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Power to the people

Improving residential aged care quality through better consumer choice

SUBMISSION TO:

ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

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PREPARED BY

This report was prepared by:

Professor Henry Cutler

Andrew Partington

For further information on this report, or about MUCHE, please contact:

Professor Henry Cutler
Director
P: + 61 2 9850 2998
M: +61 409 770 946
E: henry.cutler@mq.edu.au
health-economy.mq.edu.au

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Dr Henry Cutler
Director
Centre for the Health Economy
Macquarie University

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Executive summary

The residential aged care sector is not meeting the expectations of Australians. The Royal Commission into Aged Care Quality and Safety has highlighted systemic poor quality, with overuse of psychotropic medications and physical constraints, social isolation and neglect.

The Royal Commission now seeks to develop recommendations to improve care quality. One question that remains unanswered is why have some residential aged care providers not accepted their responsibility to deliver good care quality, given it should align with their moral and pecuniary interests?

Providers have argued that limited government funding has impacted their ability to innovate. This may be true to some extent. Around 46 per cent of providers experienced a net loss in 2017-18, primarily due to government expenditure restrictions and increased wage costs.[1] Some providers are likely to have shirked on quality to stay afloat.

This submission argues that the residential aged care market, shaped by Australian Government policy, has not delivered strong incentives for providers to deliver care quality above minimum accreditation levels. This stems from limited information on care quality available to consumers and large barriers to entry for new providers, which have dampened competition and reduced consumer choice.[2]

Several major aged care reviews since the introduction of the *Aged Care Act 1997* have recommended the Australian Government increase competition to improve care quality. This has included developing a robust quality reporting system and making quality indicators publicly available to inform consumer choice. Reviews have also recommended reducing barriers to entry by removing the aged care approvals round (ACAR) and national aged care planning ratio (NACPR).

A robust quality reporting system for residential aged care does not exist. The mandatory National Aged Care Quality Indicator Program (NACQIP) contains three clinical indicators. They are not risk-adjusted, which means they are likely invalid and will be misinterpreted. Indicators are not representative of consumer preferences for care quality, consumer satisfaction nor inputs into the production of wellbeing. Consumers are unlikely to use NACQIP indicators when choosing a provider.

Barriers to entry have also disadvantaged consumers. The ACAR has restricted the allocation of subsidised beds across geographical areas, while the NACPR has capped the total number of subsided beds available in Australia. This has benefited incumbent providers by maintaining high occupancy rates and strengthening provider market power over consumers.

Evidence of provider market power is reflected in observed market outcomes. There is no price competition around the basic daily fee, given all providers charge the maximum allowed. Consumers simply have no power to bargain with providers. Accommodation prices have also increased by 33 per

[1] Aged Care Financing Authority (ACFA) 2019, Submission to the Royal Commission into Aged Care Quality and Safety, Canberra

[2] A consumer is defined in this submission as the resident, family member or friend that either makes or helps with the decision to enter residential care, choose a residential care provider or choose an accommodation payment type.

cent between 2013-14 and 2017-18. While this has compensated providers for a reduction in interest rates, and has allowed the construction of better facilities, prices have increased by more than the marginal cost of production, reflecting the ability of providers to extract value directly from consumers. This is also reflected in the positive correlation between housing prices and accommodation prices.

Deficiencies with the NACQIP means consumers are unable to make an informed provider choice based on care quality. While the ACAR and NACPR have helped providers maintain high occupancy rates, it has meant many consumers choose a provider based on availability, not quality. Consumer preferences, and indeed community expectations, are not being met for some that enter care, with over 40,000 residents still receiving care in rooms with multiple beds and shared facilities.

Competition is ubiquitous within the Australian healthcare system, such as within primary care, allied health, dentistry, and private hospitals. While not perfect, these sectors deliver consistently good quality care. This suggests increased competition could, given the right regulatory framework, help improve quality in the residential aged care sector.

Experience in the US nursing home market also suggests increased residential aged care competition could improve care quality in Australia. Several US studies have found competition has incentivised providers to increase their quality and incentivised consumers to shift their preference towards better quality providers. Competition further increased care quality when information on quality was easier to understand by consumers, there was some latent occupancy among providers and there were more providers within the market.

For competition to improve care quality in Australia, the NACQIP must be overhauled. Valid information that represents consumer preferences for quality, delivered in summary form (e.g. a star rating) must be made publicly available, along with individual quality indicators and provider characteristics. An independent agent funded by the Australian Government to help consumers choose a provider based on care quality would further incentivise providers to increase care quality.

Removing the ACAR and NACPR is also required. This would incentivise providers to further innovate, invest, and compete for residents based on care quality, given the threat of reduced occupancy rates from new competitors. It would better enable consumers to choose their provider based on quality, rather than availability.

Providers must be able to cover the marginal cost of increased care quality. The Australian Government covers around 94 per cent of care costs in residential aged care through the Aged Care Funding Instrument (ACFI), to ensure all residents receive care regardless of their financial circumstance. Care prices may need to increase given the substantial changes required to improve care quality. Encouraging good quality providers to flourish and poor quality providers to exit, would also increase the average care quality delivered within the market, and reduce the need to increase care prices.

While competition can play a valuable role in delivering better care quality, it cannot be relied upon to deliver a minimum level of care quality. Many consumers will not have the capacity nor inclination to assess provider quality and ‘shop around’. If consumers choose a provider based on care quality, information on quality will be imperfect. This creates perverse market outcomes that must be appropriately regulated and monitored.

Rural and remote locations face additional challenges given many providers prefer not to locate in locations with low population density. This reduces the potential for competition to drive quality. Consumers who find themselves with only one provider option are more reliant on Australian Government safeguards to ensure quality reaches a minimum threshold and there is continuity of care.

Competition must be underpinned by strong and independent public institutions and policies that protect a minimum quality threshold. Accreditation frameworks and monitoring regimes, along with substantial fines and restriction of practice delivered to providers for delivering poor quality, are still required to protect consumers. Active and ongoing evaluation of the appropriateness of quality

standards is central to ensuring providers take responsibility for delivering quality that meets consumer preferences.

The question is not whether accreditation or competition should be used to ensure providers deliver good care quality. The question is how can accreditation and competition complement each other to squeeze the last bit of quality out of providers in a sustainable way. This submission presents a pathway to ensuring competition contributes optimally to this objective.

1. Introduction

The Australian population is ageing rapidly. Coupled with reduced access to informal care, the Australian Government estimates aged care expenditure will rise significantly. Expenditure has quadrupled since 1975 and is projected to double again by 2055, where it will represent 1.7 per cent of GDP.[3]

Most people prefer to receive aged care services at home. Home care services interact with a person's clinical and social needs and situational circumstances to provide a modicum of independence.[4] Around 64 per cent of people aged 80 years and over with a severe to profound core activity limitation lived at home in 2018, with 23 per cent living alone.[5]

The Australian Government has recognised that older Australians want to stay at home, increasing the number of Home Care packages from 66,149 in 2014 to 106,707 in 2019.[6] Despite this investment, the demand for Home Care packages continues to exceed supply. Around 63,000 were still waiting for a Home Care package at their approved level in September 2019.[7]

Some people enter residential care because they are unable to access an appropriate Home Care package. Others enter residential care because it becomes unsafe for them to be elsewhere. Many people enter residential care unexpectedly from the hospital due to a significant adverse event. This adds additional stress on consumers because it often means a residential care place must be found in a relatively short period.

Around 243,000 people received permanent residential aged care in 2018-19. On average, a new resident is 83 years old and will stay for 2.9 years.[8] Around 51 per cent of residents have dementia when they enter residential care.[9] Given people aged 80 years and over will increase by 147 per cent by 2055,[10] the number of people requiring residential care is expected to increase substantially.

Nearly all care is delivered by private for-profit and not-for-profit organisations. The Australian Government seeks to ensure a minimum level of care quality is delivered to consumers primarily

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[3] The Treasury, 2015, 2015 Intergenerational report. Australia in 2055, Commonwealth of Australia, Canberra.

[4] Fernandez J-L, Forder J, Knapp M, 2013, Long-term care, In: The Oxford Handbook of Health Economics, Oxford University Press, Oxford, UK.

[5] Australian Bureau of Statistics (ABS), 2019, Disability, Ageing and Carers, Australia, Cat. No 4430, Canberra.

[6] Department of Health, 2019, 2018-19 Report on the Operation of the *Aged Care Act 1997*, Commonwealth of Australia, Canberra.

[7] Department of Health, 2019, Home Care Packages Program, Data Report 1st Quarter 2019-20, Commonwealth of Australia, Canberra.

[8] Department of Health, 2019, 2018-19 Report on the Operation of the *Aged Care Act 1997*, Commonwealth of Australia, Canberra.

[9] Ibid.

[10] Australian Bureau of Statistics 2018, 3222.0 - Population Projections, Australia, 2017 (base) – 2066, Commonwealth of Australia, Canberra.

through accreditation, monitoring and enforcement. This system has failed many consumers. The Royal Commission into Aged Care Quality and Safety (the Royal Commission) has reported systemic poor quality across the residential aged care sector. It has identified the overuse of psychotropic medications and physical constraints, social isolation, and neglect.

The Royal Commission concluded the residential aged care sector is non-transparent, has little accountability, is devoid of information on quality, and lacks consumer choice. It noted many providers are apathetic about care quality, failing to deliver minimum standards of care and neglecting to invest in care that affords basic rights.[11]

The extent of poor quality found by the Royal Commission has taken some by surprise. The *Living Longer Living Better* (LLLB) reform package was introduced only five years prior, with the Minister noting they were the most significant changes to the aged care sector since the *Aged Care Act 1997*.

The LLLB reform package aimed to put the aged care sector on a path towards more consumer directed care. It sought to make funding more sustainable by asking consumers to pay more for their care. It aimed to expand workforce capacity, improve care quality and access, and strengthen protections for care recipients.[12] Initial changes focused on improving price transparency and helping consumers navigate the aged care system.

