these reforms on providers is ambiguous in that the impact of increased competition within the sector is unclear. It is the firm position of the ANMF that any reform in this regard must ensure quality outcomes for those who receive care within the sector, and that the way in which providers accept funds and deliver care is transparent, and that providers are held accountable in upholding quality of care and transparency of operation. Further the ANMF submits that any reform must promote the fair and equitable delivery of care, regardless of background or location, and supports consumer choice in attaining that care.

70. Finally, Frontier Economics explores the choice given to residents where they may choose to fund their accommodation with the service provider through either a payment made via RADs or DAPs, or a combination of the two. The report cites existence of a formula, used by the Department of Health, that is intended to ensure equivalence is maintained in terms of contribution between the two payments. Critical to this formula is the maximum permissible interest rate (MPIR). An MPIR is equal to the interest a provider would be required to pay to the resident should the resident pay for accommodation services through a RAD, in this situation the RAD is effectively a loan to the provider. Therefore, where a RAD payment is determined between the provider and resident, an equivalent DAP payment can be calculated by multiplying the RAD by the MPIR, and dividing the total by the number of days in a year, arriving at a 'daily accommodation payment'. Equivalence between the two payment methods is then reasoned where the DAP payment made to the provider is found to be equal to the interest the provider would be required to pay to the resident on a RAD.

71. The report however cites issues related to calculation of interest and reduced risk facilitated by the underwriting of RADs by the Commonwealth, creating calculated RAD and DAP payments that are not economically equivalent, with an advantaged prescribed to providers and those who are financially capable of making a RAD payment. Subsequently the report raises question of intentional policy decisions that favour RAD payments, a policy that does not meet the intention of creating economic indifference between RAD or DAP payments.

72. The ANMF submits that no economic disadvantage should be created or imposed on those

who engage with aged care services when deciding whether to pay via either RADs or DAPs and that the original policy intention should be upheld. Further, the incentivisation of payment methods that support potentially unfair profiteering by providers should be appropriately reformed so that fair outcomes are achieved. The ANMF supports the report's recommendation that the appropriate interest rate to use when considering the MPIR should be that of the providers' commercial borrowing rate in understanding this is the most fair and equitable approach to determining economic equivalence between RAD and DAP payments.

vi. Price regulation approaches for aged care, Flavio Menezes

73. The Royal Commission engaged Flavio Menezes to provide a high-level review of different price regulation approaches that may be appropriate for implementation into aged care. the setting of maximum prices by an independent regulator (independent of government) based on efficient costs.

Current price regulation in aged care

74. The report includes a high-level review of different price regulation approaches that may be appropriate for implementation into Australia's aged care sector. On page 37, the author describes several assumptions they have put in place when modelling how price regulation may be able to be implemented in the Australian residential aged care sector using three approaches (rate of return, price cap, and benchmarking).

75. The report also includes a brief discussion of the role of price regulation in aged care funding systems in Switzerland and the United States which are considered to have common elements to the Australian system as well as a review of limited existing empirical evidence on the performance of the different regulatory regimes. The author uses examples of Switzerland and the United States to show that where staffing regulations have been implemented, quality of care is improved, upheld or maintained; and that quality of care appears to be closely aligned to staffing levels. In Swiss example, quality aspects in aged care were controlled through measures of a staffing ratio when implementing a new payment system. In contrast to the US who saw reductions in quality as measured by a reduction in the number of professional staff when implementing similar a similar price regulation model. In the United States a study showed that increases in government subsidy payments led to significant increases in quality of care as measured by increases in the number of skilled nurses. Increases in competition however had a relatively small impact on the quality of care provided. Increases in quality as a result of increased competition only become mildly statistically stronger upon introduction of the NHS rating system.

76. The report suggests that price regulation may improve outcomes in residential aged care given the limited capacity for competition to result in prices that reflect the efficient costs of providing aged care services. The report suggests that with price regulation, the government would set the level of subsidies independently from the regulated prices faced by residents. In contrast, the report does not consider price regulation to be a feasible option and that instead competition regulation may be the most effective and suitable approach to reflect efficient costs in the sector.

77. The ANMF notes that the author highlights that where the report discusses how different forms of price regulation might work in residential aged care, the discussion is purely illustrative and exploratory and does not clearly spell out in detail how price regulation may

be implemented. For that, the author highlights that defining key elements of the overarching regulatory regime would be required. Another important consideration noted by the report is that introducing price regulation would necessarily be based upon a considerable amount of work, policy decision making, and implementation. Overall, the ANMF is supportive of regulation on pricing as long as the process upholds transparency and accountability for all stakeholders involved.

