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HALL & PRIOR
Health & Aged Care Group

25 August 2023

Professor Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority (IHACPA)
PO Box 483
Darlinghurst NSW 1300

cc:
Hon Mark Butler MP, Minister for Health and Aged Care
Hon Anika Wells MP, Minister for Aged Care
Hon Ged Kearney MP, Assistant Minister for Health and Aged Care
Hon Amber-Jade Sanderson MLA, WA Minister for Health
David Tune AO PSM, Chair, IHACPA
Dr Stephen Judd AM, Deputy Chair, IHACPA

Re: Pricing Framework for Australian Residential Aged Care Services 2024-25

Dear Sir

Thank you for this opportunity to make this submission to the Independent Health and Aged Care Pricing Authority (IHACPA) on the Pricing Framework for Australian Residential Aged Care Services 2024-25.

Hall and Prior Health and Aged Care

Established in 1992 by Michael Hall and Graeme Prior, the Hall & Prior Health & Aged Care Group has grown from a single family-owned nursing home to a leading Australian aged care provider with 36 homes. For 30 years, Hall & Prior has been driven by a commitment to deliver quality aged care that is accessible to everyone, no matter their background or circumstances. We believe that this commitment and dedication makes a true difference to the lives of our care recipients and their families and that our success is based on a clear understanding of this commitment and a genuine belief in what we do.

Our philosophy is that our residents and care recipients are entitled to the highest standards of professional care, privacy and dignity and we are proud to promote individuality, diversity, and inclusivity in our approach. We employ over 3,000 professional and specialist staff dedicated to planning and caring for our residents and the people we care for. Our homes provide leading care, safety and comfort, quality facilities and ensure choice in regard to accommodation and services, which is important to all individuals. We remain committed to the delivery of best practice and accessible care options.

Outline of this Submission

This submission deals *seriatim* with six issues:

- The need to better link aged care funding levels to the efficient cost of care.
- The need to recognise in the aged care funding model the additional costs of delivering aged care services on Saturdays, Sundays, Public Holidays and at night.
- The need to better index aged care funding levels each year to the cost drivers that providers face to ensure that quality care can continue to be delivered 24/7.
- The need to recognise the benefits to the Australian Government of ensuring that for-profits remain in the industry and to recognise in the aged care funding model the differential unavoidable costs that for-profit aged care providers face.
- The need to better recognise how costs vary across the nation, between states as well as between regions.
- The need to address the risks that arise from applying activity based funding to aged care, given the different volumes and purposes of aged care and hospital funding.

In making this submission, Hall & Prior Health & Aged Care has been assisted by Adjunct Professor David Cullen of Macquarie University's Centre for the Health Economy. Professor Cullen will be well known to all of you from his previous roles as Chief Economist and Head of Strategic Policy at the Australian Department of Health and as Chief Economist at the National Disability Insurance Agency as well as the almost two decades that he spent leading the development of aged care policy for several Australian governments, including as Principal Advisor to the Chair of the Royal Commission into Aged Care Quality and Safety. I am grateful to Professor Cullen for his assistance in the preparation of this submission.

Better Linking Aged Care Funding Levels to the Cost of Care

The quality, amount and types of care that a residential aged care provider must deliver to residents are set out in the *Quality of Care Principles 2014*. Schedule 1 of those Principles states that residential aged care providers must, *inter alia*, deliver the following services to all residents who need them:

- Daily living activities assistance.
- Emotional support.
- Treatments and procedures, includes bandages, dressings, swabs and saline.
- Recreational therapy.
- Rehabilitation support.
- Assistance in obtaining health practitioner services.
- Assistance in obtaining access to specialised therapy services.

- Support for care recipients with cognitive impairment.
- Furnishings related to care needs – for example, over-bed tables.
- Bedding materials related to care needs – for example, bed rails, incontinence sheets, ripple mattresses, sheepskins, tri-pillows, and water and air mattresses appropriate to each care recipient's condition.
- Goods to assist care recipients to move themselves – for example, crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs.
- Goods to assist staff to move care recipients – for example, mechanical devices for lifting care recipients, stretchers, and trolleys.
- Goods to assist with toileting and incontinence management – for example, absorbent aids, commode chairs, disposable bed pans and urinal covers, disposable pads, over-toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, and disposable enemas.
- Nursing services.
- Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services. This includes maintenance therapy designed to maintain care recipients' levels of independence in activities of daily living and more intensive therapy on a temporary basis that is designed to allow care recipients to reach a level of independence at which maintenance therapy will meet their needs. It excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.

From 1 October 2023, the Australian Government will also require providers to provide at least 200 care minutes per resident per day including at least 40 minutes of care from registered nurses each day. These minimum requirements will increase to at least 215 care minutes per resident per day, including at least 44 minutes of care from registered nurses each day, from 1 October 2024.[1]

Currently there is no legislative link between the amount of care that a residential aged care provider is required to provide to a resident under the *Quality of Care Principles* and the level of funding that they receive from the Australian Government through the Australian National

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1 Note, the term "care minutes" refers to the time spent delivering direct care to residents of an aged care home by registered nurses, enrolled nurses, personal care workers and assistants in nursing. Under the current regulatory arrangements, services delivered to residents by allied health staff and lifestyle and recreational staff do not count as care minutes, even when the aged care provider is required to deliver these services by the *Quality of Care Principles*.

See: Australia. Department of Health and Aged Care. (2023). *Care Minutes*.

Aged Care Classification (AN-ACC). A residential aged care provider must deliver the required services to a resident under their care even if the level of funding provided by the Government in respect of that resident (or in respect of all of their residents) is insufficient to cover the cost of those services.

This lack of connection between the quality standards and the funding levels has been a long-standing feature of Australia's aged care system. It was heavily criticised by the Royal Commission into Aged Care Quality and Safety ("the Royal Commission"), which attributed much of the poor quality of care that it had observed to the paucity of the funding decisions of successive governments.

> *At no point has the level of funding for aged care in Australia been determined by the actual cost of delivering aged care services to a specified quality standard. The amount spent on aged care services in Australia reflects the available funding envelope rather than the cost of delivering high quality care. This has had serious consequences for older people and the aged care sector.* [2]

This is why both Royal Commissioners recommended that an independent pricing authority should be established. Both Commissioners recommended that the Pricing Authority should have a determinative pricing power. Commissioner Pagone considered that the Pricing Authority's power to determine prices should be binding on the Australian Government, and not merely advisory. Commissioner Briggs considered that a balance needed to be struck between independence in price setting and budgetary control by the government of the day and recommended that the schedule setting out the Pricing Authority's determinations an instrument that is disallowable in Parliament. Where the Government wished to depart from the prices determined by the Pricing Authority, it would have to obtain a motion from either House of Parliament to disallow the schedule in an open and accountable manner.[3]

Neither the former Morrison Government nor the current Albanese Government has accepted this recommendation. More precisely, both "accepted" the recommendation but neither has implemented the recommendation in full. Since the passage of the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022*, the role of advising the Australian Government on aged care pricing matters has now been assigned to the Independent Health and Aged Care Pricing Authority (IHACPA). Section 131A(1)(a) of that Act states that the role of IHACPA is, *inter alia*:

> *… to provide advice to each relevant Commonwealth Minister in relation to one or more aged care pricing or costing matters, including in relation to methods for calculating amounts of subsidies to be paid under the Aged Care Act or the Aged Care (Transitional Provisions) Act 1997.*

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2 Royal Commission into Aged Care Quality and Safety. (2021). *Final Report*, Volume 2, p. 195.

3 Royal Commission into Aged Care Quality and Safety. (2021). *Final Report*, Volume 1, p. 151.

However, the role of IHACPA is only to advise on prices (subsidy levels) with the subsidy levels still determined by the Minister. Moreover, while it is true that the Instrument that sets subsidy levels is subject to disallowance such disallowance would only mean that subsidy levels remained at their previous level.

Rather than implementing the Royal Commission's recommendation, the Government has instead adopted an approach that is more in line with the recommendation that had been made a decade earlier (in 2011) by the Productivity Commission – namely:

> *… monitoring, reporting and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation for approved aged care services.* [4]

Nevertheless, although there is still technically no legislative link between the amount of care that a residential aged care provider is required to provide to a resident under the *Quality of Care Principles* and the level of funding that they receive from the Australian Government, **it is now much easier to analyse whether funding levels are adequate because the Australian Government is no longer purchasing an undefined "day of care"** which, theoretically allowed providers significant flexibility in how they went about delivering that care. Instead, the Australian Government has now defined closely what each day of care must (as a minimum) contain.

Moreover, as the residential aged care provider is not permitted to charge residents for these services, the funding the provider receives from the Australian Government through the Australian National Aged Care Classification (AN-ACC) must be adequate for the residential aged care provider to provide care services to the residents under their care that they are required to provide by legislation. In particular, the funding delivered to an aged care provider by the AN-ACC classification of a resident must be sufficient to allow an efficient aged care provider to meet:

- The full costs of any care minutes that they are required to deliver to the resident by the *Quality of Care Principles*.
- The full costs of any allied health services and any lifestyle and recreational services that they are required to deliver to the resident by the *Quality of Care Principles*.
- Any capital and consumable costs that are incurred in in respect to providing the care to the resident that is required by the *Quality of Care Principles*.[5]

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4 Productivity Commission. (2011). *Caring for Older Australians*. Inquiry Report No. 53, Vol 1, p lxxvi–lxxvii.

5 The Australian Government has repeatedly state that the funding provided by the AN-ACC is intended to cover all of these costs. See, for example:

> *AN-ACC funding is not separately allocated for different types of spending (e.g. by direct care, allied health care, lifestyle and consumable costs). Instead, providers are expected to use their AN-ACC funding to deliver*

In the attached paper, *A Lower Bound for the AN-ACC NWAU*, Professor Cullen has used the methodology, which he developed to estimate the efficient cost of delivering care minutes in the National Disability Insurance Scheme (NDIS) and that the Australian Government has used for the last five years to set the price limits for care providers in the NDIS, to estimate the fully loaded efficient cost of delivering care minutes in aged care.[6]

The attached paper shows that if a for-profit residential aged care provider is to meet all their aged care quality requirements and their industrial relations obligations then the minimum possible average fully loaded cost of delivering 200 care minutes per resident per day including at least 40 minutes of care from registered nurses is currently $257.59 per day. Given that the current NWAU is only $243.20 and that providers must incur costs other than care minute costs in delivering residential aged (allied health, recreational and lifestyle supports and care consumables) it is clear that the current NWAU is insufficient to allow providers to meet all their legal quality and industrial relations obligations. **As the attached paper demonstrates, a better estimate of the true current NWAU based on the efficient cost of care minutes and the average other direct care costs incurred across the sector is $292.87 – which is 20.5 per cent more than the current NWAU that is paid to aged care providers.**

This is, of course, not a surprise – noting that the Department of Health and Aged Care's own *Financial Report on the Australian Aged Care Sector 2021-22*, which was released on 14 August 2022, showed that the average EBITDA margin for residential aged care providers has decreased from 8.8 per cent in 2017-18 to -0.0 per cent in 2021-22.
The report stated that:

> *For providers delivering residential aged care services, profitability challenges were demonstrated by negative average earnings before interest, tax, depreciation and amortisation (EBITDA) per resident per year. In 2021–22, the average EBITDA declined for a fifth consecutive year to negative $46 per resident per year, a further decline from $3,771 per resident per year in 2020–21. While this decrease followed a trend in recent years, the decrease was greater in 2021–22 than all previous years.*[7]

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high quality care in line with what is required under the Aged Care Act 1997, including meeting the Aged Care Quality Standards

Department of Health and Aged Care (2023*). Questions and Answers: Residential Aged Care Funding Reform Webinar, 16 May 2023*, p. 14.

6 National Disability Insurance Agency. (2023). *Report of the National Disability Insurance Scheme Annual Pricing Review 2022-23.*

National Disability Insurance Agency. (2023). *National Disability Insurance Scheme Disability Support Worker Cost Model 2023-24*.

7 Department of Health and Aged Care. (2023). *Financial Report on the Australian Aged Care Sector 2021-22,* pp. 9-10.

Over the same period, the net profit before tax margin in the residential aged care sector fell from 2.4 per cent to -10.3 per cent.
Data for the first half of 2022-23 confirms that the situation is not improving.

> *Residential aged care homes continue to report poor financial performance. In the first half of 2022-23, over 63 per cent of homes operated at a loss, with an average deficit of $17.47 per resident per day. This is substantially worse than the deficit of $11.34 from a year prior. Homes' current poor performance continues a deteriorating long-term trend.*[8]

Recommendation 1
The Australian Government should immediately increase the residential aged care NWAU to $292.87 per day.

Recommendation 2
The Australian Government should better align the pricing arrangements for the aged care sector and the National Disability Insurance Scheme noting that many of the services delivered by the two sectors are similar and that the two sectors compete for the same workforce.

Recommendation 3
The Independent Health and Aged Care Pricing Authority should in future years use the Care Minutes Cost Model that has been developed by Professor Cullen as a "sense check" of its proposed NWAU.

Recognising the additional costs of delivering aged acre services on non-week days

Exhibit 1 below sets out the shift loadings for permanent workers that are imposed on residential aged care providers by the Aged Care Award (§23.1, §26.1, and §29.2) and the Nurses Award (§20.2, §21, and §28.2).

Exhibit 1: Shift Loadings, Aged Care Award and Nurses Award (Permanent Workers)

Shift	PC	PCA	EN	RN	DDON	DON
Weekday	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Saturday	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
Sunday	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
Public Holiday	150.0%	150.0%	100.0%	100.0%	100.0%	100.0%
Afternoon Shift	12.5%	12.5%	12.5%	12.5%	0.0%	0.0%
Night Shift	15.0%	15.0%	15.0%	15.0%	0.0%	0.0%

[8] Sutton N, Ma N, Yang JS, Lewi R, Woods M, Ries N, Parker D. (2023). *Australia's Aged Care Sector: Mid-Year Report (2022–23).* UTS Ageing Research Collaborative.

The loadings for Saturdays, Sundays and Public Holidays are significant and have a major effect on the cost of delivering care minutes on those days. Even where aged care providers currently meet the 200 care minute per resident per day requirement they do that on average across a quarter rather than on each day. As a result, staffing levels on Saturdays, Sundays and Public Holidays are usually much lower than on weekdays and even on weekdays care minutes are delivered by staff during normal working hours rather than at night wherever possible.

There are therefore dangers for any analysis that uses the current reported cost of delivering care minutes from the Stuart Brown Benchmarking Study or IHACPA's own cost study as these studies do not account for when the care minutes were delivered.
The current observed averaged cost of delivering, which is driven by rosters that preference weekdays, must therefore necessarily be below the true average cost of delivering care minutes to optimise quality – which would, for example, have the same levels of care minutes delivered on each day of the week.

Recommendation 4
The Australian Government should clarify whether the care minute requirement applies to each day of the week or applies on average across the reporting period.
If the care minute requirement applies to each day of the week then the Australian Government should seek advice from IHACPA on the impact of this policy change on the aged care NWAU.

Recommendation 5
IHACPA should adjust its costing study to account for when care minutes are delivered to residents.

Better indexing aged care funding levels

The Royal Commission into Aged Care Quality and Safety was very critical of the approach that successive governments had taken to the indexation of aged care subsidy levels. It found that the annual indexation arrangements that had been used for aged care subsidies had imposed an "efficiency dividend" on the sector and that between 1999-2000 and 2018-19, subsidy levels increased by 70.3% in nominal terms, whereas provider input costs increased by 116.3%. The Department of Health conceded in evidence to the Royal Commission that government action in relation to the indexation had "resulted in a history of unpredictable and unstable funding outcomes for providers" and that there was a need to address the level of indexation and for indexation to be determined in a more evidence-based way in the future.[9]

[9] Royal Commission into Aged Care Quality and Safety. (2021). *Final Report*, Volume 3, pp. 641-2.

The Royal Commission recommended (Recommendation 110) that:

1) *Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for residential aged care so that all care subsidies, and the viability supplement, are increased on 1 July each year by the weighted average of:*

   a) *60% of the yearly percentage increase to the minimum wage for an Aged Care employee – Level 3 under the Aged Care Award 2010 (clause 14.1) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages*

   b) *30% of the yearly percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the Nurses Award 2010 (clause 14.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages*

   c) *10% of the yearly percentage (to the 31 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.*

2) *Whenever the Fair Work Commission makes a change to a minimum wage in either the Aged Care Award 2010 or the Nurses Award 2010 other than as part of the annual review of award minimum wages, subsidies should be indexed from the operative date of those increases by the weighted average of:*

   a) *60% of the percentage increase to the minimum wage for an Aged Care employee – Level 3 under the Aged Care Award 2010 (clause 14.1) that is determined by the Fair Work Commission*

   b) *30% of the percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the Nurses Award 2010 (clause 14.3) that is determined by the Fair Work Commission. 3.*

3) *The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Pricing Authority has commenced independent determination of prices for residential care. PAGE 638 vol 3 rec 110.*[10]

This recommendation was not accepted by the then Australian Government, which instead made a number of one-off funding changes which did nothing to address the ongoing issue of inadequate indexation.

10 Ibid., p. 638.

Given the wealth of evidence that had been presented to the Royal Commission it was therefore disappointing to note that IHACPA's advice to the government on the indexation of aged care subsidies on 1 July 2023 continued to use a methodology that significantly undercompensated providers for the wage increase that was determined by the Fair Work Commission as part of the Annual Wage Case.

In future years, IHACPA needs to understand that workers in aged care are, in general, paid at the award wage level and that their wages will almost always move in line with movements in the award or above that. This is even truer today than it was twelve months ago since the recent 15 per cent increase as a result of the Fair Work Commission Aged Care Work Value case which has moved the award wage past any wage level set in any aged care enterprise agreement.

Hall & Prior understands that there is a technical difficulty in indexing subsidies in this way as the Fair Work Commission tends to make its Annual Wage Case Decision public in late June each year. However other Agencies, such as the National Disability Insurance Agency, have overcome this issue by expressing their indexation determination terms of the Fair Work Commission – just as the Royal Commission recommended. This means that providers have an early certainty that their income will move in some relation their expenses.

IHACPA could, for example, recommend a range of NWAU to government depending on the outcomes of the Fair Work Commission. This has the effect of ensuring that the final decision is appropriate for the given Fair Work Decision and is not "trimmed" so as to reduce the effect of such a decision.

Recommendation 6

The Australian Government should immediately seek advice from the Independent Health and Aged Care Pricing Authority as to the extent to which the indexation rate that was applied on 1 July 2023 to aged care subsidies undercompensated providers for the Fair Work Commission's Annual Wage Case.

Following receipt of the advice from the Independent Health and Aged Care Pricing Authority the Australian Government should retrospectively increase subsidy levels from 1 July 2023 to ensure that providers can meet their legal obligations and that staff are paid appropriately.

Recommendation 7

Until the Independent Health and Aged Care Pricing Authority has developed a comprehensive indexation methodology that is acceptable to the aged care sector it should accept the indexation methodology recommended by the Royal Commission.

The Importance of Ensuring Competitive Neutrality

Currently for-profit providers face significantly higher costs in delivering aged care services than their not-for-profit competitors because of the decision of the previous government in 2014 to remove the payroll tax supplement in order to generate savings. This lack of competitive neutrality, as we argue below and as Professor Cullen argues in the attached paper, *The Importance of Ensuring Competitive Neutrality in Aged Care Pricing*, must, if unaddressed, decrease the efficiency of the sector and increase costs for taxpayers.

From an economic perspective, payroll taxes are equivalent in direct effect to income taxes on employees, insofar as they add to the total cost of employment. However, they are wage-inflationary in a marginally less-productive way because they do not increase income to workers at the marginal tax rate, as they are simply a tax on overall payroll, not individual income; and they are progressive in a different way from personal income tax: instead of increasing in incidence according to individual capacity to contribute; they are a tax on scale across a business.