The Royal Commission has argued that 'the direction of current reforms puts too much faith in market forces and consumer choice as the primary driver of improvement in the aged care system'.[13] It has also suggested that framing the policy discussion around markets and consumers is potentially at odds with the 'philosophy that should underpin the aged care system'.[14]

This Submission takes an alternative view. It argues that market forces and consumer choice are significantly constrained by Australian Government policy. This means incentives for providers to innovate and produce good quality care are weak, contributing to the poor outcomes found by the Royal Commission.

This Submission is structured as follows. Chapter 2 outlines the government initiated reviews that have occurred since the introduction of the *Aged Care Act 1997*. It notes each review has recommended a shift towards more consumer choice by introducing publicly available quality indicators and either relaxing or removing the ACAR and NACPR. The chapter demonstrates that the Australian Government has failed to heed these recommendations, instead relying on accreditation and monitoring that has ultimately failed some consumers.

Chapter 3 explores the potential to harness competition to improve care quality. It relies on theoretical constructs and empirical research conducted in the UK National Health Service (NHS) and the US nursing home market, both of which have similar price characteristics to the Australian residential aged care market. Competition has improved quality in both markets but had greater impacts under specific

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[11] Royal Commission into Aged Care Quality and Safety 2019, Interim report: Neglect, Commonwealth of Australia, Canberra.

[12] Department of Health and Ageing, 2013, Aged Care (Living Longer Living Better) Bill 2013, Explanatory memorandum, Commonwealth of Australia, Canberra.

[13] Royal Commission into Aged Care Quality and Safety 2019, Aged care program redesign: Services for the future, Consultation Paper 1, Commonwealth of Australia, Canberra, pp. 3.

[14] Ibid.

conditions. Within the US nursing home market, this includes ensuring information on quality is easily understood, ensuring providers have some latent occupancy, and encouraging more providers into the market.

Chapter 4 argues that care outcomes within the residential aged care sector are shaped by Australian Government policy. It recommends the Australian Government undertake policy reform to increase competition and choice in the Australian residential care sector. This includes empowering consumers to become more sensitive and responsive to information on quality when selecting a provider. This can be achieved by introducing quality indicators relevant to consumers and providing access to an independent agent funded by the Australian Government to help consumers choose a provider using information on quality. Chapter 4 concludes by recommending that care prices reflect marginal cost of increased care quality. It also argues that competition will not improve care quality unless the ACAR and NACPR are removed.

2. The long path towards consumer choice

The *Aged Care Act 1997* was an evolutionary moment in modern Australia's aged care sector. A Review of the Structure of Nursing Home Funding had found poor care quality and old infrastructure that struggled to meet fire safety, health authority and Nursing Home Outcome standards. Regulations were complex and disjointed.[15]

The *Aged Care Act 1997* introduced wholesale structural, governance, and funding changes. It unified hostel and nursing home sectors into one residential care sector with low and high care offerings, allowing individuals to age in place. It bundled quality assurance under one system through new residential care standards and accreditation standards. Providers not meeting accreditation standards lost their subsidies.[16]

Some raised concerns about whether the *Aged Care Act 1997* could maintain care quality. A Senate Committee noted that the new quality assurance system would need to ensure nursing staff levels and skills were maintained. It also required the proposed Aged Care Standards Agency to be properly resourced and have access to adequate monitoring and enforcement mechanisms.[17]

Despite some initial improvements, the residential aged care sector remained mediocre. This led to nearly 20 government initiated reviews in the last two decades that have made recommendations to improve the aged care sector. The first was initiated in 2002, only five years after the *Aged Care Act 1997* was introduced. This chapter explores those reviews that make specific recommendations to increase care quality by improving information on quality and removing barriers to entry.

Early aged care reviews

A 2004 review of pricing arrangements in residential aged care (the Hogan Review) focused on enhancing competition to improve quality.[18] It had determined that the Australian Government's role was to secure quality, support residents with limited means, and incentivise capital investment.[19] The

[15] Cullen, D 2003, The evolution of the Australian Government's involvement in supporting the needs of older people. Background Paper No. 4, Commonwealth of Australia, Canberra.

[16] Ibid.

[17] The Royal Commission into Aged Care Quality and Safety 2019, A history of aged care reviews. Background paper 8, Commonwealth of Australia, Canberra.

[18] Hogan W, 2007, Outcomes from the Aged Care Review, Australasian Journal on Ageing, Vol.26.No 3, pp. 104-108.

[19] Ibid.

Hogan Review sought to improve quality by giving consumers more purchasing power, recommending a star rating system to assess quality, and removing the ACAR and NACPR.[20]

These recommendations were supported by a 2005 Senate Community Affairs Reference Committee Inquiry into aged care quality and equity. It extended the concept of a star rating system to include service descriptions, physical features of homes, staffing arrangements, costs of care, and accreditation status. Recommendations also sought to improve the accreditation process, including random spot checks of facilities, better complaints mechanisms, defining 'best practice' in care, and developing a benchmark level of staff mix relative to resident need.[21]

The Australian Government was slow to respond to recommendations made by the Hogan Review and Senate Affairs Reference Committee. A line was drawn under the Hogan Review in 2007, without plans to introduce better information on care quality or remove the ACAR or NACPR. It was suggested that these omissions would not allow for improvements in service quality.[22]

The Australian Government instead sought to rely on strengthening accreditation, monitoring, and enforcement. It commissioned a report in 2007 to investigate the impact of accreditation on residential care quality.[23] The report concluded that accreditation could not measure changes to quality above the minimum standard, and recommended a suite of quality indicators to measure care quality and resident quality of life.

In 2009, the National Health and Hospital Reforms Commission explored the potential to improve residential aged care quality to reduce public hospital demand.[24] It recommended that quality be improved through publicly reported quality indicators and removing the ACAR. It stopped short of recommending removal of the NACPR, instead recommending an adjustment to the ratio to better reflect the population growth of older Australians.

A question over residential aged care sustainability led to a Productivity Commission inquiry in 2011. The sector was facing similar problems outlined in the Hogan Review nearly a decade prior, including poor financial returns, low investment in new infrastructure, and a significant increase in demand as the population aged.

The Inquiry found the aged care sector was difficult to navigate, had variable quality, consumer needs were not being met and the sector was suffering from workforce shortages.[25] It recommended introducing publicly available quality indicators. This aligned with Auditor General recommendations

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[20] Ibid.

[21] Senate Standing Committees on Community Affairs, 2005, Quality and equity in aged care, Commonwealth of Australia, Canberra.

[22] Hogan W, 2007, Outcomes from the Aged Care Review, Australasian Journal on Ageing, Vol.26.No 3, pp. 104-108.

[23] Campbell Research and Consulting (CR&C), DLA Phillips Fox Lawyers, Monash University, 2007, Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes, Australian Government, Canberra.

[24] National Health and Hospitals Reform Commission (NHHRC), 2009, A healthier future for all Australians. Final report, Australian Government, Canberra.

[25] Productivity Commission, 2011, Caring for older Australians, Commonwealth of Australia, Canberra.

and was agreed to by the Department of Health and Ageing,[26] but was not acted upon until 2016 when the National Aged Care Quality Indicator Program (NACQIP) was introduced.

The Productivity Commission also recommended removing the ACAR and NACPR, while strengthening quality assurance by establishing a new Australian Aged Care Commission.[27] However, it noted that safety and quality standards should be retained given quality and safety continued to improve.[28]

The Living Longer Living Better reform package

The Living Longer Living Better (LLLB) reform package was introduced in 2014 through five bills. It initially focused on aged care funding arrangements, improving market transparency, and offering greater choice to consumers. Support for the LLLB reform package was widespread from stakeholders, including providers and consumer groups.

The LLLB reform package was built on recommendations made within the Productivity Commission Inquiry, the National Aged Care Alliance (NACA) reform blueprint, and comprehensive stakeholder consultation undertaking by the Department of Health and Ageing.

The LLLB reform package was meant to be delivered over 10 years. The first five years focused on improving the operation of the aged care market. Consumer information was improved through the *My Aged Care* website and contact centre. Price transparency was increased by requiring residential aged care providers to publish maximum prices for rooms and extra services. Consumers were given greater choice on how to pay for rooms and lump sum accommodation payments were extended to high care residents. The Australian Government also introduced greater co-contributions to care through tighter means testing arrangements.

Less direct emphasis was given to improving care quality. Replacement of the Aged Care Standards and Accreditation Agency with the Australian Aged Care Quality Agency was mostly an administrative change, although some provision was given to expand Advocacy and Community Visitors Programs. The LLLB reform package also allowed for the staged development of national aged care quality indicators, to be made publicly available on the *My Aged Care* website.[29]

The LLLB reform package did not address nine of the 58 Inquiry recommendations, one of which included removing the ACRA and NACPR. The Australian Government noted this would create a significant risk to the financial viability of providers given a more competitive environment would

[26] The Auditor General, 2011, Monitoring and compliance arrangements supporting quality of care in residential aged care homes, Audit Report No.48 2010–11, Australian Government, Canberra.

[27] Productivity Commission, 2011, Caring for older Australians, Commonwealth of Australia, Canberra.

[28] Ibid.

[29] Australian Government, 2013, Australian Government response to the Productivity Commission's Caring for Older Australians Report, Commonwealth of Australia, Canberra.

result.[30] This created detrimental outcomes for consumers in terms of reduced provider choice, increased prices and reduced care quality and innovation (see Chapter 4 for further discussion).

A focus on quality after the LLLB reform package

The Australian Government hailed the LLLB reform package as the most significant change to aged care since the *Aged Care Act 1997*. However, it provided little additional funding to the residential aged care sector. Despite the Minister for Health and Ageing announcing a commitment of $3.7 billion to support the LLLB reform package, the Australian Government estimated a total net cost of only $577 million over five years.[31]

Despite this, many residential aged care providers improved their financial position after the LLLB reforms. Until 2016-17 the sector experienced an increase in net profits, net assets, and average returns on equity, along with making a significant investment in refurbishment and new buildings.[32] This was made possible because providers 'optimised' their ACFI funding and received a significant increase in refundable accommodation deposits (RADs).