Price regulation in aged care

78. Price regulation has been defined as the setting of maximum prices by an independent regulator based on efficient costs. For costs to be efficient in aged care, services must be produced/delivered at least cost (technical/productive efficiency) and providers must be able to modify the way they deliver services in a timely manner to respond effectively to changes in consumer preferences and the process of delivering aged care services (dynamic efficiency). Prices that are reflective of efficient costs arise when the resources expended to deliver services are used most effectively to enable the greatest benefit relative to the cost of delivering the service (allocative efficiency). Competition between providers to become more efficient occurs when they strive to improve their technical/productive-, dynamic-, and allocative- efficiency. When prices are based upon efficient costs, the independent regular is seeking to mimic the outcomes of effective competition within a market (i.e. the greatest efficiency in the use of resources to deliver services).

79. Currently, the way prices in aged care are set is not based upon efficient costs or set by an independent regulator, instead the Australian Government Department of Health determines prices in part to protect taxpayers from significant increases to budget expenses. By moving to an independent price regulation approach, the report argues that the government would then be able to dissociate funding decisions from the determination of consumer prices which ideally should reflect the efficient costs of the services being provided in aged care.

80. The report highlights that the current state of price regulation in aged care is heavily determined and overseen by the Australian Government which is involved in all aspects of the provision of aged care services largely in the form of setting 'price ceilings'. The current framework for funding, assessment, and delivery of aged care services is highly complex, entails a heavy regulatory burden, imposes constraints on consumer choice, and shapes the market for aged care. The report notes due to the complex and wide-ranging intervention of government into all areas of the residential aged care sector, the impact of individuals (i.e. residents and their families), aged care providers, and the market is almost impossible to determine precisely.

Competition in residential aged care

81. The report highlights that the role of competition in the residential aged care sector in promoting socially desirable outcomes is unclear due to market power being an influential structural characteristic of the market. The example of geographic monopoly is provided, where due to demand and competition not driving the number of providers operating in a given area, regulation of the number of providers permitted to operate results in consumers of aged care services having limited choice between providers. The report highlights that the regulation of competition in aged care is unlikely to fully mitigate market power due to issues such as the importance of geographic location and the difficult decisions that consumers make when entering the sector. Put simply, many consumers can end up in less-

than preferred facilities simply due to the urgency of the decision and the availability of places/beds on offer.

Provider switching costs and consumer information gaps in residential aged care

82. The cost of switching providers and the absence of clear information for consumers also impede effective competition as they both pose barriers for consumers to make decisions about who provides care. Here, the report suggests three desirable interventions that may be considered instead of price regulation in order to address prevalent problems regarding the costs of switching providers and information gaps:

    i. Mandating consumer information provision requirements
    ii. Codes of conduct
    iii. Standardised contract terms for exiting providers

83. The ANMF considers that regardless of whether or how price regulation is to be pursued, these three other interventions are also required in the sector.

Quality of care and competition in residential aged care

84. The report highlights the important relationship between competition for residents and quality of care and that this relationship is critical to consider in the discussion of the role of price regulation, noting that recent changes and pauses to ACFI indexation has generated a context where providers have little incentive to compete for residents through the provision of better quality service and care. The report notes the problems regarding whether capitated prices or competition enhance social welfare, highlighting that while quality may be dependent upon the price set by the regulator where high price should result in higher quality, where competition between providers is feasible and price regulation is unnecessary, consumer choice is facilitated through the presence of wider variety.

85. The report suggests that increasing regulated pricing is likely to be a more effective approach to achieving better quality services in aged care than promoting additional competition between providers which may be less feasible.

86. The report suggests that there are two key objectives of price regulation in aged care:

    i. To promote efficient provision of an investment in residential aged care services
    ii. To ensure that the services that are provided meet well-defined and guaranteed quality standards

Price regulation in in-home aged care

87. In contrast to residential aged care, price regulation in the in-home care sector does not appear feasible due to the fact that the costs of supplying services for in-home care do not underpin the costs charged by providers to deliver services to clients. Here, the report argues that unless an activity-based funding model is adopted, price regulation of individual services would not be feasible. The report highlights that if regulated prices are set too low, even efficient providers may leave the market, while prices that are too high could create an undesirable economic 'coordination device' between providers.