There are a number of consequences to this structure. The first of these is the marginal excess burden of taxation (MEBT, deadweight loss), which is the distortion to allocation of capital caused by selective taxation. It is estimated that the general deadweight loss of payroll tax is 37 cents. This is to say that for every dollar raised via payroll tax, the total cost to the economy including distortions is $1.37. As noted above, the effect is marginally different from personal income tax, due to incidence, and the deadweight for payroll taxes exceed that of income taxes at 33 cents. This reflects the particular distortion of payroll tax due to the exemption of those with lower payrolls, which leads to a greater appetite for employment within smaller enterprises who face a lower average cost of employment, even though they may be more inefficient overall or delivering lower quality services.[11]

This is not dissimilar from the distortion which is caused by exempting larger not-for-profit (NFP) firms in the aged care sector from payroll tax. Clearly this will make the average cost per equivalent employee lower for NFP firms. This will add to the deadweight loss of the payroll tax both in the aged care sector and overall.[12]

This in turn has three consequences for commercial aged care providers:

- It increases labour costs without any increase in benefits to the firm or its clients;
- It provides an incentive for commercial providers to reduce employment, either directly, or by replacing employees with technology solutions; and,

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11 Murphy, C. (2016). *Efficiency of the tax system: a marginal excess burden analysis*. Tax and Transfer Policy Institute Working Paper 4/2016, Australian National University, June 2016, p.4

12 All exemptions and variations to taxes increase MEBT because they distort optimal capital flows

- While the substitute of technology for labour is a long-term growth pathway, the deadweight loss of the tax means this will only occur inefficiently, because the labour/capital trade-off is incorrectly priced due to the incentive to reduce tax.

With respect to these consequences, it is worth noting that the Henry Tax Review recognised that while in the long run, payroll tax has a very similar effect to the labour component of personal income tax (i.e., the burden falls on workers), it acknowledged that the 'short run' is an imprecise concept, and that a number of firms may continue to produce in the short run for some time, trading off the expense of relocation with the need to "re-tool".
In summary, what this means is that:

- For-profit and not-for-profit aged care operators operate at different productive horizons; and,
- There is a particular inefficiency of the commercial operators' horizon due to the tax.

The distortion may have broader, sector-wide impacts too. The Henry Tax Review also pointed out that since a payroll tax will have the long-term effect of reducing the demand for labour and lowering wages, notwithstanding the delays in getting there, it may push into the untaxed sector some workers who might otherwise be more productive in the taxed sector. This implies a decline in average labour productivity in the sector.

The distortions discussed above have the impact of simultaneously:

- Preferring one group of market participants over another due to corporate structure, which attacks the principle of competitive neutrality; and,
- Reducing the value of Commonwealth payments for the care of older Australians in commercial residential facilities and also homecare, depending upon the provider.

Looking to the first issue, Australia is an adherent to the OECD's 2021 Recommendation of the Council on Competitive Neutrality, which includes a commitment to: "… ensure Competitive Neutrality by, to the maximum extent practicable and unless overriding Public Policy Objectives require otherwise." This commitment includes a recognition that Australia should: "… avoid offering undue advantages that distort competition and selectively benefit some enterprises over others. Such advantages would for example include loans, loan guarantees and state investment in capital, at conditions not in line with market principles, as well as favourable tax treatment, grants and goods or services provided by governments at favourable prices. Where achieving an overriding Public Policy Objective requires an exception, this should be transparent to all, proportionate and periodically reviewed."[13]

[13] Organisation for Economic Co-operation and Development. (2021). Recommendation of the Council on Competitive Neutrality.

It is well established that exposing firms to greater competition and increased openness sharpens incentives to reduce costs and innovate.[14] Competitive neutrality is a key measure to ensure open market competition by removing distortions that inhibit the flow of resources to their most efficient use. Attacks on competitive neutrality are part of the cause of deadweight losses for various taxes, including labour taxes. The competitive neutrality principle is that sellers of goods and services should compete on a level playing field: that is, one provider should not receive an advantage over another due to government regulation, subsidies or tax concessions. Competitive neutrality removes artificial advantages and allows businesses to compete on a basis that offers the best cost and quality combinations to customers. This is likely to result in more effective competition and more efficient outcomes. In turn, it will lead to greater consumer surpluses, as these are also attenuated by market distortion.

There are four main types of tax concessions provided by Australian governments: input tax concessions (including fringe benefits tax (FBT) goods and services tax (GST), payroll tax, stamp duty and gambling tax concessions); income tax concessions; wealth tax concessions (such as land tax); and the capacity for organisations to receive deductible gifts. As a general rule, those NFPs which provide the most benefit to the community in terms of alleviation of disadvantage are eligible to receive the most generous tax concessions: at the top of this list is charity providers who address the consequences of market failure, rather than NFP suppliers of competitive services.

However, Australia is unusual in providing some form of concession to most not-for-profits. Most other developed nations, such as the United Kingdom and New Zealand, provide tax concessions only to organisations with a charitable purpose.

In its 1995 report on Charities, the Industry Commission argued that the income tax exemption enjoyed by not-for-profits does not compromise competitive neutrality between organisations because any organisation which, regardless of their taxation status, aims to maximise their surplus (profit) would be unaffected in their business decisions by their tax or tax-exempt status.[15] With respect to input tax exemptions, however, the Industry Commission found that they could affect resource allocation in two ways: They create distortions in the use of different inputs; and they provide a competitive advantage for the commercial activities of not-for-profits compared with for-profits.

Input tax exemptions are distortionary because they change the relative price of inputs. The exemption lowers the price of some inputs and presents an incentive for not-for-profits to favour the use of those inputs over other, relatively higher priced, inputs. Where not-for-profits are labour intensive (as in aged care) the exemptions from taxes on labour (FBT and

14 Productivity Commission. (2005). *Review of National Competition Policy Reforms, Inquiry Report*. Canberra.

15 Industry Commission. (1995). *Charitable Organisations in Australia*.

pay-roll tax), may create significant distortions, particularly for the larger organisations. This could affect efficiency because it may mean that not-for-profits, because of the tax exemptions they receive, favour the use of tax-exempt inputs over other, more efficient, mixes of inputs. A significant consequence of this is a reduction in the rate of innovation, as the price of labour is kept low relative to technology.

Input tax exemptions are also inefficient because they allow certain tax-exempt organisations to attract resources away from organisations that are not tax exempt. By lowering the costs faced by exempt organisations, less efficient organisations are able to survive — and perhaps even expand — often at the expense of firms that may be relatively more efficient but do not have access to the same competitive advantages. This holds back overall market growth. As mentioned, to the extent that it encourages some workers seeking higher wages into the untaxed sector who might otherwise be more productive in the taxed sector, it reduces average labour productivity in the sector.

The Productivity Commission reconfirmed these findings in its 2010 Inquiry into the Contribution of the Not-for-Profit Sector:

> *Input taxes, in particular payroll tax and fringe benefits tax (FBT) concessions, can confer a significant advantage to eligible organisations by reducing their employment costs. They can also distort decisions on the allocation of funds between capital and labour.*
>
> *… For organisations competing for government-funded services, competitive neutrality can be restored if input tax concessions are taken into account in assessing value for money.*
>
> *… As a rule, it would be preferable for services to be funded in a transparent fashion and not rely on input tax concessions that can be relatively complex, costly and distortionary.*[16]

Competitive neutrality is a principle that promotes the equal treatment by governments of competing organisations to achieve a 'level playing field'. By encouraging competition for inputs and market share it aids in the efficient allocation of resources. It is notable here that where the restriction on competitive neutrality is by a government consuming services directly in the market, it is a single source of distortion; but when the restriction is by one government and affects the value or price of services consumed by another government, this effect is magnified. This is the case of State restrictions on services funded by the Commonwealth: the marginal tax revenue required to fund or finance the distortion to aged care costs is a second-round source of deadweight loss to the economy.

16 Productivity Commission. (2010). *Contribution of the Not-for-Profit Sector*. Research Report, p.197

Until 2014, the Australian Government's funding arrangements for residential aged care recognised that competitive neutrality principles required additional subsidies to be paid to for-profit providers of aged care to address the differential effect of taxes on inputs. From 1987-1999, the funding arrangements for nursing homes included a reimbursement arrangement – Other Cost Reimbursed Expenditure - for staff overhead costs such as long service leave, superannuation for nursing and personal care staff, payroll tax and workers compensation. From 1999-2014, the funding arrangements for high care residents in residential aged care included a payroll tax supplement payable to providers who incurred payroll tax costs.[17]

The importance of the payroll tax supplement in aged care was reaffirmed by the Productivity Commission in its 1999 Inquiry into Nursing Home Subsidies, which recommended that:

> *The current payroll tax supplement should be replaced by a system of cost reimbursement for payroll tax paid by providers for their employees and for contract nursing and personal care staff.*[18]

In making this recommendation the Commission notes that payroll tax was non-discretionary, with rates set at arms' length by State and Territory Governments, and had particular effect on one group of providers. It found that an exemption system (with corresponding grants made to State and Territory Governments) or a cost reimbursement system would therefore be warranted.

In work undertaken for the Australian Government's Review of Pricing Arrangements in Residential Aged Care, the Allen Consulting Group found the cleanest option to remove the distortion caused by the payroll tax exemption for not-for-profits:

> *… would be to remove the tax concessions from those who receive them, but this is unlikely to be practicable given the Commonwealth's recent reaffirmation of the tax status of not-for-profits organisations. The alternative is to compensate for the different tax treatment of providers through the aged care funding arrangements. This is currently done for payroll tax and would be in line with the Productivity Commission's principle that private providers should be supplemented to offset differential taxes levied on their inputs, provided the amounts involved are significant enough.*[19]

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17 Cullen, DJ. (2020). *Expenditure Constraints and Major Budget Measures*. Royal Commission into Aged Care Quality and Safety, RCD.9999.0522.0001.

18 Productivity Commission. (1999). *Nursing Home Subsidies*. Inquiry Report, p.104

19 Allen Consulting Group. (2003). *The Role of Not-for-Profit Bodies in Residential Aged Care*. Report to the Review of Pricing Arrangements in Residential Aged Care. Canberra: Department of Health and Ageing, p.10

In its 2010 Inquiry into the Contribution of the Not-for-Profit Sector, the Productivity Commission highlighted the payroll tax supplement arrangements in residential aged care. It also noted that there was an important distinction between the fringe benefit tax concessions and the payroll tax concessions afforded to not-for-profits – namely the incidence of the benefit:

> *Unlike the payroll tax exemption, where the eligible not-for-profit is the direct beneficiary, the fringe benefit tax concessions are a benefit provided directly to employees who vary in their ability to fully use the benefit provided. In other words, the size of the tax expenditure provided by the fringe benefit tax concession varies according to its usage by employees. This benefits the not-for-profit indirectly, by allowing it to employ staff at below market salaries (although there are exceptions such as nurses in hospitals as discussed below). For many NFPs operating outside the market sector this concession helps them to attract and retain staff even when they have insufficient revenue to pay full market salaries.*[20]

While both payroll tax and FBT exemptions have some common effect of reducing the final price of labour, they differ in intent. This is because FBT exemptions are intended to help NFPs compete for access to labour supply in a scarce market, by creating a benefit consumed by employees, whereas payroll tax exemptions have the character of a direct cash subsidy.

In 2013, the Australia Government established a National Commission of Audit with "a broad remit to examine the scope for efficiency and productivity improvements across all areas of Commonwealth expenditure, and to make recommendations to achieve savings sufficient to deliver a surplus of 1 per cent of GDP prior to 2023-24."[21] The Commission noted that, "in the interests of competitive neutrality, the Commonwealth currently refunds for-profit providers for the payroll tax that they pay" but recommended that, "this supplement should be terminated, as it is effectively shifting the payment of a State tax to the Commonwealth."[22]

While this conclusion is true in a formal sense, it ignores the broader goal of efficiency in the aged care system, as well as the cost to the Commonwealth as the dominant payer for aged care services. Unfortunately, the first-best option for the States and Territories to remove taxes from all aged care providers is practically impossible (and would in any case produce deadweight losses elsewhere in the economy). The Commission's recommendation was implemented in the 2014 Budget with savings over four years of $652.7 million.[23] The Royal

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20 Productivity Commission. (2010). *Contribution of the Not-for-Profit Sector*. Research Report, pp.208-9

21 Treasurer of Australia. (2013). Media release: "Coalition commences National Commission of Audit".

22 National Commission of Audit. (2014). *Towards Responsible Government: The Report of the National Commission of Audit Phase One*, Canberra: Treasury, p.140

23 Treasurer of Australia. (2014). *Budget 2014-15: Budget Measures.* Budget Paper 2, Commonwealth of Australia, p.189

Commission into Aged Care Quality and Safety estimated that this saving represented a 1.2% reduction in expenditure in 2017-18.24

The Chair of the Royal Commission into Aged Care Quality and Safety was very critical in his final report of the way in which successive governments had approached the funding of aged care and argued that:

> *The flaws in the current system arise, in my view, to a significant extent from the decisions by successive governments to consider aged care as a form of welfare for the very needy, to be provided to the bare minimum extent required*[25]
>
> *…*
>
> *The current aged care system and its weak and ineffective regulatory arrangements did not arise by accident. The move to ritualistic regulation was a natural consequence of the Government's desire to restrain expenditure in aged care. In essence, having not provided enough funding for good quality care, the regulatory arrangements could only pay lip service to the requirement that the care that was provided be of high quality.*[26]

He further argued that:

> *… the introduction of independent pricing is critical to restore or to instil confidence and trust between the sector and Government, and to instil confidence in the sustainability of the system in the wider community."*[27]

Moreover, as noted above, he and Commissioner Briggs recommended (Recommendation 115(4)(b)), that in undertaking its functions, the Pricing Authority should be guided, inter alia, by the following object:

> *… ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services, taking into account the principles of competitive neutrality.*[28]

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24 Cullen, DJ. (2020). *Expenditure Constraints and Major Budget Measures*. Royal Commission into Aged Care Quality and Safety, RCD.9999.0522.0001, p.14

25 Royal Commission into Aged Care Quality and Safety. (2021). *Final Report: Care Dignity and Respect*. Volume 1, p.12

26 Ibid., p.20

27 Ibid., p.16

28 Ibid., p.288

The Government accepted this recommendation in its response to the Final Report of the Royal Commission.[29]

In the context of this review, and the Government's acceptance of the Royal Commission's recommendations, Hall and Prior is of the view that there is a strong case to reinstate the Commonwealth's compensation to commercial providers for the cost of payroll taxes. In the absence of this, any measures to produce adequate and independent pricing will continue to be distorted by the variation in incidence of taxes.

The argument, as set out in the attached paper, is that the productivity loss that would eventuate if for-profit firms exit the market and are replaced by NFP firms more than offsets the costs of any payroll tax supplement. Importantly, levelling the playing field should increase the appetite for competitive capital investment into commercial aged care, which will over time reduce the market share of NFPs. This is efficient because as noted above, any increase in payroll tax supplement for an increase in for-profit share will be more than compensated by the productivity gain of replacing an NFP with a for-profit provider.

The principal consequences of relatively lower efficiency of NFP providers, coupled with growth in Commonwealth expenditure, are that costs will rise by a higher-than-necessary rate, while efficiency in the sector will be held back. Both these would be corrected by Commonwealth compensation of payroll taxes for commercial providers.

Recommendation 8
The Australian Government should agree to address the market distortion that payroll taxes are currently imposing on the aged care market by immediately reintroducing a reimbursement / supplement arrangement for providers who are subject to payroll tax.
In the longer term the Australian Government should agree with the states and territories that payroll taxes should not be applied to aged care providers.

Recommendation 9
The Independent Health and Aged Care Pricing Authority should ensure that it captures cost data on payroll taxes in its costing exercise to ensure that it can take these costs into account in setting aged care prices.

Recognising how costs vary across Australia

Before the structural reform of aged care that commenced in 1997, the funding arrangements for hostels were uniform across Australia. However, the basic subsidy rates that were payable in respect of nursing home care varied by state and territory. This continued to be the case for the first few years of the new arrangements. For example, in 1998-99, the rate of basic

[29] Prime Minister of Australia. (2021). Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, p. 78

subsidy for the highest classified resident varied between $90 in Queensland and $110 in Tasmania. It was not until 1 July 2006 that a single basic subsidy rate applied across Australia.[30] The differential funding rates that had applied before 1997 reflected the fact that most aged care workers were employed under state based awards and that some of the regulatory standards for aged care were imposed by state governments and differed between the states. The policy of coalescence towards single national rates was proposed by the then Australian Government as a natural continuation of the move to national regulation for aged care quality.

> *… hostel rates had always been national, nursing home infrastructure rates had already been coalesced to a single national rate over five years and personal and care salaries were coalescing themselves in the period before structural reform. Given these developments, and the desire of the Commonwealth to purchase consistent outputs rather than to fund inputs, the strategy of coalescence was the natural progression of funding policy.*[31]

Theoretically appealing as these arguments are, the reality is that input costs do vary between states and territories just as they vary between regions. The following illustrates the extent of variation between states/territories of the costs of employing:

- Personal carers – proxied by average weekly earnings.
- Allied Health Therapists – proxied by the private billing rates of therapists.
- Nurses – proxied by payscale.com's reported average earnings.

Average weekly ordinary time earnings are currently 10.9 per cent higher than the national average in Western Australia ($2,039.30 per week compared to $1,838.10 per week) and 11.9 per cent lower in Tasmania ($1,619.30 per week) – see Exhibit 2 below. Moreover, these differentials are long standing and on-going (see Exhibit 3) and are significant enough to have an impact on the ease with which aged care providers can attract workers into the sector and wages across the care sector.[32]

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30 Productivity Commission. (1999). *Nursing Home Subsidies*. Inquiry Report.

Cullen D, and Horne M. (2003). *The Commonwealth Legislative Framework*. Review of Pricing Arrangements in Residential Aged Care: Background Paper 2.

31 Department of Health and Family Service. (1998). Submission to the Productivity Commission Inquiry into Nursing Home Subsidies, p. 20.