However, a focus on ways to improve care quality in residential aged care remained. A 2017 review of the aged care sector noted that while residential care was transitioning towards a consumer directed care system, more changes were required.[33] It recommended removing the ACAR within two years, to shift the allocation of subsidised beds from providers to consumers to improve their choice. It also recommended that the NACPR be removed within five to seven years.[34]

A separate 2017 review of the national aged care quality regulatory process found no meaningful information on quality available for consumers to help make an informed choice when selecting a provider.[35] This was despite the introduction of the voluntary NACQIP in 2016.

In 2018, a House of Representatives Standing Committee on Health, Aged Care and Sport drew similar conclusions.[36] Recommendations sought to develop better quality indicators and a consumer rating system for residential aged care facilities. Information on quality within residential aged care facilities, particularly around mistreatment, was found to be inadequate.

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[30] Ibid.

[31] Department of Health and Ageing, 2013, Aged Care (Living Longer Living Better) Bill 2013, Explanatory memorandum, Commonwealth of Australia, Canberra.

[32] Aged Care Funding Authority (ACFA), 2017, Fifth report on the funding and financing of the aged care sector, Commonwealth of Australia, Canberra.

[33] Tune D, 2017, Legislated review of aged care 2017, Commonwealth of Australia, Canberra.

[34] Aged Care Sector Committee, 2016, Aged Care Roadmap, Commonwealth of Australia, Canberra.

[35] Carnell K, Patterson R, 2017, Review of the national aged care quality regulatory process, Commonwealth of Australia, Canberra.

[36] House of Representatives Standing Committee on Health, Aged Care and Sport, 2018, Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia, Commonwealth of Australia, Canberra.

The Aged Care Funding Authority (ACFA) also identified improved competition as one important attribute to drive productivity, quality, innovation, and efficiency within residential aged care.[37] It has recommended removing the ACAR and NACPR to increase access to services for consumers and to allow better quality providers to take a greater share of the market.

Government response to recommendations

The Australian Government has failed to establish the market oriented residential aged care sector envisioned by the Hogan Review, the Productivity Commission Inquiry, the Tune Review and other reviews that have assessed residential aged care quality since the introduction of the *Aged Care Act 1997*.

The NACQIP was introduced in 2016 as a voluntary program. Unplanned weight loss, use of physical constraint and pressure injury indicators were selected from the set being used by the Victorian Government to assess public sector residential aged care services. There was little take-up by providers given the additional compliance cost, with less than 10 per cent participating.

The Australian Government made participation in the NACQIP mandatory in 2019. It has since started to explore two additional quality indicators, including falls and fractures and medication management. The former Australian Aged Care Quality Agency also developed Consumer Experience Reports. These were based on 10 questions asked by assessors of a 10 per cent sample of residents or their representative, drawn from facilities through the process of re-accreditation as part of an audit. These were stopped on 9 December 2019.

The Australian Government is once again relying on sticks to enforce good quality care rather than carrots. It has started to strengthen accreditation, monitoring and enforcement by undertaking further unannounced auditing of aged care facilities and establishing the Aged Care Quality and Safety Commission in 2019.

It has introduced a Charter of Aged Care Rights in 2019 and the Single Aged Care Quality framework. This consists of one set of eight quality standards upon which all residential and Home Care providers are assessed. The Australian Government noted the standards were one step towards shifting the aged care market towards a more market based system where consumers drive quality improvements.[38]

The Australian Government is yet to remove the ACAR and NACPR, and there is too little investment in the development of a best practice quality indictor program. The current NACQIP falls way short. As Chapter 3 and 4 of this submission explain, competition can only improve quality if consumers have good information on quality, and barriers to entry for new providers are removed.

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[37] Aged Care Funding Authority, 2019, Attributes for a sustainable aged care, A funding and financing perspective, Commonwealth of Australia, Canberra.

[38] Community Affairs Reference Committee, 2018, Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced, The Senate, Commonwealth of Australia, Canberra.

3. Harnessing competition to improve quality

The Australian Government has primarily relied on accreditation, monitoring, and enforcement to coerce residential care providers to take responsibility for delivering quality care. This is despite recommendations from several reviews to complement this approach with improved competition and choice to incentivise better care quality.

The LLLB reform package highlighted the Australian Government's willingness to accept that more competition can improve choice and quality, ushering in a new direction towards consumer directed care (CDC). Most efforts to move towards CDC have been concentrated in the Home Care market. However, consumer choice within residential care remains constrained. The Australian Government has also found it politically challenging to further measure and compare care quality among residential care providers, as demonstrated by low provider participation in the voluntary NACQIP.

This chapter describes the theoretical relationship between competition and quality and demonstrates how other countries have promoted competition to incentivise quality care in their publicly funded healthcare and nursing home markets. It shows that competition improves care quality when consumers are given more choice, relevant information on quality is presented in summary form, and providers have an incentive to compete for consumers. Care prices must also be fixed and cover the marginal cost of good quality care.

Competition under different price settings

Economists have long worked to demonstrate that competition can improve choice, productivity, and quality within an economy. While some economists believe markets alone can deliver good outcomes, most economists recognise those good outcomes are not assured. Market failure does occur, leading to non-optimal social welfare. This justifies the important role government plays in moderating markets.

Economic theory has drawn a similar conclusion. Market outcomes depend on market characteristics, such as the level of product differentiation and firm behaviour. In particular, price regulation plays a crucial role in determining quality.

A model of equilibrium used to assess firm behaviour suggests competition can either increase or reduce quality if price is determined by the market (i.e., unregulated).[39] Outcomes depend on the price sensitivity of consumers relative to their sensitivity to quality when making a choice. [40] Under market

[39] This model considers the profit maximising behaviour of firms, their choice over quality production, and imperfectly observed quality by consumers.

[40] Gaynor M, 2006, What do we know about competition and quality in healthcare markets? National Bureau of Economics, Working paper 12301, Cambridge, Massachusetts.

determined prices, competition is more likely to reduce quality if consumers are more price sensitive. This occurs when quality is poorly observed by consumers because they have little information on quality, or information on quality is unreliable or difficult to comprehend. Consumers are unable to make informed choices based on quality.

Consumers will choose a low priced provider when they are price sensitive, but this could create perverse market outcomes. A low priced provider may attract more consumers but may not maintain good quality, given that their ability to cover the marginal cost of quality is diminished. This is particularly the case if costs cannot be recovered from economies of scale.

A provider delivering good quality may find it difficult to compete if quality is poorly observed by consumers. This may force good quality providers to cut their prices to compete, along with reducing their quality to maintain profits.[41] Effectively good quality providers get driven out of the market.[42]

This may be acceptable if the quality remains above some minimum threshold. However, quality could deteriorate below this threshold if providers continue to reduce their price to maintain market share and cut quality to compensate.[43] This 'race to the bottom' can be avoided by employing a strong accreditation, monitoring, and enforcement framework, and increasing consumer sensitivity to quality by providing relevant and clear information on quality.[44]

Potentially detrimental effects of price competition on quality can be avoided if prices are fixed. When a government sets care prices, all providers receive the same price if operating in comparable markets (e.g., prices may differ between metropolitan and remote areas). The only way providers can compete is through quality. Prices must also afford providers the ability to maintain and improve quality. If prices do not cover the marginal cost of improving quality, providers cannot increase quality in response to greater competition or shifts in consumer preferences.

Fixed prices are not by themselves sufficient to ensure competition increases quality. Consumers must be sensitive to quality. This means they must be willing and able to independently formulate their preferences among provider options based on quality differences. This requires being able to predict the relative quality that would result from their choices.

All of this, however, is irrelevant without some capacity for consumers to choose between providers. This means some latent occupancy must exist within the market to ensures consumers are choosing based on quality and not just availability within their local area.

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[41] Gaynor M, 2011, Competition in healthcare markets, National Bureau of Economic Research (NBER), Working paper 17208.

[42] Akerlof G 1970, The market for 'lemons'. Quality, uncertainty and the market mechanism, The Quarterly Journal of Economics, Vol. 84, No. 3, pp. 488-500.

[43] Forder J, Allen S, 2014, The impact of competition on quality and prices in the English care homes market, Journal of Health Economics, Vol. 34, pp. 73-83.

[44] Chalkley M, Malcomson J, Contracting for health services with unmonitored quality, The Economic Journal, Vol. 108, pp 1093-1110.

Competition improves care quality

Competition in healthcare systems

Australia has a long history of competition in healthcare. Private hospitals operate within a competitive environment, mostly competing for specialists and their list of patients. While the private hospital sector is heavily regulated, and quality assurance is managed through accreditation and monitoring, private hospitals still compete on price and quality through negotiating operating room rates and facility infrastructure and amenities.

Similarly, GPs compete for patients. General practices attract patients by providing easy booking systems, providing access to experienced GPs, and co-locating near complementary medical organisations, such as diagnostic centres and pharmacies. GPs also compete among each other through their patient demeaner and in some instances, prescribing and referral behaviour.

Competition within the Australian healthcare system operates without detrimental consequences to quality. Two studies on competition in the Australian hospital sector suggest that competition can improve efficiency and quality, but this depends on the measures of quality and competition used and whether hospitals are publicly or privately owned.[45,46]

Earlier studies into competition and hospitals had delivered mixed results, with competition reducing mortality and readmissions in some studies, but increasing mortality or not affecting quality in others. These studies were conducted in hospital markets of the 1990s where competition was based on quality and price, there was limited information on the quality of hospitals to make informed choices, and incentives for managers to improve quality were relatively weak.[47]

More recent studies on hospital competition have found positive results. This is most evident in studies that have evaluated choice reforms in the UK hospital sector. Reforms within the UK National Health Service (NHS) between 2003 and 2008 introduced fixed pricing, publicly available information on hospital quality, waiting times and other attributes of care. Patients were given a choice of five hospitals to attend for their elective surgery.