88. The report highlights that competition between providers to offer home care services may

be effective in driving the costs of services to efficient levels. Here, as with residential aged care, the report suggests that addressing information asymmetries and better enabling clients to switch between providers would enhance competition in the sector. The ANMF agrees that clients should have clear and detailed information about home care providers and their services and be readily able to switch providers or to access services from a range of providers if they choose. Having access to detailed information regarding the quality and cost of services offered by different providers as well as information regarding staffing and accountability around the use of funding for the delivery of safe quality care would enable consumers to make informed choices regarding their care.

89. The report highlights that characteristics of the Home Support and Home Care programs do not lend themselves to price regulation. As Home Support is funded through grants, individuals do not face cost reflective prices. Further, because home care funding is allocated to individuals rather than providers, there is scope for competition to drive the costs of the services to efficient levels.

90. Competition-style regulation that is aimed at reducing information asymmetries and making it easier for individuals to switch providers is suggested as an approach that may increase the effectiveness of competition for home care services. Reducing regulatory barriers to entry may also increase the effectiveness of competition. Competition regulation, however, has limits. When providers have considerable market power and entry is restricted, as in the case of residential aged care, there may be a potential role for price regulation.

91. The report also suggests that ensuring that unnecessary regulatory barriers to entry to the provider market for in-home care could also be considered to promote effective competition between providers and thus a higher degree of choice and presumably quality for consumers. Here, the example is that services such as gardening and cleaning currently supplied through home care could be chosen by the client to be provided instead by other companies who are approved to provide those services but not clinical or personal care.

Interaction between price regulation in residential and in-home care

92. Price regulation in residential aged can also have an impact on the demand for in-home care, especially at the highest level of care. For example, if regulated prices for residential aged care are too high (or the subsidies too low), individuals may remain in-home care longer than what is safe or desirable due to affordability. In a similar vein, if regulated prices are too low and residential aged care providers are not incentivised to offer better quality, or if they exit the market, individuals may have no choice but to stay in-home care for longer.

Hidden information/ adverse selection

93. The report highlights the issue of hidden information or adverse selection in the context of price regulation. This is an issue when providers secure higher prices for services delivered by reporting that their costs of delivering the service are higher than they really are. Due to the absence of transparency and accountability regarding providers' use of funds in aged care to deliver care and services, the ANMF considers this to be a likely potential risk.

Approaches to price regulation

94. The author presents three strategies of price regulation;

i. Rate of return regulation
ii. Price cap regulation
iii. Benchmark regulation

95. Rate of return regulation is when a regulator sets a price that allows the provider to recover costs that have been incurred. In this situation the intention is that the regulated uniform price is equal to the total costs incurred, divided by the quantity supplied by the provider. This approach addresses the problem noted above regarding "hidden information" but raises a "moral hazard" issue where providers are not incentivised to reduce their costs to provide services which can then result in overinvestment in capital assets where the allowed rate of return is greater than the provider's true cost of capital. The report later notes that there can be an increased certainty of cost recovery for providers with rate of return regulation which can have a positive impact on the quality of services.

96. In price cap regulation, a regulator sets a maximum price that a provider is able to charge its customers. This method requires significant information gathering, auditing, and accounting. Providers are then incentivised to supply services at the least possible cost which may benefit consumers however the risks of monopoly power and underestimation of demand can become issues.

97. Benchmarking can be used when many regulated providers are providing the same service across different geographic areas. The price for each provider is then based the actual costs of the other providers, and so no single provider has influence on the price it can charge.

98. Of the three strategies, benchmarking appears to be the most feasible to implement due to its relative simplicity, low judgement requirement, and low cost. Although benchmarking is likely to be as resource intensive in terms of administration as price cap and rate of return regulation, the report notes that challenges in gathering information may be overcome as the AN-ACC system is capable of determining cost drivers, and that there is a large number (873) of approved providers. The main point of concern for the ANMF is that in implementing price regulation, the trade-off between ensuring an efficient price, in terms of the delivery of services, and the efforts of providers to recover their costs and remain viable (make a profit) incentivises providers to reduce the cost of service provision which, unregulated, is likely to come at a detriment to the delivery of quality care. The ANMF is vehemently opposed to actions that could lead to providers reducing even further the quality and safety of their services in order to make a profit. As we have seen above, around 11 percent of providers already provide relatively poor quality care and these providers appear to largely include for-profits. Further incentivising the delivery of poor quality care risks this group, which is already too large, growing further.