32 Australian Bureau of Statistics. (2023). *Average Weekly Earnings Australia, May 2023*.

Exhibit 2: Average weekly ordinary time earnings, full-time adults by state, original (May 2023)

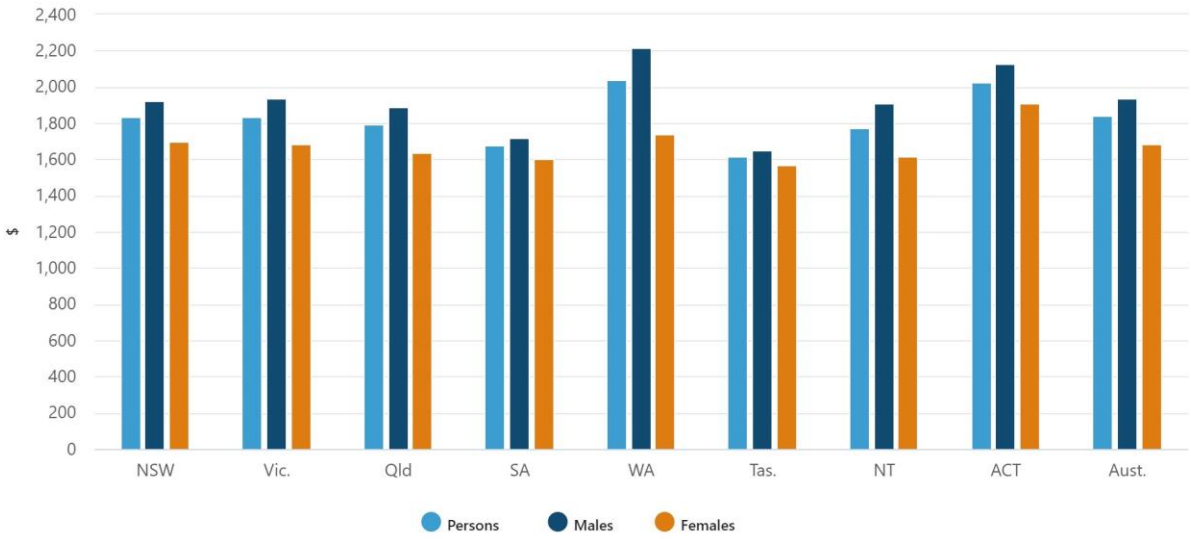
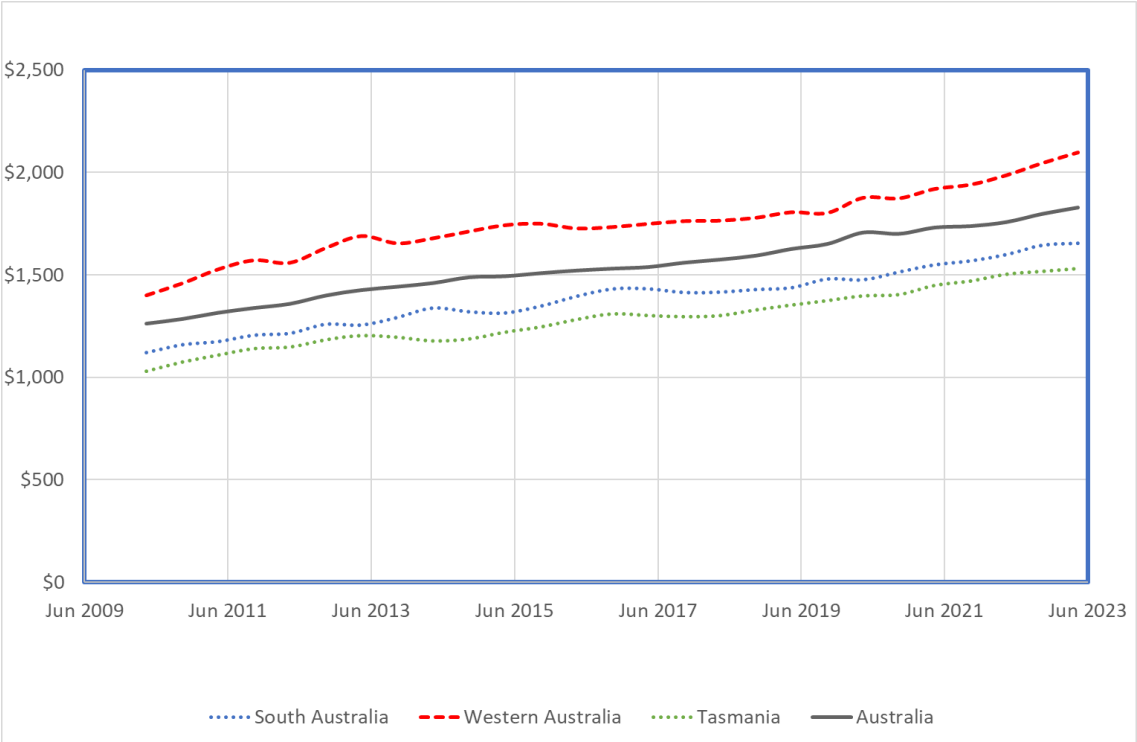


Exhibit 3: Average weekly ordinary time earnings, full-time adults by state, original (May 2010 to May 2023)



There are also significant differences in the cost of therapy between states and territories. The results of an analysis of private therapy hours rates that was undertaken by the National Disability Insurance Scheme 2022-23 Annual Pricing Review is summarised in the first two columns of Exhibit 4 below.[33] In brief, the cost of employing therapists is 4.7 per cent higher than the national average in New South Wales and 6.0 per cent lower than the national average in Queensland and Tasmania.

Exhibit 4: Statistical Model of Private Therapy Billing Rates

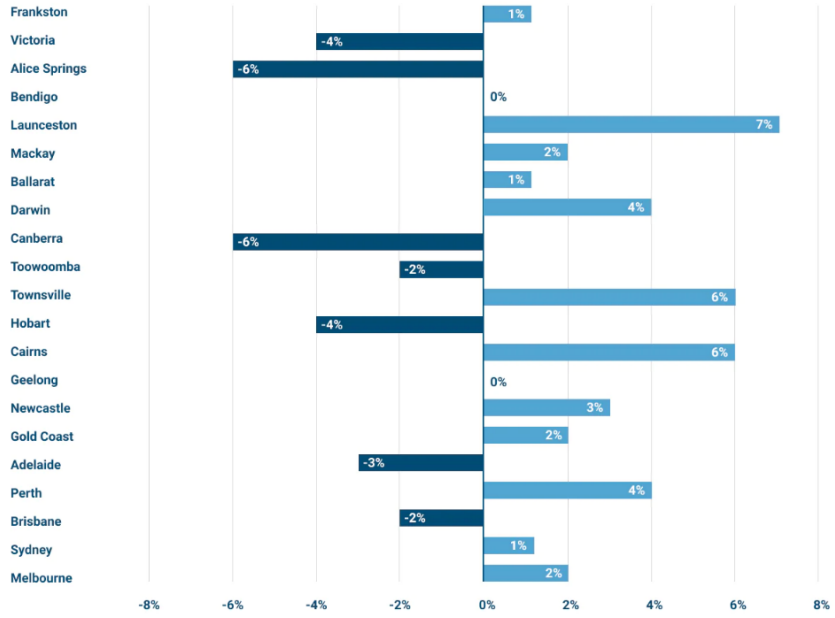
Variable	Parameter	Imputed Price	Difference to National Average
National Average		$180.51	
Constant (NSW)	188.9***	$188.90	4.7%
Victoria	-8.9***	$180.00	-0.3%
Queensland	-19.2***	$169.70	-6.0%
South Australia	-10.9**	$178.00	-1.4%
Western Australia	-7.5*	$181.40	0.5%
Northern Territory	-6.9**	$182.00	0.8%
Australian Capital Territory	-$7.9	$181.00	0.3%
Adjusted R^2	0.369		
F Statistic	152.8		

Finally, there are significant differences between and within states/territories in the costs of employing nurses (see Exhibit 5).[34]

33 National Disability Insurance Agency. (2023). *Report of the National Disability Insurance Scheme Annual Pricing Review 2022-23.*

34 https://www.payscale.com/research/AU/Job=Registered_Nurse_(RN)/Hourly_Rate

Exhibit 5: Percentage Difference from National Average (Average Nurse Wage)



The Australian Government already pays a higher fixed component basic subsidy to some providers in recognition of the higher costs faced by providers in remote areas. However, the level of that additional subsidy has not been independently verified. Nor has the issue of whether costs are sufficient different between jurisdictions to justify state based subsidy rates.

Recommendation 10

The Australian Government should fund the Independent Health and Aged Care Pricing Authority to undertake a substantive costing study to determine:

(a) Whether there are any material differences in the cost of delivering aged care services between jurisdictions.

(b) Whether there are any material differences in the cost of delivering aged care services within jurisdictions.

(c) Whether any material differences that are found to exist are likely to be sustained or transitory.

Risks that arise from applying activity-based funding to aged care

Entrenching distortions imposed by funding constraints.

As discussed above, a principal defect in the past and current aged care legislation is that there has never been and is currently no explicit link whatsoever between price levels and the

quality standards. Given the strong evidence gathered by the Royal Commission that current funding levels are insufficient to meet current quality standards – let alone the costs of meeting any increase in those quality standards through requirements for greater staff numbers or qualifications, any attempt to set prices for aged care services based on current levels of expenditure is doomed to failure.[35]

The current funding constraints on providers mean that their current expenditure levels do not necessarily represent the prices necessary to deliver high quality care. The current funding constraints also distort the expenditure decisions of providers between participants in ways that are unrelated to their relative care needs.

As a thought experiment to illustrate this distortion, assume that every care intervention has the same unit price and that a provider has three residents with the following care needs:

- Resident A – three life saving interventions and three other interventions that improve quality of life and are required by the quality regulations
- Resident B – one life saving intervention and three other interventions that improve quality of life and are required by the quality regulations
- Resident C – one life saving intervention and one other intervention that improves quality of life and is required by the quality regulations

Now the true cost relativities of the residents are 6:4:2 – but if the total funding to the provider is only five units then it is highly likely that the provider will have spent the funds in the ratio 3:1:1. Given the current artificial constraints (unrelated to care needs) on aged care funding, any classification system that builds its prices based on current levels and mix of expenditure will

- Underestimate the prices that should be paid for all residents as it will "assume" that current quality standards are met by current funding levels.
- Underestimate the relativities in costs between the different classifications of residents as the current constrained distribution of available funds does not align with the distribution of needs. In particular, the prices set for residents B and C might be the same under this methodology even though one resident has twice the care needs of the other resident.

It is also concerning that the funding model design is based on current practice within residential aged care facilities, which does not necessarily reflect best practice because it does not adequately take into account the social and emotional needs of residents, or indeed adequately meet their care needs.

[35] The additional funding provided by the Australian Government for the increase in the number of care minutes and the Fair Work Commission's Work Value Case have not addressed the fundamental underfunding of the sector as they have, at best, only provided sufficient additional funding to meet the additional costs associated with the increased requirements.

It is important to remember that the staff time data collected for the study to determine fixed and individual costs was based on what happens now in residential facilities, in a context where providers may be struggling to provide high quality care. As outlined in the thought experiment discussed above, there is a considerable risk that the introduction of the AN-ACC will result in one flawed system being replaced by another.

The relative weights of the various AN-ACC classes are especially problematic as they are a reflection not of care need but of care decisions by providers made in the face of heavily constrained funding.

Recommendation 11
The Australian Government should commission an independent study of the average care needs requirements of residents in each AN-ACC classification based on best practice and unconstrained by current funding levels.

Once that study is completed the Australian Government should seek advice from IHACPA on the impact of this policy change on the aged care NWAU.

Risks in an Activity Based Funding Approach – the Law of Small Numbers

There are fundamental issues that militate against the use of activity based funding (ABF) in aged care because the law of large numbers does not apply to aged care to the extent that it does to hospitals. The principle behind any ABF system is that paying on the basis of average costs for a particular type of episode of care will generate sufficient revenue across all episodes of care of that type to cover the aggregate costs of delivering all of the episodes of that type of care. This design principles relies on three key assumptions:

- The number of episodes of care of a given type delivered by a provider must be sufficiently large to ensure that the average costs of the sample of episodes delivered by the provider is close to the total average cost if all episodes of that type delivered by all providers.
- The variation in costs between episodes of the same type of care should not be too large, especially where samples (individual provider case loads) are not large.
- The classification system should ensure that similar episodes of care are classified similarly – which requires a large number of possible classifications and clear reasons as to why costs should vary between those classifications.

None of these assumptions obtain in the case of residential aged care. With respect to the first assumption, given statistical variance decreases with the square root of the sample size, it follows that the confidence interval around the true average payment required to meet the costs of the patient mix serviced by a provider increases as the number of billable episodes decreases. However, a large aged care home (of say 100 beds) is likely to classify about 130 residents in any given year. By contrast, the average public hospital deals with 10,000 billable episodes in a year, with large hospitals dealing with up to 100,000 billable episodes. This

means that the confidence interval around the actual payment for a residential aged care provider – is about 9 times greater than for an average public hospital and about 23 times greater than for a large public hospital. That is, there is significantly more risk in the case of residential aged care that the provider's actual costs will be significantly different from the overall average cost.

This risk is further exacerbated by the immaturity of the aged care funding arrangements which have not yet developed the special treatments that are applied to outliers in the hospital funding arrangements.

With respect to the second assumption, little evidence has been published about the within group variation in costs in the AN-ACC classification system. Moreover, the very small size of the costing population (120 homes out of 2,700) means that the study is not sufficiently large to accurately estimate the true costs of care, especially for cell sizes that are very small.

With respect to the third assumption, it is noted that there are only 13 classifications in the AN-ACC compared to about 800 in AR-DRG11.

Finally, it should also be noted that the hospital funding arrangements are essentially a funding agreement between the Commonwealth and the State. The revenue provided to each hospital by their state government is not totally dependent on the classification of their patients. By contrast, the funding arrangements in aged care are between the Australian Government and individual business which sink or swim on the basis of the classification of their residents. Moreover, unlike in hospitals, individual care recipients can be directly affected by funding decisions. **All of this argues for the IHACPA to take a very conservative view in setting funding levels with an upwards bias towards quality and safety.**

Recommendation 13

The Independent Health and Aged Care Pricing Authority should adopt a conservative view in setting funding levels with an upwards bias towards quality and safety given the direct link between the adequacy of funding levels and quality of care in aged care homes.

Again than you for the opportunity to make this submission. If you have any queries about any of the information contained in this document please don't hesitate to contact me.

Yours sincerely

GRAEME PRIOR
Chief Executive Officer

HALL & PRIOR
Health & Aged Care Group

Compassionate people, dedicated to care

A Lower Bound for the AN-ACC NWAU

Dr David Cullen

Adjunct Professor, Macquarie University Centre for the Health Economy

21 August

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Table of Contents

Executive Summary

The Care Minutes Cost Model (CMCM) set out in this document estimates the fully-loaded cost of delivering care minutes in an efficient aged care home taking into account the different types of workers who are needed to deliver that care and the different shifts that the care minutes need to be delivered across.

The CMCM estimates the care minutes component of the AN-ACC NWAU by taking account of all the costs that an efficient aged care provider must incur in delivering care minutes and attributing those costs to the care minutes that the provider is required to deliver, including:

- **Employment costs** – The costs of employing the worker who is delivering the care minutes, including their base pay; shift loadings; leave costs; worker allowances; and salary on costs like superannuation, payroll tax and workers compensation.
- **Supervision costs** – The costs of employing the front-line supervisor of the worker who is delivering the care minutes, including their base pay; shift loadings; leave costs; worker allowances; and salary on costs like superannuation, payroll tax and workers compensation.
- **Corporate and operational overheads** – The costs associated with the employment of the worker who is delivering the care minutes, including IT costs, HR costs, payroll and finance costs, training costs and a return on the working capital invested in the aged care home's care operations by the aged care provider.
- **Utilisation costs** – The employment costs of necessary but non-claimable activities that are undertaken by the worker who is delivering the care minutes This includes time spent in training; award conditions of employment, including paid breaks; and administrative tasks.

The CMCM also takes account of the different costs that arise when the care minutes are delivered by a permanently employed worker, a casually employed worker or by agency staff (or overtime).

The CMCM estimates that if for-profit residential aged care providers meet all of their industrial relations obligations then the minimum possible average fully loaded cost of delivering 200 care minutes per resident per day including at least 40 minutes of care from registered nurses is currently $257.59 per day.

The current NWAU of $243.10 per day is insufficient to allow providers to meet this cost, let alone the costs of any allied health and lifestyle and recreational services, and care consumables, that the provider is also required to deliver to the resident by the current aged care regulatory arrangements from the funding delivered by the WAY.

The best estimate of the true current NWAU based on the results of the CMCM aet out in this paper and the average other direct care costs incurred across the sector is $292.87 – which is 20.5 per cent more than the current NWAU that is paid to aged care providers.

Moreover, the analysis in this paper indicates that providers can only meet their legal and industrial obligations within the existing NWAU by:

- Significantly cutting expenditure on quality controls and staff supervision; and
- Reducing the level of care available at nights; and
- Reducing the level of care available on non-weekdays; and
- Reducing the level of allied health and lifestyle and recreational services offered to residents.

These changes would have a significant negative impact on the quality of care recipients by residential aged care residents and would not be in line with the recommendations of the Royal Commission into Aged Care Quality and Safety.

Introduction

The funding that is paid to residential aged care providers by the Australian Government on the basis of the Australian National Aged Care Classification (AN-ACC) of a resident is intended to cover the costs, including the cost of any care consumables, incurred by the provider in delivering to that resident:

- The **care minutes** that the provider is required to deliver to the resident, based on the AN-ACC classification of the resident; and
- Any allied health and lifestyle and recreational services that the provider is required to deliver to the resident.[1]

The Care Minutes Cost Model (CMCM) set out in this report estimates the **fully loaded cost** of delivering care minutes in an efficient aged care home that does not have access to the tax benefits that apply to not-for-profit providers. The CMCM does not, therefore, estimate the full National Weighted Average Unit (NWAU) that underlies the funding levels determined by the AN-ACC. Rather, it estimates the care minutes component of the NWAU, which provides a lower bound against which the adequacy of any proposed NWAU can be assessed.

The CMCM estimates the care minutes component of the AN-ACC NWAU by taking account of all the costs that an efficient aged care provider must incur in delivering care minutes and attributing those costs to the care minutes that the provider is required to deliver. The fully loaded cost of delivering care minutes includes:

- **Employment costs** – The costs of employing the worker who is delivering the care minutes, including their base pay; shift loadings; leave costs; worker allowances; and salary on costs like superannuation, payroll tax and workers compensation.

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[1] Australia. Department of Health and Aged Care. (2023). *Care Minutes*.

Australia. Department of Health and Aged Care. (2023). *Care Minutes and 24/7 Registered Nurse Responsibility Guide*.

The term **care minutes** refers to the time spent delivering direct care to residents of an aged care home by registered nurses, enrolled nurses, personal care workers and assistants in nursing. Under the current regulatory arrangements, services delivered to residents by allied health staff and lifestyle and recreational staff do not count as care minutes, even when the residential aged care provider is required to deliver these services by Schedule 1 of the *Quality of Care Principles*.

- **Supervision costs** – The costs of employing the front-line supervisor of the worker who is delivering the care minutes, including base pay; shift loadings; leave costs; worker allowances; and salary on costs.
- **Corporate and operational overheads** – The costs associated with the employment of the worker who is delivering the care minutes, including IT costs, HR costs, payroll and finance costs, training costs and a return on the working capital invested in the aged care home's care operations by the aged care provider.
- **Utilisation costs** – The employment costs of necessary but non-claimable activities that are undertaken by the worker who is delivering the care minutes This includes time spent in training; award conditions of employment, including paid breaks; and administrative tasks.

The CMCM makes its calculations by carefully distinguishing between:

- **Claimable hours** – The hours of employment when the worker engages in activities that can be counted by the aged care provider towards the number of care minutes that they are required to deliver to their residents.
- **Worked hours** – The hours of employment when a worker is available to undertake work. Worked hours include time when the worker is engaged in non-claimable activity such as training or administration as well as claimable hours.
    - These hours are accounted for in the cost model by inflating the cost of each worked hour by a **utilisation factor** to calculate the cost of each claimable hour.
- **Paid hours** – The hours when a worker is paid. Paid hours include time when the worker is on leave and worked hours that are not claimable hours and claimable hours.
    - These hours are accounted for in the cost model by including the accrued cost of leave in the computed cost of each worked hour.

Except where otherwise indicated, the assumptions in the CMCM are based on the minimum conditions of employment that are set out in the Aged Care Award, the Nursing Award, and the National Employment Standards as these represent the minimum possible cost of delivering services for an employer who is compliant with their industrial relations obligations.

Employment Costs

This chapter is concerned with estimating the direct costs of employing the workers who are delivering the "care minutes" that aged care providers are paid to deliver, including:

- Base Pay Rates.
- Shift Loadings.
- Worker Allowances.
- Leave Costs.
- Salary-Like On-Costs – Superannuation.
- Other On-Costs – Payroll Tax and Workers Compensation.

The estimates developed in this chapter are for workers who are employed on a permanent basis who are not working overtime. Adjustments to the CMCM for casual workers and for workers who are working overtime are discussed later in this document (pages 31 and 32).

KEY INDUSTRIAL CONDITIONS AND DEFINITIONS

The pay and conditions of workers in aged care are governed by the relevant industrial relations legislation. The national award for workers (other than nurses) in residential aged care is the *Aged Care Award 2010*. The national award for nurses is the *Nurses Award 2020*. The National Employment Standards govern leave and several other conditions in Awards.

Aged Care Award

For workers covered by the Aged Care Award, the **ordinary hours of work** are 38 hours per week, or an average of 38 hours per week worked over 76 hours per fortnight or 114 hours per 21 days or 152 hours per four-week period, and are required to be worked either in a period of 28 calendar days of not more than 20 work-days in a roster cycle; or in a period of 28 calendar days of not more than 19 work-days in a roster cycle, with the twentieth day taken as an accrued paid day off; or eight hours on a day shift or 10 hours on a night shift (§22.1).

The ordinary hours of work for a **Day Worker** must be worked between 6 am and 6 pm Monday to Friday (§22.2).