One study found the NHS choice reforms changed the pattern of care, with patients in areas with greater competition choosing to receive elective care in hospitals with lower mortality rates and waiting times. The choice reforms had saved lives by reducing the risk of dying without raising costs. [48]

Another UK study found that death rates from heart attacks decreased quicker in areas with greater hospital competition, estimating the NHS choice reforms led to 300 fewer deaths per year. Competition for elective patients within the NHS increased quality across the entire hospital through measures such as undertaking clinical audits, improving governance and management and investing in new

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[45] Chua CL, Palangkaraya A, Yong J, 2011, Hospital competition, technical efficiency and quality, The Economic Record, Vol. 87, No. 277, pp. 252-268.

[46] Palangkaraya A, Yong J, 2013, Effects of competition on hospital quality: an examination using hospital administrative data, European Journal of Health Economics, Vol. 14, pp. 415-429.

[47] Propper C, 2012, Competition, incentives and the English NHS, Health Economics, Vol. 21, pp. 33-40.

[48] Gaynor M, Moreno-Serra R, Propper C, 2010, Death by market power: reform, competition and patient outcomes in the National Health Service, National Bureau of Economic Research, Working Paper 16164.

technology.[49] Competition among NHS public hospitals also led to increased efficiency through reduced length of stay, without any evidence of people leaving worse off or hospitals avoiding sicker patients.[50]

Skeptics of the NHS choice reforms were concerned NHS hospitals would reduce access to care for those most in need. It was thought competition could motivate hospital managers around their self-interest rather than pursuing more social objectives. There was also concern that lower socioeconomic groups may face greater barriers to using information on quality and would have less choice because they were less mobile.[51]

While private hospitals started to treat healthier patients and leaving public hospitals with costly patients,[52] these behaviours were not observed within NHS hospitals. A study concluded that competition slightly increased the use of hospital services in deprived areas, while there was no change in non-deprived areas. Competition had therefore improved access to care for those most in need.[53] Another study found that hospitals in more competitive areas treated a greater proportion of patients with less wealth.[54]

Competition in nursing home markets

The impact of competition on quality has been explored in nursing home markets, mostly within the US. While there are large differences between the Australian and US healthcare systems, the US nursing home market contains similar characteristics to the Australia residential care sector.[55] Both markets operate with regulated government prices and care is mostly funded by the government. This makes empirical research on competition and quality in the US nursing home market relevant to the Australian setting, as providers and consumers in both markets may behave in similar ways.

Studies on competition and quality in the US nursing home market have focused on the Nursing Home Quality Initiative (NHQI). This was introduced in 2002 and included the Nursing Home Compare (NHC) website, which made information on quality available on over 17,000 Medicare or Medicaid

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[49] Cooper Z, Gibbons S, Jones S, McGuire A, 2011, Does hospital competition save lives? Evidence from the English NHS patient choice reforms, The Economic Journal, Vol. 121, pp. 228-260.

[50] Cooper Z, Gibbons S, Jones S, McGuire A, 2012, Does competition improve hospitals' efficiency? Evidence form a quasi-experiment in the English National Health Services, Centre for Economic Performance, London School of Economics, London.

[51] Cookson R, Laudicella M, Li Donni P, 2013, Does hospital competition harm equity? Evidence from the English National Health Service, Journal of Health Economics, Vol. 32, pp. 410-422.

[52] Cooper Z, Gibbons S, Jones S, McGuire A, 2012, Does competition improve hospitals' efficiency? Evidence form a quasi-experiment in the English National Health Services, Centre for Economic Performance, London School of Economics, London.

[53] Ibid.

[54] Cooper Z, Gibbons S, Jones S, McGuire A, 2012, Does competition improve hospitals' efficiency? Evidence form a quasi-experiment in the English National Health Services, Centre for Economic Performance, London School of Economics, London.

[55] The US nursing home industry contains around 16,000 nursing homes mostly funded by Medicare and Medicaid enrolees. It contains barriers to entry via state certificate-of-need (CON) laws and construction moratoria. Prices are regulated through specified Medicare and Medicaid payments and by some states through nursing home rate equalisation laws. While there is some private financing (via co-payments), around 67 per cent of long term care is funded by the US federal government. Differences include more beds per facility (around 109 beds), a lower average occupancy rate (around 83 per cent) and a greater proportion of for-profit facilities (around 68 per cent).

Service (CMS) certified nursing homes. This initially included 10 clinical indicators measuring short term outcomes such as pain management and adverse events such as the use of physical constraints.[56] More recent studies on competition and quality have explored the 2008 shift from the NHC report card to the NHC Five-Star Quality Rating System.

NHC report cards

Early US studies on the impact of competition on quality focused on the introduction of the NHC website. Overall, these studies found competition had improved quality, although the impact depended on the quality indicator used and market characteristics.

One study found nursing homes improved their quality scores after quality report cards were made publicly available on the NHC website, for example by improving pressure sore rates by around 40 per cent. But some nursing homes experienced worse NHQI scores. The study found an interaction effect between competition and quality improvement. Markets with more nursing home competition, low occupancy rates, and more competition with low occupancy rates experienced greater improvements in quality after the NHQI was introduced.[57]

Similar results were found in another study that measured the effect of NHC report cards on the demand for nursing home care and whether the effect was determined by competition levels.[58] This study explored five quality indicators, including the loss of ability in basic daily activities, infections, pressure sores (high risk), pressure sores (low risk), and physical restraints. While NHC report cards did not significantly improve overall quality, nor impact provider market share, providers with below average occupancy rates in more competitive markets increased their quality (for two quality indicators) in a clinically meaningful way. This highlighted the potential interaction between occupancy rates and the incentive to improve quality under greater competition.

Several studies have investigated NHC impacts on consumer choice. One study found the NHC increased quality associated with pain, delirium, and walking, which was derived from improvements made by nursing homes to attract more consumers.[59] Another study found actions taken by facilities led to significant quality changes in three out of five quality indicators. One indicator suggested pressure ulcers had increased,[60] which reflected either worse pressure ulcer management (i.e., poorer quality) or better identification of pressure ulcers through increased examinations (i.e., better quality).[61]

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[56] Werner RM, Konetzka RT, Kim MM, 2013, Quality improvement under Nursing Home Compare: The association between changes in process and outcome measures, Medical Care, Vol. 51, No. 7, pp. 582-588.

[57] Castle N, Engberg J, Liu D, 2007, Having Nursing Home Compare quality measure scores changed over time in response to competition? Quality and Safety in Health Care, Vol. 16, pp. 185-191.

[58] Grabowski D, Town R, 2011, Does information matter? Competition, quality and the impact of nursing home report cards, Health Services Research, Vol. 46, No. 6, pp. 1698-1719.

[59] Werner R, Konetzkac T, Stuart EA, Norton EC, Polsky D, Park J, 2009, Impact of public reporting on quality of post acute care, Health Services Research, Vol. 44, No. 4, pp. 1169-1187.

[60] Mukamel DB, Weimer DL, Spector WD, Ladd H, Zinn JS, 2008, Publication of quality report cards and trends in quality measures in nursing homes, Health Services Research, Vol. 43, No. 4, pp. 1244-1262.

[61] Zhao, X, 2016, Competition, information, and quality: Evidence from nursing homes, Journal of Health Economics, Vol. 49, pp. 136-152.

Another study also found improvements in quality associated with consumers shifting to better quality nursing homes resulting from the NHC. This effect was not evident for nursing homes with high occupancy rates, but was evident for nursing homes with some latent occupancy, with increased effects as latent occupancy increased. The study concluded the effect on quality was potentially unsustainable for providers given the small impact.[62]

NHC Five-Star Quality Rating System

NHC report cards were replaced with an NHC Five-Star Quality Rating System in 2008 to help consumers better assess nursing home quality. Consumers became able to search for and rank providers based on their star ratings, potentially reducing search costs and enabling a more informed choice. Star ratings were calculated from health inspections, quality of resident care measures, and staffing. The Quality of Resident Care star rating was derived from 17 risk adjusted quality indicators.[63]

One study explored the relationship between competition and nursing home quality in the context of introducing the NHC Five-Star Quality Rating System.[64] Before this was introduced, a 10 per cent increase in competition increased the proportion of residents without urinary tract infections by 5.9 per cent. All other five indicators were insignificant. However, the star rating system raised consumer sensitivity to quality and provided stronger incentives for nursing homes to compete. Now, a 10 per cent increase in competition increased the proportion of residents without pressure ulcers, urinary tract infections and indwelling catheter by between 3 and 8 per cent. Increased quality was a response from providers to greater competition, and competition had a greater impact on providers with less occupancy.[65]

Another study found the NHC Five-Star Quality Rating System led to consumers choosing a better quality nursing home. Nursing homes with only 1 star lost around eight per cent of their market share and 5 star nursing homes gained six per cent of their market share after the star rating system was introduced.[66] This represented a substantial shift, given the demand for 1 star nursing homes was greater than for 5 star nursing homes before 2009.[67]

The most recent study evaluating the impact of competition on quality has sought to determine whether the NHC Five-Star Quality Rating System caused consumers to choose higher quality nursing homes.[68] A regression discontinuity design was employed to evaluate the difference in new admissions on nursing homes that sat either side of each start rating cut-off point, thereby evaluating the causal effect

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[62] Werner R, Norton EC, Konetzkac T, Polskyd D, 2012, Do consumers respond to publicly reported quality information? Evidence from nursing homes, Journal of Health Economics, Vol. 31, pp. 50-61.

[63] Two quality measures on pain were dropped from the construction of Quality of Resident Care star ratings in 2019.

[64] Zhao, X, 2016, Competition, information, and quality: Evidence from nursing homes, Journal of Health Economics, Vol. 49, pp. 136-152.

[65] Ibid.

[66] Werner R, Konetzka RT, Polsky D, 2016, Changes in consumer demand following public reporting of summary quality ratings: An evaluation in nursing homes, Health Services Research, Vol. 51, No. 3, Part II, pp. 1291-1309.

[67] Zhao, X, 2016, Competition, information, and quality: Evidence from nursing homes, Journal of Health Economics, Vol. 49, pp. 136-152.