Maintaining quality alongside price regulation

99. Importantly, the report highlights that any price regulation will likely be accompanied by cost minimising measures on behalf of the providers, who in an effort to maximise their profits, are likely to make changes to their service delivery in a way which impacts the quality of care delivered (through reduced staffing as an example), and so it is recommended that any implementation of price regulation be accompanied by other regulatory measures that ensure quality of care is maintained. As we have on many occasions, the ANMF strongly recommends that mandating minimum staffing levels and skills mix is one approach that could ensure there are at least the right number of the right staff to provide quality care. This would also necessarily be accompanied by greater

transparency and accentuality in terms of the utilisation of funds for the provision of that care.

100. The report cautions that interventions to support the delivery of quality services must be considered carefully; incentive schemes with penalties for not achieving or payments for achieving defined quality targets that are too great may lead to misreporting. By verifying quality, this may be mitigated – something that already occurs through the independent hospital pricing authority's financial penalties for hospital acquired complications.

101. The report highlights that AN-ACC may be a possible starting point for price regulation in residential aged care and would also require a similar exercise to be undertaken for the implementation of price regulation of 'hotel services'.

102. The report suggests that adding an "uplift" to the national efficient price (e.g. 10 percent) where providers meet well-defined quality standards may incentivise providers to uphold quality in delivery of care. A further suggestion is also made to penalise providers when quality is not met by reducing received subsidy as portion of efficient prices (e.g. 95 percent). The ANMF highlights that this suggestion deserves substantially greater consideration, as at present this uplift and penalty appear to be simply and afterthought tacked onto the end of the remainder of the report and that the figures of 10 percent uplift and five percent penalty are not themselves based upon evidence or analysis. The ANMF are concerned that any impact of uplift and/or penalty is most likely going to be felt the keenest by residents and clients as aged care providers will clearly look to increase savings and profit margins – as described above – by reducing the quality and thereby the safety of care.

vii. Aged care reform: projecting future impacts, Deloitte Access Economics

103. The Commission asked Deloitte Access Economics to develop a detailed economic scenario model of the aged care sector to help inform the Commission's work to understand how potential reforms might impact on the operations of the sector, its workforce and required levels of funding as important parts of the overall picture of the future of aged care in Australia. The report is designed to consider the impact of aged care policy change to 2050 in comparison to a baseline scenario where no policy reform occurs.

104. The baseline scenario includes several assumptions:

i. Strong growth of demand for aged care across subsectors (i.e. age care in the home/community, residential aged care)
ii. Demand tempered by expected improvements in the physical health of the aging population.
iii. Persistence of older peoples' preference for aging at home. The ANMF notes that later in the report (Page 33) it is highlighted that the preference for care to be delivered in the home may put some people at risk of not getting the care they need. The ANMF also notes that the strong preference for staying in one's own home as one ages is likely to be significantly related to the overall very negative perception of residential aged care.[10]
iv. Home care support program remaining the largest in terms of recipients.

[10] Roy Morgan. What Australians Think of Ageing and Aged Care A survey for the Royal Commission into Aged Care Quality and Safety. 2020. Available online: https://agedcare.royalcommission.gov.au/sites/default/files/2020-07/research_paper_4_-_what_australians_think_of_ageing_and_aged_care.pdf

v. Strongest growth in-home care packages particularly in early years.

vi. That the quality of care will gradually rise despite less care time per recipient per day (see graph pg. 19). The ANMF notes however that the model appears to be predicated on people (on average) receiving only around 190 minutes of care per day in 2018. In light of the ANMF's Staffing and Skills Mix project, this is only slightly more than 'Voula' (the profile of a typical person with the lowest care needs in residential aged care). Over time, the report suggests that the time per day of care per resident would decrease even further, which may not make sense given that people in nursing homes are likely to be entering permanent care when they are older and have greater need for increased care. Further, reducing the time/amount of care people receive per day – even if technological and productivity enhancements enable such efficiencies – appears to go against widespread calls from older people, families and loved ones, and staff highlighting that there is an urgent desire and need for *more* time not less time with residents not just to provide the care that is required but to deliver that care in a way that supports dignity, respect, and personal human relationships.

vii. That rising care quality will be enabled by productivity improvements despite the gradual reduction of staff time with each person per day. As noted against assumption vi, this is concerning, as while productivity improvements may enable more efficient provision of care the interpersonal elements of care provision are important and valued by residents and staff. This is clear in much evidence already before the Commission. Notwithstanding the point that care must be cost-effective, rather than looking at ways to make care delivery 'more efficient' and staff 'more productive' should there not be a focus on making care more respectful, human, and dignified? It appears to be a single-minded focus on efficiency, productivity, and cost-saving that has resulted in much of the evidence of neglect before the Commission.