A **Shift Worker** is a worker who is regularly rostered to work their ordinary hours outside the ordinary hours of work of a Day Worker. For the purposes of the CMCM, the Aged Care Award provides for four types of Shift Workers:

- **Saturday work** – Any ordinary hours worked between midnight on Friday and midnight on Saturday.
- **Sunday work** – Any ordinary hours worked between midnight on Saturday and midnight on Sunday.
- **Afternoon Shift** – Any shift that commences at or after 1 pm and before 4 pm.
- **Night Shift** – Any shift that commences at or after 4pm and before 4 am.[2]

Full-time workers are required to receive a minimum payment of four hours for each engagement in respect of ordinary hours of work. Permanent part-time and casual workers are required to receive a minimum payment of two hours for each engagement (§22.7).

Nurses Award

Under the Nurses Award, the **ordinary hours of work** for a full-time worker are 38 hours per week, or 76 hours per fortnight, or 152 hours over 28 days (§13.1).

The ordinary hours of work for a **Day Worker** must be worked between 6.00 am and 6.00 pm Monday to Friday (§13.1).

A **Shift Worker** is a worker who is regularly rostered to work their ordinary hours outside the ordinary hours of work of a Day Worker (§13.1). The Nurses Award provides for four types of Shift Workers:

- **Saturday work** – Any ordinary hours worked between midnight on Friday and midnight on Saturday.
- **Sunday work** – Any ordinary hours worked between midnight on Saturday and midnight on Sunday.
- **Afternoon Shift** – Any shift that commences not earlier than 12.00 noon and finishes after 6.00 pm on the same day.
- **Night Shift** – Any shift that commences on or after 6.00 pm and finishes before 7.30 am on the following day.

The length of a shift or the number of ordinary hours of work per day cannot be more than 10 hours exclusive of meal breaks (§13.1). Hours of work are required to be continuous, except for meal breaks (§13.1). Except for the regular changeover of shifts, a worker cannot be required to work more than one shift in each 24 hours (§13.1).

As discussed later in this report, these minimum shift engagement periods and the other shift conditions impose significant constraints on the ability of providers to minimise their staffing costs. It is important that these constraints are fully accounted for in determining the efficient cost of delivering care minutes.

Better Off Overall Test

Some workers in aged care are employed under Enterprise Bargaining Agreements (EBAs) rather than directly under Awards. However, the Better Off Overall Test (BOOT) requires that each award covered worker, and prospective award covered worker, is better off overall under the EBA than they would be if the relevant modern award applied. EBAs can also not offer conditions below those set in the National Employment Standards.[3]

Other workers in aged care are employed under employment contract. However, these arrangements similarly cannot provide for less than the legal minimum entitlements set out in the National Employment Standards, and in awards, enterprise agreements or other registered agreements that may apply.[4]

BASE PAY RATES

Table 1 sets out the minimum wages for several key types of residential aged care workers, including front-line supervisors (if they are employed on a permanent basis). These minimum wages are specified in the Aged Care Award (§14.3 – Minimum rates for direct care workers) and the Nurses Award (§15.2 – Minimum rates for aged care employees).

Table 1: Typical Residential Aged Care Worker Classifications and Award Pay Rates, 1 July 2023

Description	Acronym	Award	Award Classification	Hourly Rate
Personal Carer	PC	Aged Care Award	Aged Care Worker – Level 4	$30.11
Personal Carer (Advanced)	PCA	Aged Care Award	Aged Care Worker – Level 5	$31.33
Enrolled Nurse	EN	Nurses Award	Enrolled Nurse Pay Point 5	$32.26
Registered Nurse	RN	Nurses Award	Registered Nurse Level 1 Pay Point 8	$39.43
Deputy Director Nursing	DDON	Nurses Award	Registered Nurse Level 4 Grade 3	$56.81
Director of Nursing	DON	Nurses Award	Registered Nurse Level 5 Grade 6	$72.83

[3] Fair Work Commission. (2021). Enterprise Agreements Benchbook, pp.135-62.

[4] Fair Work Ombudsman. (2023). Employment Contracts.

SHIFT LOADINGS

Table 2 sets out the CMCM's assumptions with respect to shift loadings for permanent workers. For Personal Carers and Personal Carers (Advanced) these are based on the provisions of the Aged Care Award (§23.1, §26.1, and §29.2). For Enrolled Nurses, Registered Nurses, Deputy Directors of Nursing and Directors of Nursing these are based on the provisions of the Nurses Award (§20.2, §21, and §28.2).

Table 2: Shift Loadings, Aged Care Award and Nurses Award (Permanent Workers)

Shift	PC	PCA	EN	RN	DDON	DON
Weekday	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Saturday	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
Sunday	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
Public Holiday	150.0%	150.0%	100.0%	100.0%	100.0%	100.0%
Afternoon Shift	12.5%	12.5%	12.5%	12.5%	0.0%	0.0%
Night Shift	15.0%	15.0%	15.0%	15.0%	0.0%	0.0%

WORKER ALLOWANCES

Under the Aged Care Award, employers are required to pay their workers several allowances in addition to their pay in certain circumstances. These include:

- A uniform allowance of $1.23 per shift, up to a maximum of $6.24 per week (§15.2).[5]
- A laundry allowance of $0.32 per shift, up to a maximum of $1.49 per week (§15.2).
- A nauseous work allowance of $0.54 per hour or part thereof with a minimum of $2.93 per week (§15.5).[6]

The uniform and laundry allowance are also payable under the Nurses Award (§17.3).

The CMCM assumes that, given the nature of the work in an aged care home, all workers are entitled to the maximum uniform and laundry allowances and the minimum nauseous work allowance – or that the provider incurs similar costs by providing and laundering the

[5] If the employer requires an employee to wear uniforms, then they must either supply the worker with an adequate number of uniforms appropriate to the occupation free of cost to employees or the employer may, by agreement with the employee, pay such employee a uniform allowance. Where such employee's uniforms are not laundered by or at the expense of the employer, the employee must also be paid a laundry allowance. The uniform allowance, but not the laundry allowance, are required to be paid during all absences on paid leave, except absences on long service leave and absence on personal/carer's leave beyond 21 days.

[6] The nauseous work allowance is payable if the worker is engaged in handling linen of a nauseous nature other than linen sealed in airtight containers and/or for work which is of an unusually dirty or offensive nature having regard to the duty normally performed by such employee in such classification.

uniforms. For 2023-24, this equates to an allowance of $0.28 per worked hour for Personal Carers and PCAs and to an allowance of $0.20 per worked hour for nurses.

LEAVE COSTS

Each permanent worker is not available to perform work on 260 days (5 * 52) each year, because, under the National Employment Standards, they must be paid for:

- Annual leave.
- Personal leave.
- Paid family and domestic violence leave.
- Long service leave.
- Public holidays.

The CMCM recognises that providers need to accrue revenue to meet the costs of these leave accruals, which are paid days, during the claimable hours worked by the worker.

Annual Leave

Entitlement

Under the Aged Care Award, permanent workers are, in general, entitled to four weeks annual leave in line with the National Employment Standards (§28.1). A permanent worker who is a Shift Worker and/or who works for more than four ordinary hours on 10 or more weekends is entitled to five weeks annual leave (§28.2).

Under the Nurses Award, permanent workers are, in general, entitled to five weeks annual leave (§22.2(a)). A permanent worker who is a Shift Worker who is regularly rostered over seven days of the week and who regularly works on weekends is entitled to six weeks annual leave (§22.2(b)).

For simplicity, the CMCM assumes that:

- All PCs and PCAs delivering day shifts are entitled to four weeks annual leave and that all PCs and PCAs delivering Afternoon, Night, Saturday, and Sunday shifts are entitled to five weeks annual leave.
- All ENs and RNs delivering day shifts are entitled to five weeks annual leave and that all ENs and RNs delivering Afternoon, Night, Saturday, and Sunday shifts are entitled to six weeks annual leave.
- DDONs and DONs are entitled to five weeks annual leave as they are assumed to perform all their work during day-shifts.

These assumptions likely underestimate the annual leave costs of some workers – those who work a mix of day shifts and other shifts – as these workers would also be entitled to the longer period of annual leave if they are regularly rostered over seven days of the week or regularly work on weekends in addition to working on day shifts.

Leave Loading

Under the Aged Care Award, permanent workers, other than Shift Workers, are entitled to be paid a 17.5 per cent loading of their ordinary pay during a period of annual leave (§28.3). A permanent worker who is a Shift Worker on annual leave is entitled to be paid, in addition to their ordinary pay, the higher of: an annual leave loading of 17.5 per cent of their ordinary rate of pay; or the weekend and shift penalties the worker would have received had they not been on leave (§28.3).

Under the Nurses Award, permanent workers, other than Shift Workers, are entitled to be paid a 17.5 per cent loading of their ordinary pay on a maximum of four weeks' annual leave per annum (§22.5). A permanent worker who is a Shift Worker on annual leave is entitled to be paid, in addition to their ordinary pay, the higher of an annual leave loading of 17.5 per cent of their ordinary rate of pay; or the weekend and shift penalties the worker would have received had they not been on leave (§22.5).

Note, for ease of calculation the CMCM applies a 14per cent loading to all five weeks of annual leave for nurses working day shifts.

Neither the Aged Care Award nor the Nurses Award provide for an additional loading on pay for any other type of leave.

Amount Claimed

Under the National Employment Standards, a worker's entitlement to annual leave accrues if it is not taken and the accrued leave entitlement must be paid out when the worker ceases employment with the provider.

The CMCM therefore assumes that all annual leave entitlements are claimed by the worker.

Personal Leave

Entitlement

Under the National Employment Standards, permanent workers are, in general, entitled to four weeks annual leave.

Amount Claimed

Although personal leave accrues if it is not used, the accrued leave entitlement is not paid out when the worker ceases employment with the provider. Nevertheless, based on recent

absence management surveys and taking into account the continued presence of COVID in the community, there is significant evidence that most employees are increasingly using a significant share of their personal leave.

The CMCM assumes that 70 per cent of personal leave entitlements are claimed each year.[7]

Paid Family and Domestic Violence Leave

Entitlement

Under the National Employment Standards, permanent workers are, in general, entitled to four weeks paid family and domestic violence leave.

Amount Claimed

The CMCM assumes that 1 per cent of entitlements to paid family and domestic violence leave will be claimed each year.[8]

Long Service Leave

Entitlement

Long service leave forms part of the National Employment Standards. If a pre-modernised award does not apply to a worker, any entitlement to long service leave is derived from applicable State or Territory long service leave laws. The State or Territory long service leave laws generally prevail over any provisions in an enterprise agreement to the extent that they are inconsistent with those laws.

- In New South Wales, Queensland, Western Australia, and Tasmania workers are entitled to long service leave after 10 years of service with the same employer accrued at the rate of 0.867 weeks per year worked.
- In Victoria and the ACT, workers are entitled to long service leave after 7 years of service with the same employer accrued at the rate of 0.867 weeks per year worked.

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[7] Direct Health Solutions. (2023). *Absence management and wellbeing survey*, 12th edition. The most recent (2022) survey found that, on average, Australian employees took 13.8 days of personal leave a year.

[8] This assumption is based on the female dominance of the care sector and the following key statistics:

- 3 per cent of females in workforce experience family and domestic violence.
- 20 per cent of females who experience family/domestic violence take leave because of that violence.
- An average usage of 8 days of leave for each person taking family and domestic violence leave.

Bankwest Curtin Economics Centre. (2021). *Family and Domestic Violence Leave Review*.

- In South Australia and the Northern Territory, workers are entitled to long service leave after 10 years of service with the same employer accrued at the rate of 1.3 weeks per year worked.

The CMCM assumes that workers are entitled to long service leave after 10 years of service with the same employer accrued at the rate of 0.867 weeks (32.93 hours) per year worked.

Amount Claimed

Workers accrue Long Service Leave entitlements as they work and providers need to accrue the revenue to meet the costs of this leave accrual during the claimable hours of the worker. However, not all workers remain with an employer for the required number of years and so do not end up being able to claim their Long Service Leave entitlements.

The CMCM assumes that the following shares of entitlements to Long Service Leave will eventually be claimed and so must be accrued each year:

- Registered Nurses - 59.2 per cent.
- Enrolled Nurses - 72.4 per cent.
- Personal Carers - 62.0 per cent.[9]

Public Holidays

Entitlement

The National Employment Standards require employers to allow workers to take public holiday leave on any public holiday that falls on a day when they would usually work and to pay workers for these public holidays as though they had worked. More technically, the National Employment Standards provides that:

- An employee is entitled to be absent from his or her employment on a day or part-day that is a public holiday in the place where the employee is based for work purposes.
- If an employee is absent from his or her employment on a day or part-day that is a public holiday, the employer must pay the employee at the employee's base rate of pay for the employee's ordinary hours of work on the day or part-day.

[9] Based on statistics on tenure in current job and likelihood of moving jobs within 12 months from: Kostas K *et al*. (2017). *The Aged Care Workforce 2016*, p. 36.

Amount Claimed

The number of public holidays varies considerably by state/territory and by year. Moreover, not all workers are rostered to work on all days that are public holidays – especially where the public holiday is on a weekend.

The CMCM assumes that each worker will, on average, be rostered to work on 8.6 public holidays each year and that the average shift loading payable on each of those days will be 24.4 per cent for Personal Carers, Enrolled Nurses and Registered Nurses and 17.9 per cent for Deputy Directors of Nursing and Directors of Nursing.[10] That is, the CMCM assumes that each worker, on average, will not be available to work on these 8.6 days and will be paid the relevant average loading on those days.

Note, this provides for the costs that the provider incurs in respect of the worker who is not working on the public holiday when it is one of their rostered days on. The costs of the worker who delivers the care minutes on the public holiday are accounted for separately in the CMCM.

Number of Working Hours in a Year

Table 3 calculates the number of paid hours that are not available as worked hours for each type of Day Worker.

Table 3: Impact of Leave Entitlements on the Number of Working Days (Day Worker)

	PC	PCA	EN	RN	DDON	DON
Annual Leave						
AL1 Number of hours of leave accrued in a year	152	152	190	190	190	190
AL2 Proportion of leave taken	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
AL3 Number of paid hours that are not worked hours	152	152	190	190	190	190
Personal Leave						
PL1 Number of hours of leave accrued in a year	76	76	76	76	76	76
PL2 Proportion of leave taken	70%	70%	70%	70%	70%	70%
PL3 Number of paid hours that are not worked hours	53.2	53.2	53.2	53.2	53.2	53.2

[10] On average, there are 12 public holidays in each year, with the number varying by state and by year. On average, therefore, a worker on a five-day roster will be due to work on 8.6 days that are public holidays.

Moreover, of these 8.6 public holidays, on average 1.23 will occur on a Saturday, 1.23 will occur on a Sunday and 6.14 will occur on a weekday. Given that the amount payable for a public holiday that is not worked is the ordinary rate of pay for that day, then the average loading that is applied across all public holidays that were rostered days of work, if the days are not worked, is therefore 24.4 per cent for Personal Carers, Enrolled Nurses and Registered Nurses and 17.9 per cent for Deputy Directors of Nursing and Directors of Nursing.

The implied average loading for Deputy Directors of Nursing and Directors of Nursing is lower because these workers are not entitled to a shift loading for afternoon and night shifts on weekdays.

	PC	PCA	EN	RN	DDON	DON
Family and Domestic Violence Leave						
FL1 Number of hours of leave accrued in a year	76	76	76	76	76	76
FL2 Proportion of leave taken	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
FL3 Number of paid hours that are not worked hours	0.76	0.76	0.76	0.76	0.76	0.76
Long Service Leave						
LSL1 Number of hours of leave accrued in a year	32.93	152	190	190	190	190
LSL2 Proportion of leave taken	62.0%	62.0%	72.4%	59.2%	59.2%	59.2%
LSL3 Number of paid hours that are not worked hours	20.42	20.42	23.84	19.50	19.50	19.50
Public Holiday Accrual						
PH1 Number of hours of leave accrued in a year	65.36	65.36	65.36	65.36	65.36	65.36
PH2 Proportion of leave taken	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
PH3 Number of paid hours that are not worked hours	65.36	65.36	65.36	65.36	65.36	65.36
Total Number of working hours in a year 52 * 38 - AL3 - PL3 - FL3 - LSL3 - PH3	1684.3	1684.3	1642.8	1647.2	1647.2	1647.2

Because Shift Workers have great annual leave entitlements, they also have a slightly smaller number of working hours (see Table 4).

Table 4: Impact of Leave Entitlements on the Number of Working Days (Shift Worker)

	PC	PCA	EN	RN	DDON	DON
Total Number of working hours in a year	1646.3	1646.3	1604.8	1609.2	1609.2	1609.2

Impact of Leave Entitlements on Fully Loaded Cost

Table 5 shows the impact of leave entitlements on the cost per worked hour (Day Workers).

Table 5: Impact of Leave Entitlements on the Cost per Worked Hour (Day Worker)

	PC	PCA	EN	RN	DDON	DON
A Standard Hourly Rate	**$30.11**	**$31.13**	**$32.26**	**$39.43**	**$56.81**	**$72.83**
B Number of working hours in a year	1684.3	1684.3	1642.8	1647.2	1647.2	1647.2
Annual Leave						
AL3 Number of paid hours that are not worked	152	152	190	190	190	190
AL4 Loading	17.5%	17.5%	14.0%	14.0%	14.0%	14.0%
AL5 Additional Cost per worked hour	**$3.19**	**$3.30**	**$4.25**	**$5.18**	**$7.47**	**$7.88**
Personal Leave						
PL3 Number of paid hours that are not worked	53.2	53.2	53.2	53.2	53.2	53.2
PL4 Loading	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PL5 Additional Cost per worked hour	**$0.95**	**$0.98**	**$1.04**	**$1.27**	**$1.83**	**$1.93**
Family and Domestic Violence Leave						
FL3 Number of paid hours that are not worked	0.76	0.76	0.76	0.76	0.76	0.76
FL4 Loading	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
FL5 Additional Cost per worked hour	**$0.01**	**$0.01**	**$0.01**	**$0.02**	**$0.03**	**$0.03**

	PC	PCA	EN	RN	DDON	DON
Long Service Leave						
LSL3 Number of paid hours that are not worked	20.42	20.42	23.84	22.79	22.79	22.79
LSL4 Loading	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LSL5 Additional Cost per worked hour	**$0.37**	**$0.38**	**$0.47**	**$0.47**	**$0.67**	**$0.71**
Public Holiday Accrual						
FL3 Number of paid hours that are not worked	65.36	65.36	65.36	65.36	65.36	65.36
FL4 Loading	24.4%	24.4%	24.4%	24.4%	24.4%	24.4%
FL5 Additional Cost per worked hour	**$1.45**	**$1.50**	**$1.60**	**$1.95**	**$2.80**	**$2.96**
Cost per worked hour of leave costs	**$5.98**	**$6.18**	**$7.38**	**$8.89**	**$12.81**	**$13.5**
Increase from permanent standard hourly rate	**19.8%**	**19.8%**	**22.9%**	**22.5%**	**22.5%**	**22.5%**

SALARY LIKE ON-COSTS – SUPERANNUATION

Employers are required to pay the superannuation guarantee charge under the *Superannuation Guarantee Charge Act 1992* if they do not make contributions to a superannuation fund for the benefit of their employees at (or above) the rate specified in the legislation. From 1 July 2023, the superannuation guarantee rate will be 11 per cent It is scheduled to increase to 11.5 per cent on 1 July 2024, and then to 12 per cent of 1 July 2025. The amount of superannuation payable in respect of an employee is calculated by applying the superannuation guarantee rate to the employee's ordinary time earnings, which includes shift loadings but not overtime (in most cases). Superannuation is payable when the employee is on paid leave.

The CMCM calculates the superannuation payable in respect of each worked hour by applying the superannuation guarantee rate to the salary and shift loading payable in respect to that hour and to the leave accruals that are accounted for against that worked hour. This is equivalent to applying the superannuation guarantee rate to each paid hour.

OTHER ON-COSTS (WORKERS COMPENSATION AND PAYROLL TAX)

Workers Compensation

Australia has 11 main workers' compensation schemes that connect the injured worker to services and support from the employers' workers' compensation insurer. There is a scheme for each state and territory and 3 Commonwealth schemes. Each one is governed by different laws and varies in the way it operates. However, in general, employers are required to have workers compensation insurance. Even where employers are permitted to self-insure they still incur costs with respect to workers compensation.