[68] Perraillon MC, Konetzka T, He D, Werner RM, 2019, Consumer response to composite ratings of nursing home quality, American Journal of Health Economics, Vol. 5, No. 2, pp.165-90.

of gaining an additional star rating. This study found that gaining an additional star resulted in new admissions, suggesting consumers could better understand differences in provider quality. However, the impact was lower for providers with a low baseline level of quality, such that obtaining two stars compared to one had no impact on new admissions. These low quality providers contained more low income residents, were larger and more likely to be for-profit.

This study also found the effects on new admissions depended on baseline market characteristics. Effects were stronger among nursing homes with lower occupancy and were operating in more competitive markets. Given low quality providers faced the same level of competition as high quality providers in the baseline, these results suggest competition and information on quality interact. Simplifying information on quality increases consumer sensitivity to quality, shifting people to better quality nursing homes. This lifts the overall quality of care delivered within the market without the need for providers to change their practice.

Other countries

Research on competition and quality in other nursing home markets is scarce. One study in the UK found competition had little impact on prices and quality.[69,70]A 10 per cent increase in competition reduced prices by around 2.2 per cent. A 10 per cent reduction in competition led to a five per cent reduction in facilities with either zero or one quality star, and a four per cent increase in facilities with three stars. The negative effect of competition on quality disappeared when prices were included in the model.

Factors impacting the relationship between competition and quality

Overall, competition has improved quality in US nursing homes, but the average effects may be smaller than initially expected by policy makers. However, focusing on average results masks some important heterogeneity within results. Competition has a larger impact on quality when information on quality is more easily understood by consumers, there is some latent occupancy and there are more providers within the market. Importantly, competition can incentivise consumers to shift from worse quality providers to better quality providers.

Average effects also have significant meaning when applied to the resident population. For example, a 5.9 per cent decrease in UTIs from a 10 per cent increase in competition found in one study,[71] would

[69] Forder J, Allan S, 2014, The impact of competition on quality and prices in the English care homes market, Journal of Health Economics, Vol. 34, pp. 73-83.

[70] The UK market is less like the Australian market. It is comprised of around 60 per cent of consumers that receive services commissioned by local councils and 40 per cent of consumers that pay using their own financial means. Price is regulated on commissioned services at the council level through council payment rates, although different councils may negotiate different payment rates. Some facilities may charge higher than the council rate, with the additional payment made by a third party.

[71] Zhao, X, 2016, Competition, information, and quality: Evidence from nursing homes, Journal of Health Economics, Vol. 49, pp. 136-152.

result in significant health improvements and reduced healthcare costs in Australia, given UTIs are the most common indication for antimicrobial prescriptions in residential aged care.[72]

The effects of competition on nursing home quality are dictated by many factors. The Centers for Medicare and Medicaid Services have sought to continue improving information on quality. However, the approach to measuring the causal relationship between competition and quality has also encountered difficulties, which have likely impacted results, including measurement error, imperfect data, and modelling limitations. These are further discussed below.

Use of information on quality

Prior to the introduction of NHC report cards in 2002, information for consumers was already available on nursing home characteristics, results from on-site inspections for health-related deficiencies and staffing levels of nurses and nurse aids.[73,74] Effects between quality and competition may have therefore been impacted from a limited change in the perception of quality from consumers, given there were around 100,000 website visits per month before the NHC report cards were introduced.[75]

Consumers have also found interpreting information on quality difficult. Processing many indicators simultaneously was complex.[76] Agents helping consumers in the US also noted that NHC report cards were not user friendly and contained invalid information.[77] Consumers were not aware of NHC report cards,[78] with only 12 per cent of people entering a nursing home using the NHC website.[79] A lack of trust in government data, unfamiliar use of the Internet, consumer cognitive impairment, and information presented only in English also limited consumer use of the NHC website.[80,81]

Factors other than quality have also impacted consumer choice. These include information received on non-clinical components of quality and 'word of mouth' quality impressions received through informal

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[72] National Centre for Antimicrobial Stewardship and Australian Commission on Safety and Quality in Health Care, 2017, 2016 Aged care national antimicrobial prescribing survey report, Australian Commission on Safety and Quality in Health Care, Sydney.

[73] Perraillon MC, Konetzka RT, He D, Werner RM, 2019, Consumer response to composite ratings of nursing home quality, American Journal of Health Economics, Vol. 5, No. 2, pp. 165-190.

[74] Harrington C, Collier E, O'Meara J, Kitchener M, Payne Simon L, Schnelle JF, 2003, Federal and state nursing facility websites: Just what the consumer needs?, American Journal of Medical Quality, Vol. 18, No. 1, pp. 21-37.

[75] Ibid.

[76] Peters E, Dieckmann N, Dixon A, Hibbard JH, Mertz CK, 2007, Less Is More in Presenting Quality Information to Consumers, Medical Care Research and Review Vol. 64, No.2, pp. 169–90.

[77] Castle NG, 2009, The Nursing Home Compare report care: Consumers' use and understanding. Journal of Ageing and Social Policy, Vol. 21, pp. 187-208.

[78] Shugarman LR, Brown JA, 2006, Nursing home selection: How do consumers choose? Volume I: Findings from Focus Groups of Consumers and Information Intermediaries, Prepared for U.S. Department of Health and Human Services.

[79] Castle NG, 2009, The Nursing Home Compare report care: Consumers' use and understanding. Journal of Ageing and Social Policy, Vol. 21, pp. 187-208.

[80] Stevenson DG, 2006, Is a public reporting approach appropriate for Nursing Home Care? Journal of Health Politics, Policy and Law, Vol. 31, Issues 4, pp. 773-810.

[81] Castle NG, 2009, The Nursing Home Compare report care: Consumers' use and understanding. Journal of Ageing and Social Policy, Vol. 21, pp. 187-208.

networks (i.e., family and friends).[82] The need to enter a nursing home quickly and limited bed availability reduced the ability of consumers to consider clinical quality. Distance from family was also an important consideration for consumers.[83]

Measurement error

The limited response from some quality measures to competition may have resulted from measurement error and noisy data contained within administration data collected from subjective provider self-assessment.[84,85,86]

NHC quality indicators fail to measure non-clinical services that may have improved due to competition.[87] One study suggests consumer satisfaction information should be incorporated within quality reporting.[88] There is also some uncertainty whether results represent true changes in quality or changes to data accuracy.[89]

Using the HHI to measure competition is also imperfect given it could be correlated to unobserved market characteristics and decisions made by providers on quality, which can introduce a missing variable problem. Coupled with potential reverse causality between competition and quality, results may contain some endogeneity bias.[90]

Defining the geographical area to calculate the HHI can also impact results. Most studies have used county boundaries, although this seems too large within urban areas.[91] Other studies have used distance, ranging from 10 to 25 kilometres around the nursing home. These are arbitrary and not suitable for all population densities.

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[82] Ibid.

[83] Office of the Assistant Secretary for Planning and Evaluation (ASPE), 2006, Nursing home selection: How do consumers choose? Volume I: Findings from focus groups of consumers and information intermediaries, U.S. Department of Health and Human Services.

[84] Forder J, Allan S, 2014, The impact of competition on quality and prices in the English care homes market, Journal of Health Economics, Vol. 34, pp. 73-83.

[85] Zhao, X, 2016, Competition, information, and quality: Evidence from nursing homes, Journal of Health Economics, Vol. 49, pp. 136-152.

[86] Konetzkaa RT, Polsky D, Werner RM, 2013, Shipping out instead of shaping up: Rehospitalization from nursing homes as an unintended effect on public reporting, Journal of Health Economics, Vol. 32. Pp. 341-352.

[87] Park J, Werner RM, 2011, Changes in the relationship between nursing home financial performance and quality of care under public reporting, Health Economics, Vol 20, pp. 783-801.

[88] Zhao, X, 2016, Competition, information, and quality: Evidence from nursing homes, Journal of Health Economics, Vol. 49, pp. 136-152.

[89] Werner R, Konetzkac T, Stuart EA, Norton EC, Polsky D, Park J, 2009, Impact of public reporting on quality of post acute care, Health Services Research, Vol. 44, No. 4, pp. 1169-1187.

[90] Propper C, 2018, Competition in health care: lessons from the English experience, Health Economics, Policy and Law, Vol. 13, pp. 492-508.

[91] Zwanziger J, Mukamel DB, Indridason I, 2002, Use of resident origin data to define nursing home market boundaries, Inquiry, Vol. 39, pp. 56-66.

4. Improving residential aged care quality

Using competition in residential care to improve care quality requires some understanding of what consumers value when determining quality. At a minimum, indicators should encompass both clinical outcomes and broader social outcomes, given both impact wellbeing.

Competition will only incentivise quality if consumers exercise their right to choose. The residential aged care market is characterised by imperfect information on quality and high search costs for consumers.

Often consumers are not aware of what information to assess quality is important, are unable to access relevant information on quality, and have limited cognitive abilities to confidently process information on quality for their own needs. This reduces their capacity and willingness to choose, highlighting the role government should take in providing robust information on quality and supporting consumers when making a choice.

Recommendations made by several aged care reviews, along with theoretical and empirical evidence, suggest the pursuit of improved residential care quality should be a combination of accreditation, monitoring, and enforcement, along with greater consumer choice and competition. This will provide a quality floor and incentivise providers to invest in further quality and innovation.

This chapter recommends changes to Australian Government policy to increase consumer choice and provider competition in the pursuit of quality. This includes increasing consumer sensitivity and responsiveness to quality through better information on care quality and supporting choice by funding independent agents to help consumers choose a facility.

It also recommends the Australian Government ensure care prices cover the marginal cost of improved quality, which is likely to require an increase in care prices. Once these two preconditions are met, the ACAR and NACPR should be removed to allow incumbent and new providers to enter new markets.

Increasing consumer sensitivity to quality

Improving information on quality

While clinical indicators are the gold standard for assessing quality in healthcare,[92] unlike hospitals, residential aged care represents a home. Services are aimed at maintaining health outcomes (or slowing the decline) and addressing the broader social and wellbeing needs of recipients.