viii. A persistence of workforce pressure driven by growing demand for workers outstripping economy-wide employment growth.

ix. An expected rise in wages in aged care in comparison to the broader economy to attract staff.

x. Rising costs of care driven by greater demand and rapid sector growth.

xi. An increased capacity for people to contribute to their care as the superannuation system matures. The ANMF notes that this assumption (as well as items xii – xiv) depends on Government action and may need further examination and consideration in terms of equity and fairness as many people – especially women, people on low incomes, the unemployed, and people in insecure employment are unlikely to have sufficient superannuation balances. Recent Government announcements regarding delays to the planned increase to mandatory superannuation are also likely to have a strong impact on this.

xii. Cost burden reduced by shift from residential care to home care packages.

xiii. Government spending on aged care expected to gradually account for a larger proportion of the national income.

xiv. An expected rise in costs relative to the overall economy that is lower than which was projected in 2015 due to assumptions around disability rates and preference toward home care packages and away from residential aged care.

105. The report includes modelling of a scenario where a package of reforms for high quality care proposed by the Commission has been implemented in order to understand the future impact of possible changes to the aged care system. The options have been incorporated within the report into a single set of results outlining an alternative future for

aged care in Australia. The scenario considers the impact of a package of wide-reaching reforms which the Royal Commission is considering. The reforms cover:

i. Improvements to care quality, staffing and training
ii. Aspects of regulation and system navigation
iii. Availability of different types of care
iv. Health service provision
v. Funding levels and allocation mechanisms

106. The package of reforms which are presented in a table in the report (pg. 23-25) appear to largely focus on; improving care quality especially in residential aged care, those with highest needs in the community (home care package 4), and the availability of home care packages. Overall, the ANMF is supportive of the reforms described in the report and has provided comments upon each below.

Residential care staffing uplift to 3-, 4- and 5- star levels

107. The ANMF is broadly supportive of the suggested introduction of improved staffing and skills mixes across the residential aged care sector in phases. As the report notes, the CMS rating system is not designed for direct transfer/translation to the Australian context. As the ANMF has submitted to the Commission previously, the CMS rating systems is also not a tool to calculate or underpin the development of staffing models but rather a guide for the public to enable more informed comparison of nursing homes in relation to a number of factors including staffing. The ANMF refers the Commission to our previous submissions in relation to the adoption of a rating system that incorporates reporting staffing levels and skills mix (ANM.0015.0001.0001).

Uncapping home care packages

108. The ANMF is supportive of the proposed uncapping of home care packages, however wishes to highlight that while a needs/demand-driven system is necessary, delivery of care is contingent on a suitably sized workforce with the requisite skills mix and training.

Extending home care packages

109. The ANMF is supportive of extending home care packages to better align subsidies with the care needs and preferences of older people who wish to receive aged care in their homes in the community. The ANMF supports aging in place, but wishes to note that in order to provide care at levels approaching that which should be available in residential aged care, a large and suitably skilled workforce will be necessary.

Respite funding

110. The ANMF is supportive of the proposed increase (15 percent) in respite services provided to informal caregivers.

Commonwealth home support program/ home care packages interaction

111. The ANMF supports the proposed changes to the way the Commonwealth home support program and home care packages would interact where a number of services previously provided under the Commonwealth home support program are shifted to uncapped home care packages.

Commonwealth home support program fees

112. The ANMF supports the removal of all recipient fees for Commonwealth home support programs.

Funding controls

113. The ANMF is supportive of the proposal implementation of Government funding controls. The proposal is to apply these to residential aged care providers to ensure a "sufficient share of funding is spent to deliver care to all recipients." The ANMF submits that the definition of "sufficient" must be clearly and specifically defined to ensure that providers are not able to continue to provide an insufficient quantity and quality of care to recipients based upon a vague and non-prescriptive definition. As the ANMF has submitted to the Commission on many previous occasions, there must be transparency and accountability regarding the use of both Government and resident contributed funds for care provision. Further, the ANMF suggests that these funding control measures should also be implemented for the provision of care in the home particularly as this area is expected to increase significantly.