The insurance premium rate that applies to an employer depends on the state/territory in which they are operating and the sector/industry in which they are operating it is also adjusted for the past claims performance of the employer. Table 6 sets out the indicative average premium rates for the residential aged care industry in each state and territory (other than the Northern Territory).

Table 6: Workers Compensation Insurance Average Premium Rates, by Jurisdiction, 2023-24[11]

NSW	VIC	QLD	WA	SA	TAS	ACT
3.100%	4.161%	2.633%	2.520%	3.704%	4.170%	5.200%

The revenue base to which the premium rate is applied includes:

- Salary/wages.
- Overtime, shift and other allowances.
- Over award payments.
- Bonuses, commissions.
- Payments for sick leave, public holidays and the associated leave loadings.
- Employer paid or payable superannuation contributions.
- Grossed up value of fringe benefits.
- Long service leave payments (including lump sum payments instead of leave).
- Termination payments (lump sum payments in respect of annual leave, long service leave, sick leave, and related leave loadings).

For simplicity, the CMCM assumes that all residential aged care providers either pay workers compensation insurance premiums or incur similar costs through self insurance arrangements. It also assumes a premium rate of 3.32 per cent, which is the population

[11] Icare NSW. (2023). *NSW Workers Compensation Industry Classification Rates and Dust Diseases Contribution 2023-24.*

Victorian WorkCover Authority. (2023). *Workcover Premiums Order (No. 31) 2023/2024: Specific Values and Rates Determined by the Authority Itself.*

WorkCover Queensland. (2023). *WorkCover Queensland Notice (No. 1) of 2023*.

WorkCover Western Australia. (2023). *Premium Rates for 2023-24*.

Return to Work South Australia. (2023). *Industry premium rates 2023-24*.

WorkSafe Tasmania. (2023). Suggested Rates for 2023-24.

Chief Minister, Treasury and Economic Development Directorate. (2023). ACT Workers' Compensation Scheme Suggested Reasonable Premium Rates 2023-24.

weighted average of the mandated or recommended average premium rates for the residential aged care industry across the states and the ACT. The CMCM applies this premium rate to the sum of the employment costs associated with employing the worker: base salary rate, shift loading, worker allowance and leave costs.

Payroll Tax

Payroll tax is a general-purpose state and territory tax assessed on wages paid or payable by an employer to its employees, when the total wage bill of an employer (or group of employers) exceeds a threshold amount. The payroll tax rates and thresholds vary between states and territories (see Table 7).

Table 7: Payroll Tax Thresholds and Rates, by Jurisdiction, 2023-24[12]

State	Annual Threshold	Rate	Notes
NSW	$1,200,000	5.45%	
VIC	$700,000	4.85%	Rate is 1.2125% in regional areas.
QLD	$1,300,000	4.75%	Rate is 4.95% for employers or groups of employers with annual employee expenses more than $6.5 million in Australian taxable wages.
WA	$1,000,000	5.5%	A diminishing threshold applies for employers with employee expenses more than $1,000,000 but less than $7.5 million. Above $7.5 million, no threshold is granted. For employers with more than $100 million in employee expenses, the rate is: 4.5% for wages up to $100 million PLUS 6% for wages from $100 million to $1.5 billion PLUS 6.5% for wages above $1.5 billion
SA	$1,500,000	4.95%	Rate is from 0% to 4.95% depending on wages paid for the full financial year if annual employee expenses are between $1,500,000 and $1,700,00 and 4.95% if annual employee expenses are above $1,700,000
TAS	$1,250,000	4%	Rate is 6.1% for employers or groups of employers with employee expenses more $2 million
ACT	$2,000,000	6.85%	
NT	$1,500,000	5.5%	

For simplicity, the CMCM assumes that all for-profit residential aged care providers pay payroll tax at an effective rate of 3.9 per cent based on an analysis of the financial reports made by aged care providers.[13] This rate takes into account the threshold amounts on which providers do not pay payroll-tax. The CMCM applies this premium rate to the sum of the employment costs associated with employing the worker.

[12] https://www.payrolltax.gov.au/resources#resources__rates_and_thresholds

[13] Cullen, D. (2023). "The importance of competitive neutrality in aged care pricing." Independent Health and Aged Care Pricing Authority Conference 2023.

IMPACT OF EMPLOYEE ENTITLEMENTS ON FULLY LOADED COST

Table 8 calculates the total employment costs per worked hour for workers employed on a permanent basis. That is, it shows the cumulative effect of shift loadings, worker allowances leave entitlements, superannuation and on-costs on the cost per worked hour.

Table 8: Total Employment Cost per Worked Hour, by Type of Worker, by Shift

	PC	PCA	EN	RN	DDON	DON
Day Shift						
Standard Hourly Rate	$30.11	$31.13	$32.26	$39.43	$56.81	$59.89
Shift Loading	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Worker Allowances	$0.28	$0.28	$0.20	$0.20	$0.20	$0.20
Leave Costs	$5.98	$6.18	$7.38	$8.89	$12.81	$13.50
Superannuation	$3.97	$4.10	$4.36	$5.32	$7.66	$8.07
Other On-Costs	$2.91	$3.01	$3.19	$3.89	$5.34	$5.90
Total	$43.25	$44.70	$47.39	$57.73	$82.82	$87.57
Increase Above Standard Hourly Rate	43.6%	43.6%	46.9%	46.4%	45.8%	46.2%
Afternoon Shift						
Standard Hourly Rate	$30.11	$31.13	$32.26	$39.43	$56.81	$59.89
Shift Loading	$3.76	$3.89	$4.03	$4.93	$0.00	$0.00
Worker Allowances	$0.28	$0.28	$0.20	$0.20	$0.20	$0.20
Leave Costs	$6.93	$7.17	$8.42	$10.16	$14.64	$15.43
Superannuation	$4.49	$4.64	$4.92	$6.00	$7.86	$8.29
Other On-Costs	$3.28	$3.39	$3.59	$4.38	$5.47	$6.04
Total	$48.85	$50.50	$53.43	$65.10	$84.98	$89.86
Increase Above Standard Hourly Rate	**62.2%**	**62.2%**	**65.6%**	**65.1%**	**49.6%**	**50.0%**
Night Shift						
Standard Hourly Rate	$30.11	$31.13	$32.26	$39.43	$56.81	$59.89
Shift Loading	$4.52	$4.67	$4.84	$5.91	$0.00	$0.00
Worker Allowances	$0.28	$0.28	$0.20	$0.20	$0.20	$0.20
Leave Costs	$6.93	$7.17	$8.47	$10.22	$14.72	$15.52
Superannuation	$4.57	$4.73	$5.01	$6.11	$7.87	$8.29
Other On-Costs	$3.34	$3.45	$3.66	$4.46	$5.48	$6.05
Total	**$49.75**	**$51.42**	**$54.44**	**$66.34**	**$85.08**	**$89.96**
Increase Above Standard Hourly Rate	**65.2%**	**65.2%**	**68.8%**	**68.2%**	**49.8%**	**50.2%**
Saturday Work						
Standard Hourly Rate	$30.11	$31.13	$32.26	$39.43	$56.81	$59.89
Shift Loading	$15.06	$15.57	$16.13	$19.72	$28.41	$29.95
Worker Allowances	$0.28	$0.28	$0.20	$0.20	$0.20	$0.20
Leave Costs	$8006	$8.33	$10.07	$12.17	$17.54	$18.49
Superannuation	$5.85	$6.05	$6.43	$7.84	$11.30	$11.92
Other On-Costs	$4.27	$4.42	$4.69	$5.72	$7.87	$8.69
Total	**$63.64**	**$65.78**	**$69.79**	**$85.09**	**$122.13**	**$129.13**
Increase Above Standard Hourly Rate	**111.3%**	**111.3%**	**116.3%**	**115.8%**	**115.0%**	**115.6%**

	PC	PCA	EN	RN	DDON	DON
Sunday Work						
Standard Hourly Rate	$30.11	$31.13	$32.26	$39.43	$56.81	$59.89
Shift Loading	$22.58	$23.35	$24.20	$29.57	$42.61	$44.92
Worker Allowances	$0.28	$0.28	$0.20	$0.20	$0.20	$0.20
Leave Costs	$8.93	$9.23	$11.22	$13.57	$19.55	$20.61
Superannuation	$6.78	$7.01	$7.44	$9.08	$13.09	$13.80
Other On-Costs	$4.95	$5.12	$5.43	$6.62	$9.11	$10.06
Total	**$73.63**	**$76.11**	**$80.75**	**$98.48**	**$141.36**	**$149.47**
Increase Above Standard Hourly Rate	**144.5%**	**144.5%**	**150.3%**	**149.8%**	**148.8%**	**149.6%**
Public Holiday Work						
Standard Hourly Rate	$30.11	$31.13	$32.26	$39.43	$56.81	$59.89
Shift Loading	$45.17	$46.70	$32.26	$39.43	$56.81	$59.89
Worker Allowances	$0.28	$0.28	$0.20	$0.20	$0.20	$0.20
Leave Costs	$5.98	$6.18	$7.38	$8.89	$12.81	$13.50
Superannuation	$8.94	$9.24	$7.91	$9.65	$13.91	$14.66
Other On-Costs	$6.52	$6.74	$5.77	$7.04	$9.68	$10.69
Total	**$96.99**	**$100.27**	**$85.78**	**$104.64**	**$150.22**	**$158.84**
Increase Above Standard Hourly Rate	**222.1%**	**222.1%**	**165.9%**	**165.4%**	**164.4%**	**165.2%**

Other Costs of Delivering Care Minutes

SUPERVISION COSTS

In general, direct care is delivered by PCs. PCA, ENs and RNs. This direct care is supervised by a DDON or a DON. The time that DDONs and DONs spend supervising the direct care delivered by other workers cannot be counted as care minutes under the aged care regulatory arrangements. However, the costs of that supervision must be accounted for as part of the cost of the care minutes that are provided. Moreover, the costs of the supervisor include all the employment costs of the supervisor including leave costs, superannuation, and on-costs.

For simplicity, the CMCM assumes that each worker is supervised by a DDON working on the same shift as the worker and at a worker to supervisor ratio of 30:1. That is, the CMCM adds 1/30th of the hourly employment costs (cost per claimable hour) of a DDON to the hourly employment cost (cost per worked hour) of the worker. Note, the cost per claimable hour is used for the supervisor rather than the cost per worked hour as the DDON cannot supervise stall when they are undertaking training or on a scheduled break. The calculation is made on a worked hour basis for the direct care worker as the worker does not need to be supervised when they are on leave. Table 9 calculates the total employment costs per worked hour for workers employed on a permanent basis and their supervisors.

Table 9: Supervision Cost per Worked Hour, by Type of Worker, by Shift

	PC	PCA	EN	RN
Day Shift				
Employment Costs of Direct Care Worker	$43.25	$44.70	$47.39	$57.73
Employment Costs of Front-Line Supervisor	$2.76	$2.76	$2.76	$2.76
Total Employment Costs	**$46.01**	**$47.46**	**$50.15**	**$60.49**
Supervision Share of Employment Costs	**6.0%**	**5.8%**	**5.5%**	**4.6%**
Afternoon Shift				
Employment Costs of Direct Care Worker	$48.85	$50.50	$53.43	$65.10
Employment Costs of Front-Line Supervisor	$2.83	$2.83	$2.83	$2.83
Total Employment Costs	**$51.69**	**$53.33**	**$56.26**	**$67.93**
Supervision Share of Employment Costs	**5.5%**	**5.3%**	**5.0%**	**4.2%**
Night Shift				
Employment Costs of Direct Care Worker	$49.75	$51.42	$54.44	$66.34
Employment Costs of Front-Line Supervisor	$2.84	$2.84	$2.84	$2.84
Total Employment Costs	**$52.58**	**$54.26**	**$57.28**	**$69.17**
Supervision Share of Employment Costs	**5.4%**	**5.2%**	**5.0%**	**4.1%**

	PC	PCA	EN	RN
Saturday Work				
Employment Costs of Direct Care Worker	$63.64	$65.78	$69.79	$85.09
Employment Costs of Front-Line Supervisor	$4.07	$4.07	$4.07	$4.07
Total Employment Costs	**$67.71**	**$69.85**	**$73.86**	**$89.16**
Supervision Share of Employment Costs	**6.0%**	**5.8%**	**5.5%**	**4.6%**
Sunday Work				
Employment Costs of Direct Care Worker	$73.63	$76.11	$80.75	$98.48
Employment Costs of Front-Line Supervisor	$4.71	$4.71	$4.71	$4.71
Total Employment Costs	$78.34	$80.82	$85.46	$103.19
Supervision Share of Employment Costs	**6.0%**	**5.8%**	**5.5%**	**4.6%**
Public Holiday Work				
Employment Costs of Direct Care Worker	$96.99	$100.27	$85.78	$104.64
Employment Costs of Front-Line Supervisor	$5.01	$5.01	$5.01	$5.01
Total Employment Costs	**$102.00**	**$105.27**	**$90.79**	**$109.65**
Supervision Share of Employment Costs	**4.9%**	**4.8%**	**5.5%**	**4.6%**

UTILISATION COSTS (CLAIMABLE HOURS VERSUS WORKED HOURS)

Not all worked hours are claimable. For example, the Aged Care Award provides that "two separate 10-minute intervals (in addition to meal breaks) will be allowed to each employee on duty during each ordinary shift of 7.6 hours or more" and that "tea breaks will count as time worked). The Nurses Award similarly provides that "every employee will be entitled to a paid 10-minute tea break in each 4 hours worked at a time to be agreed between the employee and employer". Workers also need to undertake training and attend to administrative issues.

Table 10 sets out the CMCM assumptions with respect to worked hours that are not claimable hours for each type of worker.

Table 10: Unclaimable Hours, by Type of Worker

	PC / PCA	EN/RN
Breaks	2 ten-minute paid breaks in each 7.6-hour shift 4.39% of worked hours	1 ten-minute paid break in each four hours 4.17% of worked hours
Training	1 day per year 0.45% of worked hours	2 days per year 0.97% of worked hours
Administrative time	15 minutes in each 7.6-hour shift 3.29% of worked hours	15 minutes in each 7.6-hour shift 3.29% of worked hours
Share of Worked Hours that are Claimable Hours	91.88% for day workers 91.87% for shift workers	91.59% for day workers 91.57% for shift workers

OPERATIONAL AND CORPORATE OVERHEADS

Residential aged care providers incur costs other than the employment costs of the worker who is delivering the care minutes and their front-line supervisor which must also be attributed to the cost of each care minute, since the care minutes could not be delivered if these costs were not incurred. These costs include:

- Operational overheads such as the cost of staff employed to oversee quality and safeguarding requirements and the non-labour costs of training provided to workers.
- Corporate overheads such as IT costs, HR costs, payroll and finance costs.
- A return on the working capital invested in the aged care home's care operations by the aged care provider.

Operational Overheads

Direct care workers require access to experts – for example, in wound management. Staff are also employed in ensuring ongoing compliance with the Quality Standards and in dealing with the Aged Care Quality and Safety Commission. The CMCM assumes that these tasks are carried out by registered nurses and that each expert can manage the quality and safeguarding requirements for 60 residents.

Corporate Overheads

A recent analysis of the financial performance of the residential aged care sector found that in the 12 months to December 2022, residential aged care providers spent, on average, $17.11 per day on administrative costs associated with the provision of direct care with an average of 186.2 minutes of care delivered each day.[14] This equates to $5.51 per claimable hour in 2023.

The CMCM assumes this level of corporate overhead (indexed by the projected CPI for 2023-24 of 3.25 per cent[15]). That is, it assumes that $6.00 in administrative costs would be incurred in respect of each claimable hour in 2023-24.

[14] Sutton N, Ma N, Yang JS, Lewis R, Woods M, Ries N, Parker D. (2023). Australia's Aged Care Sector: Mid-Year Report (2022–23). UTS Ageing Research Collaborative, The University of Technology Sydney, p. 93.

[15] Australia. (2023). *Budget 2023-24: Budget Paper No 1*, p. 58.

Return on Working Capital

Residential aged care providers require working capital to operate their businesses and need to be paid a reasonable return on that capital. The CMCM adopts the approach taken with respect to the provision of care services in the Disability Support Worker Cost Model that is used by the National Disability Insurance Agency to set the price limits for supports funded by the National Disability Insurance Scheme.[16] Namely, it assumes that providers need to have a working capital equal to three months of months of salaries and entitlements and that providers are entitled to an 8 per cent return on that working capital. This equates to a 2 per cent loading on employment costs.

[16] National Disability Insurance Agency. (2023). *Disability Support Worker Cost Model: Assumptions and Methodology, 2023-24*.

Fully Loaded Cost Per Claimable Hour

Table 8 calculates the fully loaded cost per worked hour for workers employed on a permanent basis. That is, it shows the cumulative effect of:

- Employment costs per worked hour, including supervision costs;
- Utilisation costs per claimable hours (the cost per claimable hour of the attribution of the costs of worked hours that are not claimable); and
- Operational and corporate overheads.

Table 11: Fully Loaded Cost Per Claimable Hour, by Type of Worker, by Shift

	PC	PCA	EN	RN
Day Shift				
Employment Costs of worker	$43.25	$44.70	$47.39	$57.73
Employment Costs of supervisor	$2.76	$2.76	$2.76	$2.76
Utilisation Costs	$4.07	$4.20	$4.61	$5.56
Operational and Corporate Overheads	$8.07	$8.10	$8.16	$8.39
Total Cost per Claimable Hour	**$58.15**	**$59.76**	**$62.93**	**$73.43**
Afternoon Shift				
Employment Costs of worker	$48.85	$50.50	$53.43	$65.10
Employment Costs of supervisor	$2.83	$2.83	$2.83	$2.83
Utilisation Costs	$4.58	$4.72	$5.19	$6.26
Operational and Corporate Overheads	$8.33	$8.37	$8.44	$8.69
Total Cost per Claimable Hour	**$64.60**	**$66.42**	**$69.88**	**$82.88**
Night Shift				
Employment Costs of worker	$49.75	$51.42	$54.44	$66.34
Employment Costs of supervisor	$2.84	$2.84	$2.84	$2.84
Utilisation Costs	$4.66	$4.81	$5.28	$6.37
Operational and Corporate Overheads	$8.38	$8.41	$8.48	$8.74
Total Cost per Claimable Hour	**$65.62**	**$67.48**	**$71.04**	**$84.29**
Saturday Work				
Employment Costs of worker	$63.64	$65.78	$69.79	$85.09
Employment Costs of supervisor	$4.07	$4.07	$4.07	$4.07
Utilisation Costs	$6.00	$6.19	$6.81	$8.22
Operational and Corporate Overheads	$9.08	$9.12	$9.22	$9.55
Total Cost per Claimable Hour	**$82.78**	**$85.16**	**$89.88**	**$106.92**
Sunday Work				
Employment Costs of worker	$73.63	$76.11	$80.75	$98.48
Employment Costs of supervisor	$4.71	$4.71	$4.71	$4.71
Utilisation Costs	$6.94	$7.16	$7.88	$9.51
Operational and Corporate Overheads	$9.57	$9.62	$9.73	$10.12

	PC	PCA	EN	RN
Total Cost per Claimable Hour	**$94.85**	**$97.61**	**$103.07**	**$122.82**
Public Holiday Work				
Employment Costs of worker	$96.99	$100.27	$85.78	$104.64
Employment Costs of supervisor	$5.01	$5.01	$5.01	$5.01
Utilisation Costs	$9.02	$9.31	$8.34	$10.08
Operational and Corporate Overheads	$10.20	$10.27	$9.96	$10.38
Total Cost per Claimable Hour	**$121.22**	**$124.86**	**$109.10**	**$130.10**

The following four charts provide more detail on the breakdown of the fully loaded costs for each claimable hour for each type of shift and each type of worker.