[92] Smith P, Mossialos E, Papanicolas I, Leatherman S, 2009, Performance measurement for health system improvement. Experiences, challenges and prospects, Cambridge University Press, New York.

The Australian Government made the NACQIP mandatory in 2019. Every residential aged care facility must report against three indicators every quarter, including pressure injuries, use of physical restraint, and unplanned weight loss. Data is reported through the Australian Institute of Health and Welfare website, along with other collected aged care data.

Assessing the NACQIP against best practice performance reporting frameworks suggests it fails on several metrics. It will not increase consumer sensitivity to care quality differences, so the first task to improve quality through competition is to completely overhaul the NACQIP.

A major problem with the NACQIP is its reliance on a limited set of clinical indicators. Other characteristics that impact wellbeing, or consumers believe are important, are not reported.[93] The two additional clinical indicators being explored by the Australian Government, including falls and fractures, and medication management will not fix this problem.

A better understanding of consumer preferences for quality is required. New quality indicators must be balanced with the complexity and cost of collecting data, but should not be avoided because of these characteristics. If some quality indicators are considered too costly to collect, for example, because they rely upon measuring health or wellbeing outcomes, there are likely to exist less costly process measures that represent a good substitute.

One complexity when comparing residential care quality is the large variation in the composition of residents. This must be considered when comparing indicators and attributing differences to alternative care practices. Without risk adjustment, a residential care facility with a greater than average frailty mix of residents could be wrongly blamed for delivering poorer outcomes. Alternatively, poor performing residential care facilities could receive good performance outcomes if their frailty mix is below average.

The NACQIP does not risk adjust quality indicators, suggesting its indicators are invalid and most likely misinterpreted.[94] This will increase distrust with the NACQIP and lead to consumers, providers and the Australian Government to disregard results altogether.

The NACQIP must be risk adjusted to ensure differences in provider care quality are causal and not representative of differences in resident populations. Basic risk adjusters could include age, gender and socioeconomic status, although these are unlikely to be sufficient. Frailty is already being measured through ACFI assessments, which provides a readily accessible data source for more detailed risk adjustment on activities of daily living, behaviour, and the need for complex healthcare. Ultimately, risk adjustment methods must be developed and validated specifically for the quality indicators chosen. This may require collecting additional data from medical records and directly from consumers.

Additional NACQIP quality indicators must measure care processes and the outcomes that residential care facilities can influence. While understanding consumer preferences for quality should be the ultimate goal, a starting point is to consider quality indicators that align with the eight standards already developed within the Aged Care Quality Standards.[95]

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[93] Jeon, Y-H 2016, Quality domains for the development of a consumer experience report on quality of residential aged care, Australian Aged Care Quality Agency, Commonwealth of Australia, Canberra.

[94] Smith P, Mossialos E, Papanicolas I, Leatherman S, 2009, Performance measurement for health system improvement. Experiences, challenges and prospects, Cambridge University Press, New York.

[95] Aged Care Quality and Safety Commission, 2019, Guidance and resources for providers to support the Aged Care Quality Standards, Commonwealth of Australia, Canberra.

Some quality indicators could initially be derived from the Consumer Experience Reports previously undertaken by the Aged Care Quality and Safety Commission. The quality domains used to determine questions asked of residents or their representative were based on a literature review of quality that matters to consumers.[96] However, more data collection would be required given these reports are no longer produced. They had also relied on audits undertaken at different times, so they cannot be directly compared across providers, and were not risk adjusted.

Ultimately, the NACQIP should present quality indicators that matter most to consumers. Indicators should not be developed based on available data, but on consumer preferences, which then dictates the data collection process. Investment in data collection and IT systems by providers and the Australian Government will be required.

The complexity in managing resident wellbeing means many indicators are required to capture care quality. As outlined in Chapter 3, consumers become overwhelmed if they are required to consider many quality indicators simultaneously. More difficult is making trade-offs across indicators. The NHC Five-Star Quality Rating System increased the capacity of consumers to determine quality differences among providers and shifted their preference to better quality providers.

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

One challenge is to estimate weights for each quality indicator included in the composite indicator. A composite indicator that heavily weights one component over another may not correlate with consumer preferences. A study examining 15,652 nursing homes found stars allocated through the NHC Five-Star Quality Rating System were weakly correlated with patient safety.[97] Another study examining US nursing homes found a weak correlation between stars and consumer satisfaction.[98] The correlation was lowest among providers with between two to four stars in both studies.

Composite indicator weights should represent the strength of consumer preference for each quality indicator. Mean consumer weights for each quality indicator could be derived by surveying consumers using a discrete choice experiment (DCE). However, average weights across broad segments of consumers are unable to represent the preferences of all consumers who have legitimate, heterogeneous needs. A more flexible composite indicator would enable consumers to apply their own weights when assessing provider quality, based on their needs and preferences for care.

Quality report cards are essential to ensure providers take responsibility for delivering quality care. Improving the NACQIP will increase consumer sensitivity and responsiveness to quality, given the search costs for seeking information on quality diminishes. This will incentivise providers to increase quality to attract consumers (conditional on other market changes discussed below). An improved

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[96] Jeon, Y-H 2016, Quality domains for the development of a consumer experience report on quality of residential aged care, Australian Aged Care Quality Agency, Commonwealth of Australia, Canberra.

[97] Brauner D, Werner RM, Shippee TP, Cursio J, Sharma H, Tamara Konetzka R, 2018, Does Nursing Home Compare reflect patient safety in nursing homes?, Health Affairs (Millwood), Vol. 37, No. 11, pp. 1770-78.

[98] Williams A, Straker JK, Applebaum R, 2016, The Nursing Home Five Star Rating: How does it compare to resident and family views of care? The Gerontologist, Vol. 56, No. 2, pp. 234-42.

NACQIP will help consumers select providers with better quality, thereby increasing 'average' quality delivered within the market. Importantly, providers would become better equipped to compare their performance against 'like' providers, to identify areas of poor quality and stimulate action to improve.

Making information on quality more accessible

Improving the NACQIP will inspire some consumers to use information on quality when selecting a provider. Others will continue to rely on informal quality assessments through word of mouth, or visit facilities and judge care quality based on proxy measures, such as room quality. Some consumers will consider factors unrelated to care quality, such as proximity to family, as their most important selection criteria.

The ability and willingness to use information on quality will vary across consumer characteristics. For example, higher education is positively associated with involvement in hospital choice,[99] while increased age and lower socioeconomic status are negatively associated with patient choice and ability to travel beyond their nearest hospital.[100]

When consumers use information on quality to choose a provider, they must assume that the provider's past performance reflects its future performance (stability). They must also assume that the provider was caring for residents with needs like theirs, when performance was measured (applicability).[101] Performance information must also be timely to ensure validity.

Consumers will have different decision-making processes and preferred level of involvement when choosing a provider.[102] Many consumers will choose their provider by themselves based on quality,[103] but some may wish to consult a professional to help them make the choice.[104,105] These consumers may be less able, but no less willing, to comprehensively understand information on quality relative to their own needs.[106]

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[99] Fotaki M, Roland M, Boyd A, McDonald R, Scheaff R, Smith L, 2008, What benefits will choice bring to patients? Literature review and assessment of implications, Journal of Health Services Research and Policy, Vol. 3 No. 3, pp.178-84.

[100] Aggarwal A, Lewis D, Mason M, Sullivan R, van der Meulen J. 2016, Patient Mobility for Elective Secondary Health Care Services in Response to Patient Choice Policies: A Systematic Review. Medical Care Research Review, Vol. 74, No. 4, pp. 379-403.

[101] Berwick DM, James B, Coye MJ, 2003, Connections between quality measurement and improvement, Medical Care, Vol.41, pp. 30-38.

[102] Gebele C, Tscheulin DK, Lindenmeier J, Drevs F, Seemann AK, 2014, Applying the concept of consumer confusion to healthcare: development and validation of a patient confusion model. Health Services Management Research, Vol. 27. No. 1-2, pp. 10-21.

[103] Coulter A, 2004, What price choice? Health Expectations, Vol. 7, No. 3, pp. 185-86.

[104] Fotaki M, 2013, Is patient choice the future of health care systems? International Journal of Health Policy Management, Vol. 1, No. 2, pp. 121-23.

[105] Magee H, Davis LJ, Coulter A, 2003, Public views on healthcare performance indicators and patient choice. Journal of the Royal Society of Medicine, Vol. 96, No. 7, pp. 338-42.

[106] Zwijnenberg NC, Hendricks M, Damman OC, Bloemendal E, Wendel S, de Jong JD, et al, 2012, Understanding and using comparative healthcare information; the effect of the amount of information and consumer characteristics and skills, BMC Medical Informatics & Decision Making, Vol. 12, No. 1, pp. 101-11.

The Australian Government already assists disadvantaged groups to facilitate more patient choice and promote equitable access. For example, support coordination is available within the National Disability Insurance Scheme (NDIS) at three levels depending on need, to help consumers connect with local providers and choose a mix of services in line with their needs and preferences. This includes help accessing Specialist Disability Accommodation.

The driving force behind increasing quality through competition is ensuring providers receive a signal that consumers believe quality is important. This can either be real or imaginary. The threat to providers of either being unable to attract new residents, or losing current residents due to poor quality, may be sufficient to incentivise them to invest in better quality.[107]

Not all consumers need to choose their provider based on quality for the market to signal quality is important to consumers. But the greater the number of consumers choose their provider based on quality, the stronger the signal becomes, and the more likely providers will compete and deliver on quality expectations.

One option to increase the proportion of consumers choosing a provider based on quality is to provide Supported Choice.[108] This would rely on an independent agent to help consumers choose a provider within their local area. Responsibilities of the agent could include monitoring and interpreting information on quality presented through an overhauled NACQIP, supplemented with additional information sourced from audit reports and serious risks found within providers.

The agent would seek to understand care preferences, identify special needs, and best match these with local providers. The agent could book provider appointments on behalf of consumers and clarify information the consumer received from each provider, if needed. The agent would also ensure consumer rights are fully understood by consumers, and adhered to by providers, upon entry into residential care. Having an independent agent would remove some of the stress related to navigating entry into residential aged care.