Removing RADs

114. The ANMF is supportive of the removal of RADs. The ANMF however cautions that as many providers – particularly large, for-profit providers – appear to rely upon RADs (specifically through transferring them through complex related entities) to make a profit, removal of RADs could risk providers cutting costs elsewhere resulting in the provision of care of a reduced quality and quantity. Other measures to ensure that safe, high quality care provision in incentivised and maintained must accompany the removal of RADs.

AN-ACC Funding

115. As the ANMF has submitted previously, we are supportive of the implementation of the new AN-ACC funding system to replace the existing ACFI system. The ANMF refers the Commission to our previous submissions regarding AN-ACC for further details.

Independent assessment of care needs

116. The ANMF supports the introduction of the independent assessment of care needs as a critical component of the new AN-ACC system. The ANMF notes that the frequency of assessments must be carefully planned and applied to ensure that care recipients' changing needs and preferences are effectively and efficiently responded to with the provision of safe, quality care.

Health initiatives

117. The ANMF is supportive of the range of health initiatives proposed in the report. The ANMF suggests that the proposed "designated care coordinators" would be effectively modelled on the existing nurse care coordinator/nurse navigator roles that have shown clear evidence of success and quality beyond aged care. These care coordinators, along with the other health initiatives, would also be effectively adopted within the in-home sector where significant care coordination is also required. The ANMF also suggests that additional health initiatives should also include greater utilisation and support for nurse practitioners and mental health nurses in aged care delivered in nursing homes and in the community.

Mandatory Certificate III

118. The ANMF is supportive of the minimum requirement for all personal care workers to hold a relevant Certificate III qualification to work in aged care. The ANMF notes that appropriate clinical supervision and guidance is required at all times and that the role of enrolled nurses in aged care should not be overlooked.

National personal care worker register

119. The ANMF is supportive of the national regulation of personal care workers in a similar manner to how registered and enrolled nurses are registered with the Nursing and Midwifery Board of Australia (NMBA). It will be vital that personal care workers not only sign onto a national register but that requirements for the maintenance of adherence to professional standards are put in place and monitored. This will also require employers to play a part in ensuring that personal care workers are able to maintain their registration in line with the requirements.

Young people with a disability

120. The ANMF is supportive of ensuring that younger people are able to be safely and effectively cared for in accordance with their individual needs and preferences outside of the residential aged care system. The ANMF however points out that in places such as regional and remote areas, the "specialist accommodation" referred to in the report may not be readily available or appropriate. Further planning will be required to ensure that younger people currently residing within aged care facilities are provided with more appropriate care options and services more suitable to their needs and preferences.

Care finders

121. The ANMF is broadly supportive of the implementation of the role of "care finders" to enable people to better navigate the aged care system with face-to-face support from qualified and trained individuals. The ANMF notes that the term "care finder" has been used by various reports and submissions before the Commission and that use of this term and the description/explanation of the anticipated role and designation of care finders has not been entirely consistent or clear. The ANMF refers the Commission to our previous submissions where we have addressed the issue of care finders in aged care and highlights the need to develop a clear and consistent explanation of this role and its anticipated responsibilities in aged care.

Public guardians

122. The ANMF is supportive of the proposed increase in funding to public guardians to support people living away from family.

Wage parity

123. The ANMF is supportive of the proposed increases to wages in aged care to equivalence with wages in the health sector.

Immigration measures

124. The ANMF highlights that workforce pressures within aged care should first be addressed through genuine investment and support for the improved education and training, attraction, and retention of locally trained and educated carers and healthcare

professionals. Reliance on skilled migration of health workers from international countries has a strong potential to deplete already strained workforces in less well-resourced contexts where carers and health professionals are in short supply. This is an established issue,[11] and one that has prominence in the World Health Organizations 'State of the World's Nursing Report 2020.[12] Further, the COVID-19 pandemic has clearly demonstrated that the global mobility of people can be unpredictable and a reliance on other countries' workforces to support our domestic aged care sector is unlikely to be feasible particularly in the short term. Post-COVID-19, relying on international skilled workers is unethical and irresponsible when many of the countries we look to for skilled migrant workers in aged care (e.g. the Philippines, India) have (and continue to be) battered by the ongoing pandemic.