Figure 1: Fully Loaded Cost Per Claimable Hour, by Shift, Personal Care Worker

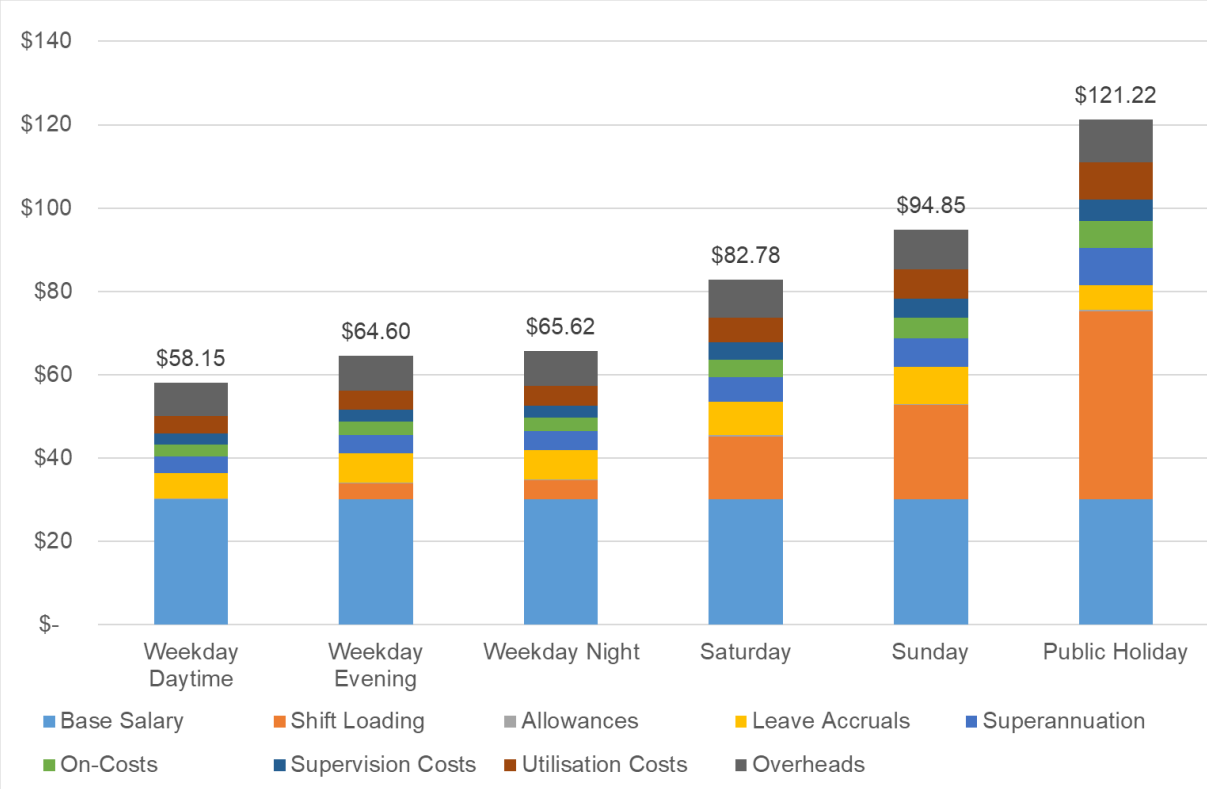


Figure 2: Fully Loaded Cost Per Claimable Hour, by Shift, Personal Care Worker (Advanced)

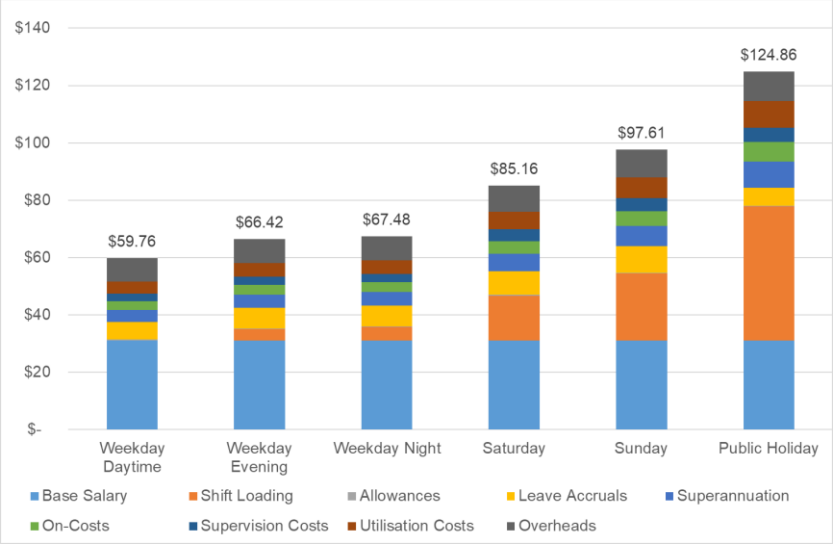


Figure 3: Fully Loaded Cost Per Claimable Hour, by Shift, Enrolled Nurse

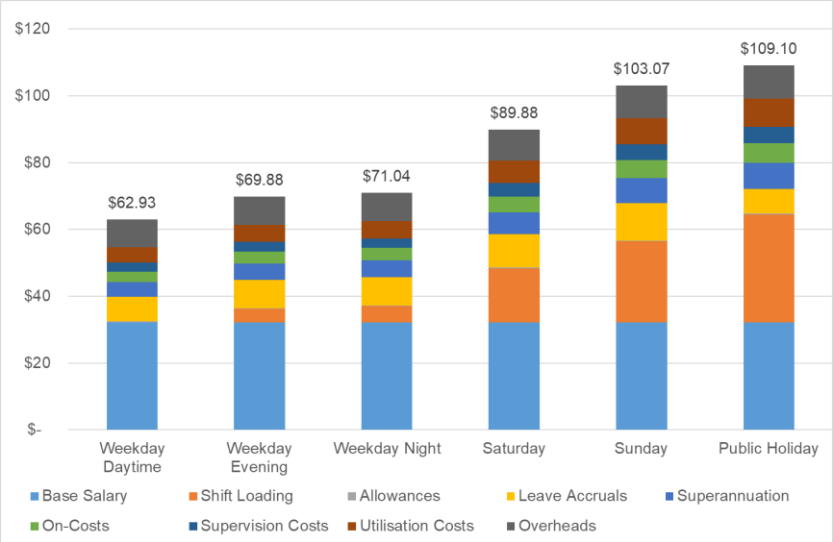
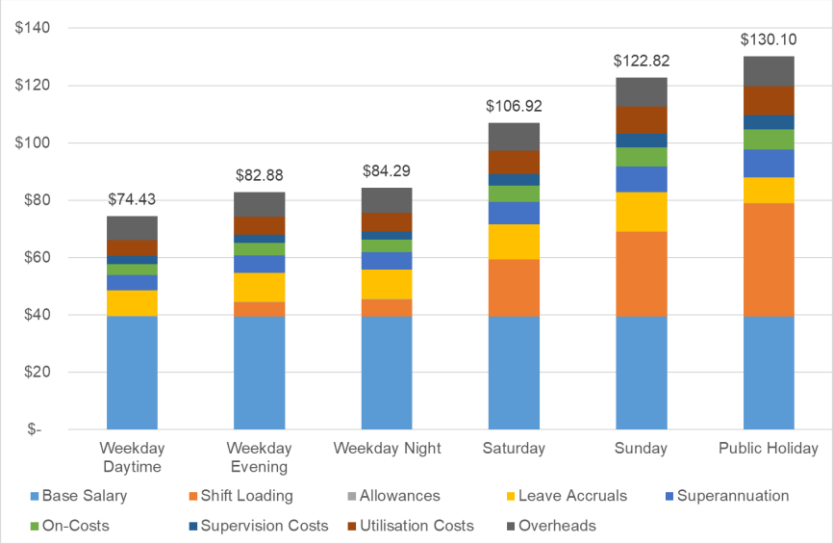


Figure 4: Fully Loaded Cost Per Claimable Hour, by Shift, Registered Nurse



On average across all types of direct care workers and shifts:

- Payments to direct care staff and their front-line supervisors (including salaries' allowances, superannuation, and leave) account for 89.2 per cent of total cost of each care minute – with the share varying between 86.1 per cent and 92.0 per cent.
- Payments to staff undertaking quality and safeguarding assurance account for 1.8 per cent of total cost of each care minute – with the share varying between 1.5 per cent and 2.0 per cent across types of workers and shifts.
- Corporate overheads, including a return working capital, account for 9.1% of total cost of each care minute – with the share varying between 6.4% and 12.0% across types of workers and shifts.

ADJUSTING THE CMCM FOR CASUAL WORKERS

Casual Workers are paid a higher hourly rate in lieu of leave entitlements. Table 12 sets out the CMCM's assumptions with respect to shift loadings for casual workers, which are based on the Aged Care award (PCs and PCAs) and the Nurses Award (ENs and RNs). Table 13 compares the fully loaded cost of each claimable hour for casual and permanent workers.

Table 12: Shift Loadings, Aged Care Award and Nurses Award (Casual Workers)

Shift	PC	PCA	EN	RN
Weekday	25.0%	25.0%	25.0%	25.0%
Saturday	75.0%	75.0%	75.0%	75.0%
Sunday	100.0%	100.0%	100.0%	100.0%
Public Holiday	170.0%	170.0%	125.0%	125.0%
Afternoon Shift	37.5%	37.5%	37.5%	37.5%
Night Shift	40.0%	40.0%	40.0%	40.0%

Table 13: Fully Loaded Cost Per Claimable Hour, Casual Worker versus Permanent Worker

	PC	PCA	EN	RN
Day Shift				
Permanent Worker	$58.15	$59.76	$62.93	$74.33
Casual Worker	$60.26	$61.95	$63.84	$75.70
Difference (+ve = causal rate is higher)	**3.6%**	**3.7%**	**1.5%**	**1.7%**
Afternoon Shift				
Permanent Worker	$64.60	$66.42	$69.88	$82.88
Casual Worker	$65.42	$67.27	$69.37	$82.71
Difference (+ve = causal rate is higher)	**1.3%**	**1.3%**	**-0.7%**	**-0.2%**
Night Shift				
Permanent Worker	$65.62	$67.48	$71.04	$84.29
Casual Worker	$66.44	$68.32	$70.46	$84.04
Difference (+ve = causal rate is higher)	**1.2%**	**1.3%**	**-0.8%**	**-0.3%**
Saturday Work				
Permanent Worker	$82.78	$85.16	$89.88	$106.92
Casual Worker	$82.06	$84.41	$87.11	$104.14
Difference (+ve = causal worker is higher)	**-0.9%**	**-0.9%**	**-3.1%**	**-2.6%**
Sunday Work				
Permanent Worker	$94.85	$97.61	$103.07	$122.82
Casual Worker	$92.94	$95.64	$98.73	$118.19
Difference (+ve = causal rate is higher)	**-2.0%**	**-2.0%**	**-4.2%**	**-3.8%**
Public Holiday Work				
Permanent Worker	$121.22	$125.86	$109.10	$130.10
Casual Worker	$123.31	$127.01	$109.94	$131.81
Difference (+ve = causal rate is higher)	1.7%	1.7%	0.8%	1.9%

ADJUSTING THE CMCM FOR OVERTIME

Under the Aged Care Award, workers are entitled to be paid overtime rates if they work in excess of 38 hours per week or work more than 10 hours on any day.

Table 14 sets out the Cost Model's assumptions with respect to overtime penalty rates. These assumptions are taken from the Aged Care Award. For simplicity they are expressed as loadings on the base rate of pay that would be payable in addition to the base rate of pay.

Table 14: Overtime Penalty Loadings, Aged Care Award

Shift	Permanent	Casual
Weekday, first two hours of overtime	50.0%	87.5%
Weekday, third and subsequent hour of overtime	100%	150.0%
Saturday	100.0%	150.0%
Sunday	100.0%	150.0%
Public Holiday	150.0%	212.5%

Under the Nurses Award, workers are entitled to be paid overtime rates if they have done work in addition to their rostered ordinary hours on any day of if they have worked more than 10 hours on any day.

Table 15 sets out the Cost Model's assumptions with respect to overtime penalty rates. These assumptions are taken from the Aged Care Award. For simplicity they are expressed as loadings on the base rate of pay that would be payable in addition to the base rate of pay.

Table 15: Overtime Penalty Loadings, Nurses Award

Shift	Permanent	Casual
Weekday, first two hours of overtime	50.0%	75.0%
Weekday, third and subsequent hour of overtime	100.0%	125.0%
Saturday, first two hours of overtime	50.0%	75.0%
Saturday, third and subsequent hour of overtime	100.0%	125.0%
Sunday	100.0%	125.0%
Public Holiday	150.0%	175.0%

Table 16 compares the fully loaded cost of each claimable hour for permanent workers to workers who are being paid overtime rates for each type of worker and shift, based on the Awards' minimum wages.

Table 16: Fully Loaded Cost Per Claimable Hour, Overtime (Permanent Workers)

	PC	PCA	EN	RN
Day Shift				
Permanent Worker	$58.15	$59.76	$62.93	$74.43
Overtime (first two hours)	$79.72	$82.04	$86.21	$102.63
Difference (+ve = overtime rate is higher)	**37.1%**	**37.3%**	**37.0%**	**37.9%**
Afternoon Shift				
Permanent Worker	$64.60	$66.42	$69.88	$82.88
Overtime (first two hours)	$81.13	$83.50	$87.78	$104.50
Difference (+ve = overtime rate is higher)	25.6%	25.7%	25.6%	26.1%
Night Shift				
Permanent Worker	$65.62	$67.48	$71.04	$84.29
Overtime	$81.14	$83.51	$87.84	$104.58
Difference (+ve = overtime rate is higher)	23.6%	23.8%	23.7%	24.1%
Saturday Work				
Permanent Worker	$82.78	$85.16	$89.88	$106.92
Overtime	$103.99	$107.09	$91.45	$108.66
Difference (+ve = overtime rate is higher)	25.6%	25.7%	1.7%	1.6%
Sunday Work				
Permanent Worker	$94.85	$97.61	$103.07	$122.82
Overtime	$106.35	$109.49	$115.58	$137.88
Difference (+ve = overtime rate is higher)	12.1%	12.2%	12.1%	12.3%

	PC	PCA	EN	RN
Public Holiday Work				
Permanent Worker	$121.22	$124.86	$109.10	$130.10
Overtime	$122.91	$126.58	$132.39	$158.31
Difference (+ve = overtime rate is higher)	1.4%	1.4%	21.4%	21.7%

Average Cost Per Claimable Hour

Currently, residential aged care providers are required to provide at least 200 care minutes per resident per day including at least 40 minutes of care from registered nurses each day (on a casemix adjusted basis). This Chapter estimates the minimum costs of delivering those care minutes taking into account the different costs that are associated with different types of workers and different shifts. Separate estimates are developed for weekdays, Saturdays, Sundays and Public Holidays.

Roster of Care – Baseline

Table 17 sets out the Roster of Care that the CMCM uses to calculate the cost of delivering the required number of care minutes for each day.

Table 17: Roster of Care

	Nursing Minutes	Personal Care Worker Minutes	Total Minutes
Day Shift (6 am to 2 pm)	13.5	65	78.5
Afternoon Shift (2pm to 10 pm)	13.5	65	78.5
Night Shift (10pm to 6am)	13	30	43
Total	**40**	**160**	**200**

Table 18 sets out the ratios of staff to residents that are implied by these rosters of care.

Table 18: Implied Ratio of Residents to Staff

	Residents per Nurse	Residents per Care Workers	Residents per Staff Member
Day Shift (6 am to 2 pm)	35.6	7.4	6.1
Afternoon Shift (2pm to 10 pm)	35.6	7.4	6.1
Night Shift (10pm to 6am)	36.9	16	11.2
Total	**36.0**	**9.0**	**7.2**

A sensitivity analysis of the impact of alternative rosters of care on the cost of delivering the required care minutes is undertaken later in this report (see page 39).

The baseline roster of care is developed on the following principles:

- Nursing staff are required to be available 24/7 and so the 40 minutes of required nursing time per day is spread across the three shifts.
- Most personal care, on the other hand, is delivered during the period when residents are awake and so only 18.75 per cent of personal care hours are rostered on for the eight hour night shift.
- Saturdays, Sundays and Public Holidays are staffed at the same levels as weekdays.

Mixture of Workers - Baseline

The CMCM makes the following assumptions about the mixture of hours delivered by workers engaged on a permanent or casual basis, based on the findings of the 2020 Aged Care Workforce Census:

- 78 per cent of registered nurses were employed on a permanent basis.
- 82 per cent of enrolled nurses were employed on a permanent basis.
- 79 per cent of personal care workers were employed on a permanent basis.

The 2020 Aged Care Workforce Census: also found that about 66 per cent of personal care workers held a Certificate Level III and that about 9.6 per cent of care staff that are not registered nurses are enrolled nurses.[17] The CMCM therefore assumes that:

- 80.4 per cent of the care minutes that are not delivered by registered nurses are delivered by Aged Care Employees – Level 4.
- 10 per cent of the care minutes that are not delivered by registered nurses are delivered by Aged Care Employees – Level 5.
- 9.6 per cent of the care minutes that are not delivered by registered nurses are delivered by Enrolled Nurses.

In line with industry benchmarks, the CMCM also assumes that:

- 8.0 per cent of the care minutes that were delivered by Registered Nurses were either delivered by agency staff or by workers being paid overtime penalty rates.
- 13.9 per cent of the care minutes that were delivered by Enrolled Nurses were either delivered by agency staff or by workers being paid overtime penalty rates.
- 6.9 per cent of the care minutes that were delivered by Personal Care Worker were either delivered by agency staff or by workers being paid overtime penalty rates. [18]

A sensitivity analysis of the impact of alternative staff mixtures on the cost of delivering the required care minutes is undertaken later in this report.

Estimated Cost

Table 19 sets out the calculation of the average cost of delivering the required number of care minutes per day. It shows that the cost of providing 200 care minutes per day when for-

[17] Ibid., p. 6 and p.12.

[18] Sutton N, Ma N, Yang JS, Lewis R, Brown D, Woods M, McEwen C, Parker D. (2022). *Australia's Aged Care Sector: Full-Year Report (2021–22)*. UTS Ageing Research Collaborative, The University of Technology Sydney, p. 118-9.

profit providers operate according to industry benchmarks and meet all their industrial relations obligations is $257.79 per day.

Table 19: Average Cost per Claimable Hour

	Day Shift	Afternoon Shift	Night Shift	Weekday	Saturday	Sunday	Public Holiday
Care Minutes delivered by Permanent Workers							
RN	9.7	9.7	9.3	28.7	28.7	28.7	28.7
EN	4.4	4.4	2.0	10.8	10.8	10.8	10.8
PCA	4.8	4.8	2.2	11.8	11.8	11.8	11.8
PC	38.4	38.4	17.7	94.6	94.6	94.6	94.6
Care Minutes delivered by Casual Workers							
RN	2.7	2.7	2.6	8.1	8.1	8.1	8.1
EN	1.0	1.0	0.4	2.4	2.4	2.4	2.4
PCA	1.3	1.3	0.6	3.1	3.1	3.1	3.1
PC	10.2	10.2	4.7	25.2	25.2	25.2	25.2
Care Minutes delivered at Overtime Rates							
RN	1.1	1.1	1.0	3.2	3.2	3.2	3.2
EN	0.9	0.9	0.4	2.1	2.1	2.1	2.1
PCA	0.4	0.4	0.2	1.1	1.1	1.1	1.1
PC	3.6	3.6	1.7	8.9	8.9	8.9	8.9
Cost Per hour (Permanent Worker)							
RN	$74.43	$82.88	$84.29		$106.92	$122.82	$130.10
EN	$62.93	$69.88	$71.04		$89.88	$103.07	$109.10
PCA	$59.76	$66.42	$67.48		$85.16	$97.61	$124.86
PC	$58.15	$64.60	$65.62		$82.78	$94.85	$121.22
Cost Per hour (Casual Worker)							
RN	$75.70	$82.71	$84.04		$104.14	$118.19	$131.81
EN	$63.84	$69.37	$70.46		$87.11	$98.73	$109.94
PCA	$61.95	$67.27	$68.32		$84.41	$95.64	$127.01
PC	$60.26	$65.42	$66.44		$82.06	$92.94	$123.31
Cost Per hour (Overtime)							
RN	$102.63	$104.50	$104.58		$108.66	$137.88	$158.31
EN	$86.21	$87.78	$87.84		$91.45	$115.58	$132.39
PCA	$82.04	$83.50	$83.51		$107.09	$109.49	$126.58
PC	$79.72	$81.13	$81.14		$103.99	$106.35	$122.91
Cost Per Claimable Hour (Permanent)							
RN	$12.02	$13.39	$13.11		$51.18	$58.79	$62.28
EN	$4.62	$5.13	$2.41		$16.25	$18.63	$19.72
PCA	$4.76	$5.29	$2.48		$16.69	$19.13	$24.47
PC	$37.23	$41.35	$19.39		$130.45	$149.46	$191.03
Cost Per Claimable Hour (Casual)							
RN	$3.44	$3.76	$3.68		$14.02	$15.92	$17.75
EN	$1.03	$1.12	$0.52		$3.46	$3.92	$4.36
PCA	$1.32	$1.43	$0.67		$4.41	$5.00	$6.64

	Day Shift	Afternoon Shift	Night Shift	Weekday	Saturday	Sunday	Public Holiday
PC	$10.29	$11.17	$5.23		$34.48	$39.06	$51.82
Cost Per Claimable Hour (Overtime)							
RN	$1.85	$1.88	$1.81		$5.80	$7.35	$8.44
EN	$1.25	$1.27	$0.59		$3.25	$4.11	$4.71
PCA	$0.61	$0.62	$0.29		$1.97	$2.01	$2.33
PC	$4.79	$4.88	$2.25		$15.38	$15.73	$18.18
Total Cost Per Day	$83.20	$91.29	$52.43	$226.92	$297.34	$339.12	$411.73
Average Days in Year				252.9	50.6	50.6	11.0
Average Cost Per Day							**$257.59**

Sensitivity Analysis

IMPACT OF EMPLOYMENT ARRANGEMENTS

Table 20 illustrates the sensitivity of the CMCM to some of its assumptions about the employment arrangements of staff by examining a number of scenarios.