One potential criticism is the resource requirements given around 52,000 people enter residential aged care each year.[109,110] While not all residents would require Supported Choice, a large proportion of consumers seeking help would mean a significant investment. Funding could come from the Australian Government, consumers, or a combination of both. Those with less financial means could have their costs covered, while others could pay a subsidised rate.

However, a strong argument exists for the Australian Government to cover all costs of Supported Choice, regardless of consumer financial means. Encouraging more consumers to choose based on quality provides a stronger signal to providers to increase quality, providing benefits to all consumers. The subsequent increase in care quality and benefits to wellbeing would be more than enough to offset costs.

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[107] Castle N, Engberg J, Liu D, 2007, Have Nursing Home Compare quality measure scores changed over time in response to competition? Quality and Safety in Health Care, Vol. 16, pp. 185-191.

[108] Dixon A, Le Grand J, 2006, Is greater patient choice consistent with equity? The case of the English NHS. Journal of Health Services Research and Policy, Vol. 11, No. 3, pp. 162-66.

[109] Productivity Commission 2020, Report on Government Services 2020, Commonwealth of Australia, Canberra.

[110] This was calculated by taking the difference between the number of people receiving permanent residential aged care services in 2018-19 and the number of occupied residential aged care places.

Covering the cost of improved quality

The Australian Government currently covers around 94 per cent of care costs through the ACFI, with the remaining contributions made by residents.[111] The amount of funding given to providers and the way funding is delivered can impact care quality.[112] A higher care price gives a provider greater capability to cover the cost of increased quality. However, it also provides an opportunity to increase profits without any change in quality.

The extent to which a provider can raise prices without commensurate increases in quality depends on the level of market power held by a provider, the capacity for the consumer to identify differences in quality and the consumers' sensitivity of quality compared to price. Most consumers are completely insensitive to care prices given costs are funded by the Australian Government, but they are also insensitive to care quality given this cannot be easily determined.

Higher care prices have increased nursing home quality in other countries. A study that investigated the relationship between prices and quality across 7,400 German nursing homes found higher prices significantly increased a quality index comprised of seven risk factors drawn from report cards.[113,114] Quality report cards based off 82 statutory criteria have been publicly reported in Germany since 2009.

US studies have found increased Medicaid reimbursement led to higher professional staff intensity, although this did not translate to improved quality.[115] Another US study found a reduction in Medicare cost reimbursement for short stay residents led to increased pressure sores and urinary tract infections due to reduced staffing.[116] Improved US nursing home profit margins have also led to increased total staff hours per resident, but only when quality report cards were available.[117]

This evidence suggests Australian residential care quality is linked to ACFI prices. Wages make up around 70 per cent of operational costs and there is a positive relationship between the total number of nursing staff, their qualifications and care quality.[118] ACFI funding is also used by providers to invest in other staff practices important for care quality, such as management processes, teamwork, training, retention and staff morale.[119]

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[111] Tune D, Legislated review of aged care 2017, Commonwealth of Australia, Canberra.

[112] Konetzka T, Norton E, Stearns S, 2006, Medicare payment changes and nursing home quality: Effects on long-stay residents, International Journal of Health Care Finance and Economics, Vol. 6, No. 3, pp. 173-189.

[113] Herr A, Hottenrott H, 2016, Higher prices, higher quality? Evidence from German nursing homes, Health Policy, Vol. 120, pp. 179-89.

[114] This study accounted for potential endogeneity given that higher quality could have increased higher prices.

[115] Cohen JW, Spector WD, 1996, The effect of Medicaid reimbursement on quality of care in nursing homes, Journal of Health Economics, Vol. 15, pp. 23-48.

[116] Konetzka T, Norton EC, Stearns SC, 2006, Medicare payment changes and nursing home quality: Effects on long stay residents, International Journal of Health Care Finance and Economics, Vol. 6, No. 3, pp 173-89.

[117] Park J, Werner RM, 2011, Changes in the relationship between nursing home financial performance and quality of care under public reporting, Health Economics, Vol. 20, pp. 783-801.

[118] Spilsbury, K, Hewitt, C, Stirk, L, et al, 2011, The relationship between nurse staffing and quality of care in nursing homes: A systematic review, International Journal of Nursing Studies, Vol. 48, pp. 732-750.

[119] Ibid.

The link between ACFI prices and care quality has implications for increasing quality through competition. Providers can only increase quality in response to competition if the marginal cost of quality improvement is compensated.

If the Royal Commission recommends significant changes to residential care that aligns with prior recommendations made by aged care reviews, this will substantially increase provider costs. [120] Recent provider financial statements suggest many providers will struggle to cover the marginal cost of improved quality under current financial arrangements. Around 46 per cent of aged care providers experienced a net loss in 2017-18, primarily due to restrictions on ACFI prices and increased wage costs.[121] Earnings have dropped to a seven year low and planned investment to upgrade or rebuild facilities has halved between 2015-16 and 2017-18.[122]

There is limited capacity for providers to cross subsidise improved care quality, given cross subsidisation already occurs, providers already charge the maximum daily living fee and there are restrictions on accommodation pricing. Regardless, cross subsidies are generally considered inefficient given they can distort demand and investment. The only reasonable option is to ensure ACFI prices cover the cost of improved quality.

There is currently little direct relationship between ACFI prices and the cost of delivering care. ACFI prices have never been based on care cost, and recent changes to ACFI prices have reflected attempts by the Australian Government to manage budgets, rather than reflect any change in costs. Given many providers are performing poorly financially and changes to provider operations to improve care will be costly, care prices will most likely need to increase.

The Australian Government is exploring an alternative to ACFI, known as the Australian National Aged Care Classification (AN-ACC).[123] This is a casemix classification that allocates funding based on the cost of delivering care to different types of residents and facilities. There is a much greater capacity to ensure care funding covers the cost of increased quality using this model.

If implemented, the Australian Government would have the means to set one price that reflects the efficient production of good care quality. While this sounds easy, identifying what service mix reflects good quality (on average) with a heterogenous provider mix, while encouraging innovation, and setting an appropriate price, will be technically and politically challenging. There are lessons from the acute-care sector on how casemix funding together with comparative statistics, can be used to identify unwarranted quality gaps and price the value of quality improvement.[124] At a minimum, there should be an independent pricing setting authority.

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[120] Royal Commission into Aged Care Quality and Safety, 2019, A history of aged care reviews, Background Paper 8, Commonwealth of Australia, Canberra.

[121] Aged Care Financing Authority (ACFA), 2019, Submission to the Royal Commission into Aged Care Quality and Safety, Canberra.

[122] Aged Care Financing Authority (ACFA), 2019, Seventh report on the funding and financing of the aged care industry, Canberra.

[123] Eagar K, McNamee J, Gordon R, Snoek M, Duncan C, Samsa P, Loggie C, 2019, The Australian National Aged Care Classification (AN-ACC). The resource utilisation and classification study; Report 1, Australian Health Services Research Institute, University of Wollongong.

[124] Karnon J, Partington A, Horsfall M, Chew D, 2016, Variation in Clinical Practice: A Priority Setting Approach to the Staged Funding of Quality Improvement, Applied Health Economics and Health Policy Vol. 14, pp. 21–27.

A natural question is whether providers should be allowed to charge prices higher than the care prices set by the Australian Government (i.e., the Australian Government effectively sets a floor price rather than a maximum price for care).[125] Some providers have argued this would allow them to increase quality and invest more in innovation.

However, providers could instead seek to extract value from consumers to increase profits without increasing quality, given local market power, barriers to entry and limited information on quality that currently characterises the market. Some consumers may be unable to access residential care in their local area if care prices increase too much. Consumers in rural and remote regions may be particularly exposed given they have a limited set of providers to choose from. It is therefore prudent to ensure care prices remain fixed throughout the sector.

Facilitating greater competition

The residential aged care sector is shaped by Australian Government policy. None more so than the ACAR and the NACPR. The ACAR means consumer access to subsidised beds is somewhat dictated by the Australian Government, while the NACPR caps the size of the sector. Both policies have served the Australian Government and providers to the detriment of consumers.

The ACAR and NACPR were developed to provide the Australian Government with a strong lever to control government aged care expenditure. The ACAR competitively allocates the supply of subsidised beds across geographical regions, based on the demand from providers. This does not necessarily reflect demand from consumers. The number of subsidised beds allocated through the ACAR is implicitly capped by the NACPR.

There were 910 residential aged care providers in Australia in 2019 operating 2,929 facilities.[126] The largest provider had operated 3.4 per cent of subsidised beds in 2019, with the top 10 providers operating around 22 per cent of subsidised beds.

The residential aged care sector seems competitive based on these statistics. However, these are national figures and the market is not national according to consumers. The residential aged care sector contains many hundreds of local markets, given most residents want to receive care close to their prior home or near family support.

Barriers to entry are reflected in occupancy rates, which averaged 90.3 per cent in 2018.[127] Other estimates suggest occupancy rates are higher, averaging around 94 per cent when only operational beds are counted.[128] There is variation in occupancy rates across locations, with the highest occupancy rates

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[125] This funding approach is used in the private hospital setting. The Australian Government pays 75 per cent of the MBS scheduled fee for all services provided by a medical practitioner in hospital when treating a private patient. Medical practitioners can set their consumer price at higher levels, with the difference typically paid for by private health insurance and out-of-pocket expenditure.

[126] Department of Health, 2019, Australian Services List, Commonwealth of Australia, Canberra.

[127] Productivity Commission, 2020, Report on Government Services, Commonwealth of Australia, Canberra.

[128] StuartBrown, 2020, Aged Care Sector Report, https://www.stewartbrown.com.au/images/documents/StewartBrown---Aged-Care-Financial-Performance-Survey-Sector-Report-December-2019.pdf, accessed 19 April 2020.

in major cities. A recent decrease in occupancy rates has prompted some providers to voice their concern that further falls will reduce the cash-flow and viability of some facilities.[129]

The ACAR and NACPR have significantly benefited providers, on the whole. The ACAR has acted as a barrier to entry for new entrants into local markets. The NACPR has stopped new providers entering the residential care sector at the national level. Both have embedded market power for incumbents.