125. A number of key issues/outcomes of the reforms are described:

i. The package would be largely funded via Australian Government, Medicare, and other government programs.
ii. Designed to encourage a greater number of people into aged care and substantial movement from residential care to home care packages.
iii. An immediate decrease of the number of older people in residential aged care who move to community-based care with the preference for homecare persisting.
iv. Significant workforce constraints in response to mandating the increases in staff time per resident which is rapidly resolved.
v. That care recipients are expected to favour Commonwealth home support programs due to being free of charge for recipients, but that this effect would be anticipated to subside by 2030 when the program services all eligible recipients.
vi. Anticipated additional pressure on the aged care workforce, particularly enrolled nurses, as care requirements rise. The ANMF notes that there is relatively little detail within the report regarding why specifically enrolled nurses have been noted to face increased pressure and highlights the need for the sector to continue to attract and retain enrolled nurses as important contributors to care.
vii. Aged care sector wages increases (around 5.5 percent PA to 2050) to attract workers from other sectors and through additional training.
viii. The assumption that 30 percent of new aged care sector workers will be sourced through skilled migration programs. As noted above, the ANMF strongly suggests that Australian workers should be better supported to enter and remain in the aged care sector before relying upon international migration, which is especially under the current climate, unethical.
ix. That the demand for care, increased quality requirements, and a 'tighter' workforce will lead to the increased cost of care.
x. That increased costs and overall level of funding will be tempered by movement from residential aged care (more resource intensive) to in-home care (less resource intensive).
xi. That aged care providers will be fully compensated by the government for additional costs of implementing the above policy reforms. The ANMF highlights that this must occur with clear and transparent accountability for the use of funding on the provision of care.
xii. That expenditure in residential care is anticipated to be the greatest despite

[11] McElmurry BJ, Solheim K, Kishi R, Coffia MA, Woith W, Janepanish P. Ethical concerns in nurse migration. Journal of professional nursing. 2006 Jul 1;22(4):226-35. Available at: https://www.sciencedirect.com/science/article/abs/pii/S8755722306000615
[12] State of the world's nursing 2020: investing in education, jobs and leadership. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO. Available online: https://www.who.int/campaigns/year-of-the-nurse-and-the-midwife-2020

fewer residents while spending on home care packages will rise strongly but involve less cost per recipient.

126. Overall, the model predicts that adoption of the proposed package of reforms in order to achieve the equivalent of different CMS ratings (i.e. 3-Star, 4-Star, and 5-Star) would result in the aged care sector incurring additional costs of:

i. 0.3% of GDP/ 1/5 of the projected baseline aged care budget (3-Star).
ii. 0.5% of GDP/ 1/3 of the projected baseline aged care budget (4-Star).
iii. 0.8% of GDP/ 1/2 of the projected baseline aged care budget in 2050 (5-Star).

127. The report notes that each of the above costs also include additional health expenditure outside of aged care amounting to approximately 0.04% of GDP

128. The report goes on to explain how the proposed reform package would be funded and suggests an approach that is explained would ensure no material change in government debt. While the report suggests that the government could fund the additional expenditure through; a new tax, increasing existing taxes, broadening the base of existing taxes, and/or cutting expenditure in other areas, the modelling only considers increasing the Medicare Levy and increasing in income tax rate across all thresholds (see Table 1). The ANMF notes that the report does not mention enforcing more stringent tax practices on providers to ensure that aggressive tax minimisation practices are not utilised to increase provider profits utilising Government funded subsidies.

Table 1: The report's proposed approaches to funding aged care reform packages

	Reform package		
Funding option	**3-Star**	**4-Star**	**5-Star**
Increase to Medicare Levy	0.51%	0.89%	1.31%
Increase to income tax	0.58%	1.01%	1.48%

129. The ANMF has a number of further comments on the content of the report.

130. The report suggests three categories of labour (Pgs. 10-11):

i. Care management, registered nurses, allied health professionals
ii. Enrolled and licenced nurses and other allied health
iii. Unlicensed personal care staff

131. The division of the workforce into these three categories may require further explanation and consideration is for example, it is unclear why enrolled nurses have been categorised with "other allied health".

132. The report makes a number of assumptions on workforce:

i. High wages = greater enrolments in training courses.
ii. Shortages in skilled labour limit total amount of aged care provided.
iii. More qualified pool of workers can lead to higher productivity.

133. The report appears , wrongly in ANMF's view, to equate quality of care with quantity of care per individual per day. This appears to be similar but different to residential care

hours per day which the report suggests does not capture the contributions of technology or 'other productivity enhancing measures' to improve care quality for a given staffing level (pg. 11).