Table 20: Average Cost per Claimable Hour, Sensitivity Analysis, Employment Conditions

Scenario	Details – employment conditions	Details - Roster	Average Cost Per Day	Difference from Baseline
Baseline	• All staff are paid award minimum wages. • The distribution of hours of care delivered by permanent, casual and Agency (overtime) staff is as per the industry average. • The distribution of skills of workers is as per the industry average.	• Resident to nurse ratio: ○ 35.6:1 in day-time ○ 36.9:1 at night • Resident to care worker ratio: ○ 6.1:1 in day-time ○ 11.2:1 at night. • Saturdays, Sundays, and Public Holidays are staffed as per weekdays	$257.59	
No Casual Staff	• As per baseline except all casual staff are permanent staff.	• As per baseline	$257.63	-0.1%
All Permanent Staff	• As per baseline except all care minutes are delivered by permanent staff.	• As per baseline	$253.12	-1.8%
All Casual	• As per baseline except all care minutes are delivered by casual staff.	• As per baseline	$253.90	-1.5%
All Agency	• As per baseline except all care minutes are delivered by Agency staff (with overtime rates as a proxy or Agency rates).	• As per baseline	$312.17	+21.1%
No Overtime	• As per baseline except no Agency staff or overtime.	• As per baseline	$253.29	-1.7%
More overtime	• Use of overtime and Agency staff is doubled	• As per baseline	$262.30	+1.7%

These six scenarios examine the impact of the mix of permanent, casual and Agency/Overtime hours on the cost of care.

- In the “No Casual Staff” scenario, it is assumed that all staff who are directly employed are employed on a permanent basis.
  - This assumption reduces the average daily cost slightly by 0.1 per cent to $257.63.
  - Note, however, that this slight saving (0.1%) is premised on the provider being of sufficient scale as to not require access to casual staff to fill occasional vacancies.

- In the "All Permanent Staff" scenario, it is assumed that all staff who are directly or indirectly employed are employed on a permanent basis.
    - This assumption reduces the average daily cost by 1.8 per cent to $253.12.
    - Note, however that this 1.8% savings in costs is driven by the assumption that the provider will never need to use overtime or agency staff. In practice, it can often be more efficient to pay overtime to a worker for a short period rather than engage another worker for an entire shift.
- In the "All Casual Staff" scenario, it is assumed that all staff are directly employed on a casual basis.
    - This assumption reduces the average daily cost by 1.5% to $253.90.
    - This slight savings is premised on the assumption that all casual vacancies can be filled at causal rates.
- In the "All Agency Staff" scenario, it is assumed that all care hours are delivered by staff being paid the equivalent of overtime rates.
    - This assumption increases the average daily cost by 21.1 per cent to $312.17.
- In the "No Overtime" scenario, it is assumed that no staff are employed on an Agency or overtime basis.
    - This assumption reduces the average daily cost by 1.7 per cent to $253.29.
- In the "More Overtime" scenario, it is assumed that the rate of use of Agency and overtime staff is doubled.
    - This assumption increases the average daily cost by 1.7 per cent to $263.05.

In summary, variations in employment arrangements (between casual and permanent staff) have relatively little impact on the overall full-loaded cost of delivering care minutes, with a variation of less than +/- 2 per cent from the base line cost. This is unsurprising, given the role of the casual loading in the industrial relations systems is to roughly equilibrate the remuneration of casual and permanent workers.

The degree of reliance on Agency (and overtime) worker has the potential to much more significantly impact the cost of care delivery. If the share of care minutes delivered by Agency (and overtime) workers in an aged care home is double the industry average than the cost of delivering the required care minutes will be 21.1 per cent higher than the industry average.

IMPACT OF QUALITY

Table 21 illustrates the sensitivity of the CMCM to some of its assumptions about the quality of care that is delivered by the aged care home.

Table 21: Average Cost per Claimable Hour, Sensitivity Analysis, Quality

Scenario	Details – employment conditions	Details - Roster	Average Cost Per Day	Difference from Baseline
Baseline	• All staff are paid award minimum wages. • The distribution of hours of care delivered by permanent, casual and Agency (overtime) staff is as per the industry average. • The distribution of skills of workers is as per the industry average.	• Resident to nurse ratio: ○ 35.6:1 in day-time ○ 36.9:1 at night • Resident to care worker ratio: ○ 6.1:1 in day-time ○ 11.2:1 at night. • Saturdays, Sundays, and Public Holidays are staffed as per weekdays	$257.59	
Lower Skilled Staff	• As per baseline	• As per baseline except that all care minutes other than nursing minutes are delivered by Aged Care Employees – Level 4	$257.24	-0.2%
Minimally Skilled Staff	• As per baseline	• As per baseline except that all care minutes other than nursing minutes are delivered by Aged Care Employees – Level 3	$256.76	-0.4%
No Supervision	• As per baseline	• As per baseline except that staff no longer have a direct 30:1 supervisor	$245.21	-4.8%
No Quality Expertise	• As per baseline	• As per baseline except there are no quality experts overseeing care	$253.07	-1.8%
Reduce staffing levels at night	• As per baseline	• As per baseline except all care workers are employed on day shifts and the nurse to resident ratio is 1:60 at night	$249.31	-3.3%
Lower staffing levels on non-weekdays	• As per baseline	• As per baseline except that care minutes average 100 minutes per day on non-weekdays and 240 minutes per day on weekdays	$239.29	-7.2%

These scenarios examine the impact of changes in quality of care on the cost of care.

- In the "Lower Skilled Staff" scenario, it is assumed that the skill level of workers delivering non-nursing care minutes is lowered so that all non-nursing care minutes are delivered by Aged Care Employees – Level 4.
  - This reduces the average daily cost slightly by 0.2 per cent to $257.24.
- In the "Minimally Skilled Staff" scenario, it is assumed that the skill level of workers delivering non-nursing care minutes is lowered so that all non-nursing care minutes are delivered by Aged Care Employees – Level 4.
  - This reduces the average daily cost slightly by 0.4 per cent to $256.76.

- In the "No Supervision" scenario, it is assumed that all staff work without supervision.
  - This reduces the average daily cost by 4.8 per cent to $245.21.
- In the "No Quality Expertise" scenario, it is assumed that the aged care home does not employ and quality specialist staff to assist other staff undertaker their caring duties.
  - This reduces the average daily cost by 1.8 per cent to $253.07.
- In the "Reduce Staffing Levels at Night" scenario, it is assumed that all non-nursing staff work day shifts and that the nurse to resident ratio is 60:1 at night.
  - This reduces the average daily cost by 3.3 per cent to $249.31.
- In the "Lower Staffing Levels on Non-Weekdays" scenario, it is assumed that care minutes average 100 minutes per day on non-weekdays and 240 minutes per day on weekdays.
  - This reduces the average daily cost by 7.2 per cent to $239.29.

In summary, the most significant drivers of the cost of care that are able to be influenced by the aged care provider are the extent of supervision that is provided to staff and the extent to which service levels are maintained across all days of the week (rather than met on an on average basis across the week).

CONCLUSIONS

In any case, given the current NWAU is $243.10 per day and that providers have to meet the costs of any allied health and lifestyle and recreational services that the provider is required to deliver to the resident, and any care consumables, as well as the cost of care minutes from the funding provided by the NWAU it is clear that the current NWAU is inadequate as the CMCM indicates that the cost of the care minutes themselves is higher than the current NWAU.[19] Indeed, the best estimate of the current NWAU based on the results of the CMCM and the average other direct care costs incurred across the sector is $292.87 – which is 20.5 per cent more than the current NWAU that is paid to aged care providers.

Moreover, the analysis above indicate that providers can only meet their legal and industrial obligations within the existing NWAU by:

[19] The most recent survey of the residential aged care industry indicates that the costs of allied health and lifestyle and recreation services were about $27.36 per day, on average, in first six months of 2022-23 and the cost of care consumables was about $6.18 per day, on average, in first six months of 2022-23.

Sutton N, Ma N, Yang JS, Lewis R, Woods M, Ries N, Parker D. (2023). Australia's Aged Care Sector: Mid-Year Report (2022–23). UTS Ageing Research Collaborative, The University of Technology Sydney, p. 93.

- Significantly cutting expenditure on quality controls and staff supervision; and
- Reducing the level of care available at nights; and
- Reducing the level of care available on non-weekdays; and
- Reducing the level of allied health and lifestyle and recreational services offered to residents.

These changes would have a significant negative impact on the quality of care recipients by residential aged care residents and would not be in line with the recommendations of the Royal Commission into Aged Care Quality and Safety.

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The Importance of Ensuring Competitive Neutrality in Aged Care Pricing

Dr David Cullen

Adjunct Professor, Macquarie University Centre for the Health Economy

21 August 2023

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Executive Summary

The Royal Commission into Aged Care Quality and Safety recommended that a new Pricing Authority should be established with the objective of ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services, taking into account the principles of competitive neutrality.

This paper addresses two questions concerned with the issue of competitive neutrality:

1) What are the effects of selectively levying payroll tax upon commercial providers of aged care services, while exempting not-for-profit providers from the same tax?
2) What may efficiently be done to remedy this problem.

The principal recommendation of this paper is that the Australian Government should undertake to pay aged care providers who are subject to payroll tax an additional subsidy equivalent to the payroll tax levied by States and Territories on their aged care businesses.

This arrangement was in place until the 2014-15 budget. At that time, it was removed to generate savings to the Commonwealth Budget of $652.7 million over four years (a 1.2 per cent reduction in the available funds for residential aged care). This recommendation by the National Commission of Audit was justified on the basis that the Commonwealth should not (directly or indirectly) pay state taxes. That justification was weak in its own right and seriously flawed (as we show in this paper) in that it did not take into account the various distortions and inefficiencies – including the reduction in the efficiency of Commonwealth aged care funding – which flow from a failure to address the differential tax treatments.

In this paper we discuss the four major economic distortions that result from the differential treatment of for-profit and not-for profit aged care providers with respect to the requirement to pay payroll taxes:

- The fiscal drag of the additional marginal excess burden of taxation.
- The importance of competitive neutrality to open market competition from the removal of distortions that inhibit the flow of resources to their most efficient use.
- The impact on prices of distortions in the competition between not-for-profit and for-profit firms because of the different optimisation strategies of for-profit and not-for-profit firms.

- The implicit subsidy already paid to for-profit firms under the current aged care funding arrangements given the strong evidence of their weaker technical efficiency.

The paper demonstrates that , since commercial firms are 5.8 per cent to 11.9 per cent more efficient than not-for-profit firms, average costs in the sector (assuming a market share of 40 per cent for for-profit providers) is between 3.1 per cent and 7.1 per cent higher than it would be if all services were delivered by for-profit providers. This equates to an effective subsidy to the not-for-profit sector of between $1.6 billion and $3.3 billion per annum in 2023-24. Moreover, this level of inefficiency will increase as for-profit providers vacate the field, or do not invest in the required expansion of supply.

If, alternatively, the Australian Government was to address the disincentive imposed by the differential cost of payroll tax for for-profit providers then, based on an effective payroll tax rate of 4 per cent and a 40 per cent market share for the for-profit sector, the cost of the additional payroll tax subsidy would be $2.5 billion over the next four year – which is less than half the increase in costs that will occur if for-profits do not take part in the expansion of the sector and less than a quarter of the increase in costs that will occur if for-profits vacate the field.

Importantly, levelling the playing field should increase the appetite for competitive capital investment into commercial aged care, which will over time reduce the market share of not-for-profits. This is efficient because as noted above, any increase in payroll tax supplement for an increase in for-profit share will be more than compensated by the productivity gain of replacing a not-for-profit with a for-profit provider.

The principal consequences of relatively lower efficiency of not-for-profit providers, coupled with growth in Commonwealth expenditure, are that costs will rise by a higher-than-necessary rate, while efficiency in the sector will be held back. Both these would be corrected by Commonwealth compensation of payroll taxes for commercial providers.

Introduction

The Royal Commission into Aged Care Quality and Safety found that:

> *[Australia's] aged care system fails to meet the needs of our older, often very vulnerable, citizens. It does not deliver uniformly safe and quality care for older people. It is unkind and uncaring towards them. In too many instances, it simply neglects them.*[1]

It also found that a principal cause of this neglect was that the system was (deliberately) underfunded. Indeed, it found that:

> *At no point has the level of funding for aged care in Australia been determined by the actual cost of delivering aged care services to a specified quality standard. The amount spent on aged care services in Australia reflects the available funding envelope rather than the cost of delivering high quality care. This has had serious consequences for older people and the aged care sector.*[2]

To address this issue the Royal Commission recommended (Recommendation 115) that a new Pricing Authority should be established with the objective of:

- Ensuring the availability and continuity of high quality and safe aged care services for people in need of them.
- Ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services, ***taking into account the principles of competitive neutrality***.
- Promoting efficient investment in the means of supply of high quality and safe aged care services in the long-term interests of people in need of them.

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1 Royal Commission into Aged Care Quality and Safety. (2019). *Interim Report*, p. 1.

2 Royal Commission into Aged Care Quality and Safety. (2021). *Final Report: Care, Dignity and Respect*, Vol. 2, p. 195.

- Promoting the development and retention of a highly motivated and appropriately skilled and numerous workforce.[3]

This paper addresses two questions concerned with the issue of competitive neutrality:

3) What are the effects of selectively levying payroll tax upon commercial providers of aged care services, while exempting not-for-profit providers from the same tax?
4) What may efficiently be done to remedy this problem.

These questions are broken down further into sub-questions as follows:

- With respect to the impact of payroll tax:
  - The specific penalty it provides to commercial investment in aged care.
  - The cost to the Commonwealth from reduced company tax revenues.
  - The cost to the Commonwealth from increased aged care subsidies.
  - The disincentive to employment.
  - The broader supply effect on the whole of the aged care sector.
- With respect to solutions:
  - What is the significance of the rate of taxation?
    - Does every level of tax need the same solution?
    - What is the impact of various thresholds?
    - Might the Commonwealth subsidise tax imposts more in some jurisdictions than in others?
  - What is the potential cost to the Commonwealth?
  - What are the deadweight losses associated with Commonwealth compensation?
  - What are the risks of gaming, and how are these best managed?

[3] Royal Commission into Aged Care Quality and Safety. (2021). *Final Report: Care, Dignity and Respect*, Vol. 1, p. 288, emphasis added.

CORE RECOMMENDATION

The principal recommendation of this paper is that the Australian Government should undertake to pay aged care providers who are subject to payroll tax an additional subsidy equivalent to the payroll tax levied by States and Territories on their aged care businesses.

This arrangement was in place until the 2014-15 budget (see page x below). At that time, it was removed to generate savings to the Commonwealth Budget of $652.7 million over four years (a 1.2 per cent reduction in the available funds for residential aged care).[4]

This recommendation by the National Commission of Audit was justified on the basis that the Commonwealth should not (directly or indirectly) pay state taxes. That justification was weak in its own right and seriously flawed (as we show in this paper) in that it did not take into account the various distortions and inefficiencies – including the reduction in the efficiency of Commonwealth aged care funding – which flow from a failure to address the differential tax treatments.

The identification and quantification of these distortions and inefficiencies is the subject of this report.

[4] Cullen, DJ. (2021). *Expenditure Constraints and Major Budget Measures*. Royal Commission Research Brief. Royal Commission into Aged Care Quality and Safety.

Background

THE RESIDENTIAL AGED CARE SECTOR

In 2021-22, residential aged care services were supplied across Australia by 805 residential aged care providers.[5] As Exhibit 1 illustrates, consolidation continues to occur in the aged care sector, with the number of residential aged care providers continuing to decrease at the same time as the numbers of facilities and beds increase.

Exhibit 1: Number of residential aged care providers and residents, 30 June 2016 to 30 June 2022

	30 June 2016	30 June 2018	30 June 2020	30 June 2022
Providers	949	886	845	805
Facilities	2,669	2,695	2,722	2,671
Operational places	195,825	207,142	217,145	219,965
Occupancy	92.4%	90.3%	88.3%	86.2%
Total residents	181,048	186,597	189,954	188,208

Not-for-profit providers continue to represent the largest proportion of ownership type in residential care, with 56 per cent of providers and 55 per cent of places (see Exhibit 2).

Exhibit 2: Number of residential aged care providers and residents, 30 June 2022, by ownership type

	All	Not-For-profit	For-profit	Government
Providers	805	453	266	87
Facilities	2,671	1,515	929	227
Operational places	219,965	120,137	91,658	8,170
Occupancy	86%	88%	85%	85%
Total residents	188,208	104,391	77,032	6,785

Total expenditure in 2020-21 by residential care providers was $24.3 billion, up 27.9 per cent from $19.0 billion in 2019-20 – that is, expenses have grown by 8.5 per cent per annum for each of the last three years.

Employee costs represented 65.4 per cent of the total expenses incurred by providers in 2021-22. As Exhibit 3 illustrates, employee expenses are consistently between 65 per cent and 71 per cent of all expenses for residential aged care providers.

[5] Except where otherwise noted, data quoted in this report are drawn from the Aged Care Financing Authority (2021); the Department of Health and Aged Care (2022, 2023); and Sutton et al (2023).