Evidence of market power is reflected within the market itself. There is no price competition around the basic daily fee, with providers charging the maximum 85 per cent of the single person rate of the basic age pension.[130] The average price agreed between providers and residents has also increased by 33 per cent, from $296,000 in 2013-14 to $393,000 in 2017-18.[131,132] While some increase has compensated providers for a reduction in interest rates and led to improved facilities, it also reflects the capacity of providers to extract increased wealth from residents due to rising house prices.

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

Providers have since argued the Aged Care Pricing Commissioner should be removed. The Aged Care Guild argued that accommodation pricing should be consumer driven, while ACSA argued there is no '*need for Government to regulate to protect wealthy older people*'.[133] The problem is, the residential aged care market is not consumer driven given barriers to entry. Furthermore, those with money are also vulnerable when entering residential aged care, and are most likely the consumers that need the greatest protection.

Market power has manifested in other ways besides price. The ACAR and NACPR have allowed poor quality providers to survive, beyond reasonable performance turn-around periods. This has reduced the average quality of care within the market. Barriers to entry have also reduced the need for some providers to invest in innovative care models or better facilities and equipment, with over 40,000 residents still receiving care in rooms with multiple beds and shared facilities, although this type of

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[129] Ibid.

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

[131] Department of Health, 2014, 2013-14 Report on the Operation of the *Aged Care Act 1997*, Commonwealth of Australia, Canberra.

[132] Aged Care Financing Authority (ACFA), 2018, Sixth report on the funding and financing of the aged care sector, Commonwealth of Australia, Canberra.

[133] Tune, D 2017, Legislated Review of Aged Care 2017, Commonwealth of Australia, Canberra.

accommodation is in decline.[134] These room types do not align with individual consumer preferences or community expectations.

Consumers have lost out from the ACAR and NACPR. In addition to higher prices and poorer quality care, high occupancy rates mean that many consumers do not enter their first-choice facility, particularly if they require quick entry into residential care. Some consumers will experience long waits before entering their preferred facility. For example, the median elapsed time between ACAT approval and entry into residential aged care was 152 days in 2018-19, which has increased from 45 days in 2013-14.[135,136]

The Australian Government is exploring alternative models to the ACAR.[137] Initial consultations suggest most providers do not support the current model.[138] One alternative on offer is to continue allocating places to providers but through an adjusted ACAR framework. The other alternative on offer is to stop allocating places to providers and start allocating 'places' to consumers, although the total number of places allocated would remain capped.

Australian Government should remove the ACAR and NACPR completely. Supporting incumbent providers by maintaining barriers to entry may mitigate some negative financial impacts from increased competition, but this comes at a cost. It provides an environment where providers with poor financial performance and poor quality can continue to operate. Good performing providers are unable to expand as rapidly under the ACRA and NACPR. Consumers also experience worse care quality and higher accommodation prices than otherwise. Investment in new infrastructure lags, delaying a shift towards consumer preferences. Consumer choices will also remain restricted due to continued high occupancy rates.

Increased financial pressure on providers is of concern from a government perspective, but this should only be to the extent that it impacts consumers. Poor financial performance exacerbated by increased competition will make it more difficult for providers to increase their quality, and consumers may need to find an alternative if their provider closes due to financial distress. This incurs a personal switching cost to existing residents, given changing circumstances can be stressful. In rural and remote regions, consumers may be left without a provider operating in their local area, having to instead locate away from their family and friends. This would be unacceptable to most Australians.

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[134] Aged Care Financing Authority (ACFA), 2019, Seventh report on the funding and financing of the aged care industry, Australian Government, Canberra.

[135] Productivity Commission, 2020, Report on Government Services, Commonwealth of Australia, Canberra.

[136] The median elapsed time between ACAT approval and entry into residential aged care services does not necessarily reflect waiting times for entry into residential care due to limited bed availability. The median elapsed time is also influenced by consumer decisions on when to enter residential care once they have been assessed. This can depend on access to Home Care packages, capacity for the consumer to continue living at home and the level of preparation made by the consumer for entry into residential care, among other factors.

[137] University of Technology Sydney and Stuart Brown, 2019, Residential aged care: proposed alternative models for allocating places. Discussion paper, https://consultations.health.gov.au/aged-care-policy-and-regulation/alternative-allocation-models-residential-care/user_uploads/discussion-paper---residential-aged-care---proposed-alternative-models-for-allocating-places-1.pdf, accessed 19 April 2020.

[138] Woods M, Corderoy G, 2019, Summary of feedback. Consultation forums: Alternative models for allocating residential aged care places, https://www.health.gov.au/sites/default/files/documents/2020/01/consultation-forums-alternative-models-for-allocating-residential-aged-care-places-summary-of-feedback.pdf, accessed 19 April 2020.

The Business Improvement Fund established in 2019 already provides a mechanism for the Australian Government to manage a transition to a more competitive environment. Assistance could include further care subsidies, accommodation supplements, and other viability supplements, together with operational turn-around planning, implementation of quality improvement initiatives, and assistance in finding an alternative provider to take over a failing facility. At a minimum, assistance should be targeted at facilities at risk of closure where no alternative facility exists, such as within rural and remote regions. In extreme circumstances, the Australian Government may need to take ownership of a facility and tender out its operation to another provider under specific tender conditions.

Removing the NACPR would not generate a large increase in residential care expenditure for the Australian Government. For this to occur, it would require a significant increase in the demand for residential care once access is expanded. Considering most people prefer to stay at home and receive a Home Care package, most consumers think of residential care as an option of last resort. A study that investigated increased access to beds across US states found an inelastic demand for nursing home care.[139]

While the Australian Government and some providers may be nervous with the approach outlined above, it will benefit consumers in the long run. Research from US states that have Certificate of Need (CON) and construction moratorium legislation suggest restricting the number of beds to manage aged care expenditure increased barriers to entry and created excess demand. This discouraged innovation, diminished nursing home quality, raised prices, and lowered access to care.[140] Removing the ACAR and NACPR will not only make providers more responsive to consumer needs, and allow good providers to flourish, but is necessary for competition to drive quality.

[139] Grabowski DC, Gruber J, 2007, Moral hazard in nursing home use, Journal of Health Economics, Vol. 26, pp. 560-77.

[140] Grabowski DC, 2017, Nursing home Certificate-of-Need laws should be repealed, Health Affairs Blog, 9 June 2017.

5. Conclusion

Competition is the cornerstone of a dynamic Australian economy. Improved competition policy has created greater productivity, delivered increased real incomes, and provided a greater standard of living for all Australians. The Australian Government has committed to providing greater consumer choice and enabling informed choice by consumers throughout all sectors of our economy.[141]

This submission has argued that competition in the residential aged care market is restricted by Australian Government policy. The market is unable to generate incentives for providers to increase quality above that dictated by accreditation. Gaps in monitoring and enforcement have allowed some providers to operate below this threshold, resulting in poor quality outcomes described by the Royal Commission.

The Australian Government must ensure providers take responsibility for delivering care quality acceptable to consumers and society. This should be achieved using two sets of complementary reforms.

The Australian Government needs to continue strengthening its accreditation, monitoring, and enforcement activities to ensure a minimum level of quality is delivered. The recently formed Aged Care Quality and Safety Commission is a step in the right direction. However, this should be complemented by harnessing the power of competition and choice to ensure providers deliver quality beyond the minimum dictated by accreditation. Both are essential to building a residential aged care system that Australians can be proud of.

This submission has argued that competition can increase quality under the right regulatory framework. Improving information on quality and making it accessible to consumers will mean consumers are more likely to choose a provider based on quality. However, there should be some latent occupancy within the residential care sector and care prices should be fixed at levels that cover the marginal cost of improved quality.

Providers currently invest too little in care quality beyond the minimum threshold because it provides them with little return. Positive externalities from good care quality are not priced into the market, leading to underinvestment in care quality compared to what is optimal. High occupancy rates mean consumers are easy to attract for providers, so the incentive to spend money to increase quality and innovate is mute. This must change.

This submission argues that the NACQIP should be completely overhauled. It must contain quality indicators that are relevant to consumers and provides summary quality ratings (along with individual indicators and provider characteristics) that allow consumers to easily rank providers. The Australian Government should fund independent agents to deliver Supported Choice to consumers when choosing a provider.

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[141] Australian Government, 2015, Australian Government Response to the Competition Policy Review, Commonwealth of Australia, Canberra.

Some may argue that consumers are unlikely to use quality indicators, even if improved. If that were the case, there would still be more choice of provider based on quality compared to today. That would help provide the right signals to providers to invest in quality.

There is a strong argument for a robust NACQIP regardless of whether it impacts choice. Better, more relevant indicators would lead to greater transparency, which can put a spotlight on poor quality outliers and provide a benchmark upon which other providers can measure their outcomes.

While overhauling the NACQIP is necessary, it is not sufficient for competition to improve quality. This submission argues that the ACAR and NACPR should be removed to benefit consumers. It would provide more choice and help promote good quality providers to flourish within the market. Poor financial performance experienced by nearly half of all providers each year is not conducive to improved quality. The Australian Government should determine an efficient care price based on the cost of expected quality. This will most likely require increasing care prices beyond what is delivered under ACFI.

Recommendations laid out within this submission are not new, having been identified repeatedly over the last two decades by several aged care reviews and more recently, by the Aged Care Funding Authority. While many providers are wary of removing the ACRA and NACPR, it seems the majority favour this approach, including peak bodies such as ACSA and LASA.

It is untrue to suggest the Australian Government cannot afford either supporting providers to transition towards a new competitive environment or increased care prices. Even with a substantially increased budget deficit resulting from the Covid-19 response, Australia remains a rich country with little net debt as a proportion of GDP compared to other developed countries. It is therefore a matter of choice.

Australians want a vibrant aged care system that delivers good quality care. What Australia cannot afford is the continued operation of a residential aged care sector that delivers poor outcomes found by the Royal Commission.