134. In the accompanying document, 'economic scenario model documentation', the authors describe their approach to several key concepts within their model.[13] One of these concepts is "defining output and 'quality'". Here, the authors present an approach where the amount of care provided to each individual is measured using a 'point' system, explaining that the baseline for such a system is calibrated so that the number of 'points' of care delivered to an individual is consistent with the basic subsidy that person has attracted in line with ACFI. The authors highlight that "this is the same as saying a dollar of ACFI subsidy is associated with a 'point' of residential care delivery." The ANMF raises considerable concern here for two reasons. One; based on the fact that ACFI has been widely and substantially criticised as not being fit for purpose using it as a baseline for coming up with a measure of care quality appears to be unreasonable and not based on clear evidence. Two; that using a baseline scenario predicated on the current delivery of quality care in Australia's residential aged care system would appear to be significantly misleading since as the Commission has heard, the provision of quality care is far from guaranteed and unlikely to be measured by equating the level of care with the level of ACFI subsidies reported.

135. The ANMF is concerned that overall, the point-based approach to care quality measurement is not evidence-based and that the simplistic assumption that "higher levels of care need mean more points are required to deliver the same quality of care" glosses over ensuring that those people with higher care needs actually receive the care necessary to meet those needs in a safe, appropriate, and effective manner. While the authors do note that "points per recipient is one factor in assessing care 'quality', with lower levels of provision at a given level of care need potentially representing a poorer outcome for recipients" and that 'points' per recipient measures quantity but not quantity of care, overall, the ANMF is not convinced that the 'points' assumption in the model sufficiently captures the complexity of the measurement of quality care in aged care and must be examined and unpacked further. In Deloitte's main report, the number of points per recipient per day are expected to rise, but how this relates to the increased provision of quality care that is safe, appropriate, and effective is not so clear.

136. This model also does not appear to engage sufficiently with the issue of workforce capability and capacity to deliver care. Later on in the document, the model addresses the potential impact of a minimum nursing staff (but not care worker, allied health, or other staff) to resident ratio in aged care and briefly presents three different choices governments could make regarding the implementation of minimum nursing staff to resident ratios, concisely; i) increase the number of nurses used per 'point' of care but allow providers to reduce the use of other forms of labour and capital, ii) force providers to increase the number of nurses without altering use of other labour and capital, and iii) raise the number of 'points' until the desired number of nurses is reached (which also raises other labour and capital costs).

[13] Deloitte Economics. Economic scenario model documentation A report for the Royal Commission into Aged Care Quality and Safety. July 2020. A commercial-in-confidence report provided to the ANMF by the Royal Commission.

137. On page 32, the report suggests; “with this package of reforms making study free for those who wish to take up an aged care qualification government faces both a greater share of the cost of training workers and the added cost of training a larger worker pool.” It is unclear from the report where the authors have recommended that training becomes free or what training is referred to (i.e. training for personal care workers and/or nurses/ other health care workers in aged care?). The ANMF suggests that further clarity is required here.

138. Page 34 notes that “In the long run the mandatory minimum ratios on staffing levels in residential care limit the ability of productivity gains to reduce costs in the sector. With staff time per resident mandated by regulation there is reduced scope for labour productivity growth under this reform package. This results in costs that rise over time relative to the baseline, where ongoing productivity growth is assumed to be a feature of the aged care sector.” The supposition appears to suggest that mandated minimum staffing levels and skills mix run counter to the utilisation of other means to increase productivity in aged care. The ANMF rejects the foregoing analysis and submits, as we have many times before, that without the right number of the right skills mix of staff to provide care, safe, quality care will be impossible to deliver and sustain. Enhancing labour productivity to reduce costs through diminishing the time staff are able to provide care to residents appears to run the risk of further eroding the necessary human, interpersonal relationships and contact time between staff, residents, and families/loved ones.

139. Rather than seeing mandated minimum staffing levels and skills mixes as a barrier to the efficient provision of care, it must be seen as the baseline number and skills mix of staff required to provide at least the minimum standard of safe, quality care in a manner were other innovations and interventions can further enhance care provision and quality. Staffing ratios need not stifle innovation. Instead, they can lay the foundation on which better quality standards can be built. And while mandated staffing ratios alone are not the only indicator of high-quality aged care services, it is certain that high quality care cannot be achieved without them.

Conclusion

140. This submission has detailed the ANMF’s responses the regarding the series of reports and documents provided to us by the Commission in preparation for next weeks’ hearings. Here, we follow up our ‘final public submission’ and our recommendations therein with key considerations regarding transparency and accountability, financing of aged care, the relationship between provider ownership and the quality of care outcomes, the measurement of safety and quality of care in aged care, and our responses to a number of sector reforms and strategies.

Australian Nursing and Midwifery Federation

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