Exhibit 3: Employee share of expenses, residential aged care providers, 2013-14 to 2021-22

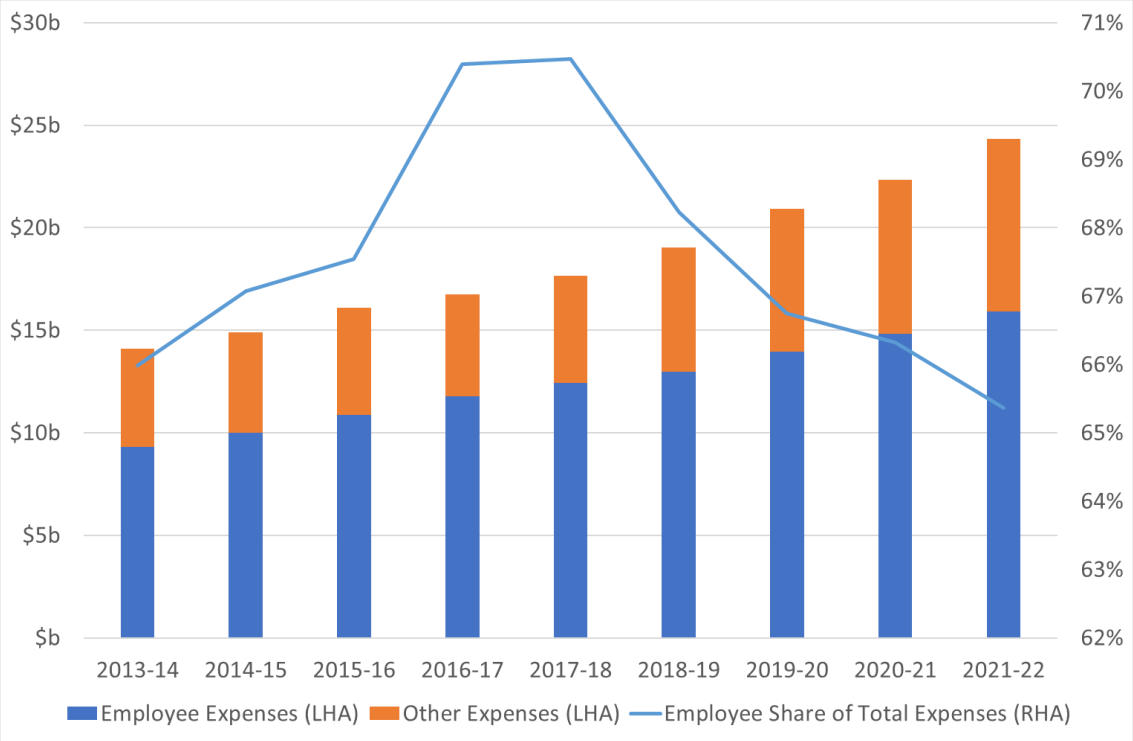

Exhibit 4 provides a breakdown of the financial results by ownership type.

Exhibit 4: Financial results, residential aged care providers, 2021-22, by ownership type

	All	Not-for-profit	For-profit	Government
Revenue	$22,075m	$11,794m	$9,255m	$1,026m
Expenses	$24,339m	$13,046m	$10,097m	$1,196m
Net Profit Before Tax (NPBT)	-$2,264m	-$1,252m	-$842m	-$171m
EBITDA	-$9m	-$136m	$223m	-$96m
EBITDA Margin	0.0%	-1.2%	2.4%	-9.3%
NPBT margin	-10.3%	-10.6%	-9.1%	-16.6%

In 2020-21, residential aged care providers paid $235.5 million in payroll taxes to state and territory governments with almost all of this paid by for-profit providers. The average effective rate of payroll tax for for-profit providers was 4.1 per cent of employee labour costs and 2.3 per cent of all costs (see Exhibit 5).

Exhibit 5: Payroll tax payments, residential aged care providers, 2021-22, by ownership type

	All	Not-for-profit	For-profit	Government
Employee labour costs	$14,531.3m	$8107.7m	$5,606.5m	$816.3m
Payroll tax expenditure	$235.5m	$3.9m	$231.8m	$0.6m
Effective rate of payroll tax				
- as a % of employee labour costs	1.6%	0.0%	4.1%	0.1%
- as % of total costs	1.0%	0.0%	2.3%	0.0%

THE HOME CARE SECTOR

In 2021-22, home care services were supplied across Australia by 916 aged care providers. As Exhibit 6 illustrates, 36 per cent of home care providers are from the for-profit sector and these providers deliver services to 33 per cent of all home care recipients.

Exhibit 6: Number of home care providers and recipients, 30 June 2022, by ownership type

	All	Not-For-profit	For-profit	Government
Providers	916	473	334	109
Recipients	215,743	131,980	71,563	12,200

Total expenditure in 2020-21 by home care providers was $4.5 billion. Exhibit 7 provides a breakdown of the financial results by ownership type.

Exhibit 7: Financial results, home care providers, 2021-22, by ownership type

	All	Not-for-profit	For-profit	Government
Revenue	$4,689.8m	$2,910.9m	$1,521.0m	$258.0m
Expenses	$4,492.4m	$2,795.9m	$1,466.8m	$249.7m
Net Profit Before Tax (NPBT)	$197.4m	$114.9m	$74.1m	$8.4m
EBITDA	$240.1m	$138.1m	$92.8m	$9.3m
EBITDA Margin	5.1%	4.7%	6.1%	3.6%
NPBT margin	4.2%	3.9%	4.9%	3.2%

In 2020-21, home care providers paid $25 million in payroll taxes to state and territory governments with almost all of this paid by for-profit providers. The average effective rate of payroll tax for for-profit providers was 5.3 per cent of employee labour costs and 1.5 per cent of all costs (see Exhibit 8).

Exhibit 8: Payroll tax payments, residential aged care providers, 2021-22, by ownership type

	All	Not-for-profit	For-profit	Government
Employee labour costs	$1,815.0m	$905.4m	$414.1m	$82m
Payroll tax expenditure	$25m	$3m	$22m	$1m
Effective rate of payroll tax				
- as a % of employee labour costs	1.4%	0.3%	5.3%	1.2%
- as % of total costs	0.6%	0.1%	1.5%	0.4%

CURRENT PAYROLL TAX ARRANGEMENTS

Payroll tax is a self-assessed, general-purpose state and territory tax assessed on wages paid or payable by an employer to its employees, when the total wage bill of an employer (or group of employers) exceeds a threshold amount. The payroll tax rates and thresholds vary between states and territories. All Australian States and Territories have harmonised a number of key areas of payroll tax administration. Other areas of payroll tax administration

differ between states and territories. Exhibit 9 sets out the basic arrangements for each state and territory in 2023-24.

Exhibit 9: Payroll Tax arrangements, 2023-24, by State/Territory

Jurisdiction	Income Range	Tax Rate	Tax Free Threshold
New South Wales	$0 - $1.2m	0.00%	
	Above $1.2m	5.45%	$1.2**m**
Victoria	$0 - $0.7m	0.00%	
	Above $0.7m	4.85%	$0.7**m**
	Regional employers	1.2125%	$0.7**m**
Queensland	$0 - $1.3m	0.00%	
	$1.3m - $6.5m	4.75%	$1.3**m**
	$6.5m - $10m	4.95%	$1.3**m**
	$10m - $100m	5.20%	$1.3**m**
	Above $100m	5.70%	$1.3**m**
South Australia	$0 - $1.5m	0.00%	
	$1.5m to $1.7m	0.00%-4.95%	$1.5**m**
	Above $1.7m	4.95%	$1.5**m**
Western Australia	$0 - $1.0m	0	
	$1.0m - $7.5m	5.5%	Reducing
	Above $7.5m	5.5%	Nil
Tasmania	$0 - $1.25m	0.00%	
	$1.25m - $2.0m	4.00%	$1.25**m**
	Above $2.0m	6.10%	$1.25**m**
ACT	$0 - $2.0m	0.00%	
	Above $2.0m	6.85%	$2.0**m**
Northern Territory	$0 - $1.5m	0.0%	
	Above $1.5m	5.50%	$1.5**m**

Economic Impact of Payroll Taxes

In this chapter we discuss the four major economic distortions that result from the differential treatment of for-profit and not-for profit aged care providers with respect to the requirement to pay payroll taxes:

- The fiscal drag of the additional marginal excess burden of taxation.
- The importance of competitive neutrality to open market competition from the removal of distortions that inhibit the flow of resources to their most efficient use.
- The impact on prices of distortions in the competition between not-for-profit and for-profit firms because of the different optimisation strategies of for-profit and not-for-profit firms.
- The implicit subsidy already paid to for-profit firms under the current aged care funding arrangements given the strong evidence of their weaker technical efficiency.

FISCAL DRAG OF THE ADDITIONAL MARGINAL EXCESS BURDEN OF TAXATION

From an economic perspective, payroll taxes are equivalent in direct effect to income taxes on employees, insofar as they add to the total cost of employment. However, they are wage-inflationary in a marginally less-productive way because:

- Payroll taxes do not increase income to workers at the marginal tax rate, as it is simply a tax on overall payroll, not individual income.
- Payroll tax is progressive in a different way from personal income tax: instead of increasing in incidence according to individual capacity to contribute; it is a tax on scale across a business.

There are a number of consequences to this structure. The first of these is the marginal excess burden of taxation (MEBT or deadweight loss), which is the distortion to allocation of capital caused by selective taxation. It is estimated that the general MEBT of payroll tax is 37 cents. This is to say that for every dollar raised via payroll tax, the total cost to the economy including distortions is $1.37.[6]

The effect is marginally different from personal income tax, due to incidence, and the MEBT for payroll taxes exceed that of income taxes at 33 cents. This reflects the particular

[6] Murphy C. (2016). *Efficiency of the tax system: a marginal excess burden analysis*. Tax and Transfer Policy Institute Working Paper 4/2016.

distortion of payroll tax due to the exemption of those with lower payrolls, which leads to a greater appetite for employment within smaller enterprises who face a lower average cost of employment. This is not dissimilar from the distortion which is caused by exempting larger not-for-profit firms in the aged care sector from payroll tax. Clearly this will make the average cost per equivalent employee lower for NFP firms. This will add to the MEBT of the payroll tax both in the aged care sector and overall.[7]

This in turn has three consequences for commercial aged care providers:

- It increases labour costs without any increase in benefits to the firm or its clients.
- It provides an incentive for commercial providers to reduce employment, either directly, or by replacing employees with technology solutions.
- While the substitute of technology for labour is a long-term growth pathway, the deadweight loss of the tax means this will only occur inefficiently, because the labour/capital trade-off is incorrectly priced due to the incentive to reduce tax.

With respect to these consequences, it is worth noting that the Henry Tax Review recognised that while in the long run, payroll tax has a very similar effect to the labour component of personal income tax (i.e., the burden falls on workers), it acknowledged that the 'short run' is an imprecise concept, and that a number of firms may continue to produce in the short run for some time, trading off the expense of relocation with the need to "re-tool".[8]

In summary, what this means is that:

- Commercial and not-for-profit aged care operators operate at different productive horizons.

  AND

- There is a particular inefficiency of the commercial operators' horizon due to the tax.

The specific costs of these problems are modelled below.

The distortion may have broader, sector-wide impacts too. The Henry Tax Review also pointed out that since a payroll tax will have the long-term effect of reducing the demand for labour and lowering wages, notwithstanding the delays in getting there, it may push into the untaxed sector some workers who might otherwise be more productive in the taxed sector. This implies a decline in average labour productivity in the sector.

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[7] All exemptions and variations to taxes increase MEBT because they distort optimal capital flows.

[8] Henry K, Harmer J, Piggot J, Ridout H, and Smith G. (2010). Australia's Future Tax System Review Final Report, pp. 293-301.

BENEFITS OF COMPETITIVE NEUTRALITY

The distortions discussed above have the impact of simultaneously:

- Preferring one group of market participants over another due to corporate structure, which attacks the principle of competitive neutrality.

  AND

- Reducing the value of Commonwealth payments for the care of older Australians in commercial residential facilities and homecare, depending upon the provider.

Looking to the first issue, Australia is an adherent to the OECD's 2021 Recommendation of the Council on Competitive Neutrality. [9] That recommendation urges nations to commit to ensure Competitive Neutrality to the maximum extent practicable and unless overriding Public Policy Objectives require otherwise. This commitment includes a recognition that nations should:

> *… avoid offering undue advantages that distort competition and selectively benefit some enterprises over others. Such advantages would for example include loans, loan guarantees and state investment in capital, at conditions not in line with market principles, as well as favourable tax treatment, grants and goods or services provided by governments at favourable prices. Where achieving an overriding Public Policy Objective requires an exception, this should be transparent to all, proportionate and periodically reviewed.*

It is well established that exposing firms to greater competition and increased openness sharpens incentives to reduce costs and innovate.[10] Competitive neutrality is a key measure to ensure open market competition by removing distortions that inhibit the flow of resources to their most efficient use. Attacks on competitive neutrality are part of the cause of deadweight losses for various taxes, including labour taxes. The competitive neutrality principle is that sellers of goods and services should compete on a level playing field: that is, one provider should not receive an advantage over another due to government regulation, subsidies or tax concessions. Competitive neutrality removes artificial advantages and allows businesses to compete on a basis that offers the best cost and quality combinations to customers. This is likely to result in more effective competition and more efficient outcomes.

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9 OECD. (2021). *Recommendation of the Council on Competitive Neutrality*.

10 See, for example: Productivity Commission. (2005). Review of National Competition Policy Reforms.

In turn, it will lead to greater consumer surpluses, as these are also attenuated by market distortion.

There are four main types of tax concessions provided by Australian governments:

- Input tax concessions – including fringe benefits tax (FBT), goods and services tax (GST), payroll tax, and stamp duty concessions.
- Income tax concessions.
- Wealth tax concessions – such as land tax exemptions.
- The capacity for some organisations to receive deductible gifts.

As a general rule, those not-for-profits that provide the most benefit to the community in terms of alleviation of disadvantage should be eligible to receive the most generous tax concessions. At the top of this list is charity providers who address the consequences of market failure. The argument for providing such concessions to not-for-profit suppliers of competitive services is much weaker. However, Australia is unusual in providing some form of concession to most not-for-profits. Most other developed nations, such as the United Kingdom and New Zealand, provide tax concessions only to organisations with a charitable purpose.

In its 1995 report on Charities, the Industry Commission argued that the income tax exemption enjoyed by not-for-profits does not compromise competitive neutrality between organisations because any organisation which, regardless of their taxation status, aims to maximise their surplus (profit) would be unaffected in their business decisions by their tax or tax-exempt status.[11] With respect to input tax exemptions, however, the Industry Commission found that they could affect resource allocation in two ways: they create distortions in the use of different inputs; and they provide a competitive advantage for the commercial activities of not-for-profits compared with for-profits.

Input tax exemptions are distortionary because they change the relative price of inputs. The exemption lowers the price of some inputs and presents an incentive for not-for-profits to favour the use of those inputs over other, relatively higher priced, inputs. Where not-for-profits are labour intensive (as in aged care) the exemptions from taxes on labour (FBT and pay-roll tax), may create significant distortions, particularly for the larger organisations. This could affect efficiency because it may mean that not-for-profits, because of the tax exemptions they receive, favour the use of tax-exempt inputs over other, more efficient, mixes of inputs. A significant consequence of this is a reduction in the rate of innovation, as the price of labour is kept low relative to technology.

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[11] Industry Commission. (1995). *Charitable Organisations in Australia*.

Input tax exemptions are also inefficient because they allow certain tax-exempt organisations to attract resources away from organisations that are not tax exempt. By lowering the costs faced by exempt organisations, less efficient organisations are able to survive — and perhaps even expand — often at the expense of firms that may be relatively more efficient but do not have access to the same competitive advantages. This holds back overall market growth. As mentioned, to the extent that it encourages some workers seeking higher wages into the untaxed sector who might otherwise be more productive in the taxed sector, it reduces average labour productivity in the sector.

The Productivity Commission reconfirmed these findings in its 2010 Inquiry into the Contribution of the Not-for-Profit Sector:

> *Input taxes, in particular payroll tax and fringe benefits tax (FBT) concessions, can confer a significant advantage to eligible organisations by reducing their employment costs. They can also distort decisions on the allocation of funds between capital and labour. … For organisations competing for government-funded services, competitive neutrality can be restored if input tax concessions are taken into account in assessing value for money. … As a rule, it would be preferable for services to be funded in a transparent fashion and not rely on input tax concessions that can be relatively complex, costly and distortionary.* [12]

Competitive neutrality is a principle that promotes the equal treatment by governments of competing organisations to achieve a 'level playing field'. By encouraging competition for inputs and market share it aids in the efficient allocation of resources. It is notable here that where the restriction on competitive neutrality is by a government consuming services directly in the market, it is a single source of distortion; but when the restriction is by one government and affects the value or price of services consumed by another government, this effect is magnified. This is the case of State restrictions on services funded by the Commonwealth: the marginal tax revenue required to fund or finance the distortion to aged care costs is a second-round source of deadweight loss to the economy.

Until 2014, the Australian Government's funding arrangements for residential aged care recognised that competitive neutrality principles required additional subsidies to be paid to for-profit providers of aged care to address the differential effect of taxes on inputs. From 1987-1999, the funding arrangements for nursing homes included a reimbursement arrangement – Other Cost Reimbursed Expenditure for staff overhead costs such as long

[12] Productivity Commission. (2010). *Contribution of the Not-for-Profit Sector*, p. 197.

service leave, superannuation for nursing and personal care staff, payroll tax and workers compensation. From 1999-2014, the funding arrangements for high care residents in residential aged care included a payroll tax supplement payable to providers who incurred payroll tax costs.[13]

The importance of the payroll tax supplement in aged care was reaffirmed by the Productivity Commission in its 1999 Inquiry into Nursing Home Subsidies, which recommended that:

> *The current payroll tax supplement should be replaced by a system of cost reimbursement for payroll tax paid by providers for their employees and for contract nursing and personal care staff.*[14]

In making this recommendation the Commission noted that payroll tax was non-discretionary, with rates set at arms' length by State and Territory Governments, and had particular effect on one group of providers. It found that an exemption system (with corresponding grants made to State and Territory Governments) or a cost reimbursement system would therefore be warranted.

In work undertaken for the Australian Government's 2002 Review of Pricing Arrangements in Residential Aged Care, the Allen Consulting Group found the cleanest option to remove the distortion caused by the payroll tax exemption for not-for-profits:

> *… would be to remove the tax concessions from those who receive them, but this is unlikely to be practicable given the Commonwealth's recent reaffirmation of the tax status of not-for-profits organisations. The alternative is to compensate for the different tax treatment of providers through the aged care funding arrangements. This is currently done for payroll tax and would be in line with the Productivity Commission's principle that private providers should be supplemented to offset differential taxes levied on their inputs, provided the amounts involved are significant enough.*[15]

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[13] Cullen, DJ. (2021). *Expenditure Constraints and Major Budget Measures*. Royal Commission Research Brief. Royal Commission into Aged Care Quality and Safety.

[14] Productivity Commission. (1999). *Nursing Home Subsidies Inquiry Report*, p. 104

[15] Allen Consulting Group. (2003). *The Role of Not-for-Profit Bodies in Residential Aged Care. Report to the Review of Pricing Arrangements in Residential Aged Care*. Canberra: Department of Health and Ageing, p. 10

In its 2010 Inquiry into the Contribution of the Not-for-Profit Sector, the Productivity Commission highlighted the payroll tax supplement arrangements in residential aged care. It also noted that there was an important distinction between the fringe benefit tax concessions and the payroll tax concessions afforded to not-for-profits – namely the incidence of the benefit:

> *Unlike the payroll tax exemption, where the eligible not-for-profit is the direct beneficiary, the fringe benefit tax concessions are a benefit provided directly to employees who vary in their ability to fully use the benefit provided. In other words, the size of the tax expenditure provided by the fringe benefit tax concession varies according to its usage by employees. This benefits the not-for-profit indirectly, by allowing it to employ staff at below market salaries (although there are exceptions such as nurses in hospitals as discussed below). For many NFPs operating outside the market sector this concession helps them to attract and retain staff even when they have insufficient revenue to pay full market salaries.*[16]

While both payroll tax and FBT exemptions have some common effect of reducing the final price of labour, they differ in intent. This is because FBT exemptions are intended to help not-for-profits compete for access to labour supply in a scarce market, by creating a benefit consumed by employees, whereas payroll tax exemptions have the character of a direct cash subsidy.

In 2013, the Australia Government established a National Commission of Audit with "a broad remit to examine the scope for efficiency and productivity improvements across all areas of Commonwealth expenditure, and to make recommendations to achieve savings sufficient to deliver a surplus of 1 per cent of GDP prior to 2023-24."[17]

The Commission noted that, "in the interests of competitive neutrality, the Commonwealth currently refunds for-profit providers for the payroll tax that they pay" but recommended that, "this supplement should be terminated, as it is effectively shifting the payment of a State tax to the Commonwealth."[18]

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[16] Productivity Commission. (2010). *Contribution of the Not-for-Profit Sector*, pp. 208-9.

[17] Australia. Treasurer. (2013). *Coalition commences National Commission of Audit*. Media release, 22 October 2013.

[18] National Commission of Audit. (2014). Towards Responsible Government: The Report of the National Commission of Audit, p. 140.

While this conclusion is true in a formal sense, it ignores the broader goal of efficiency in the aged care system, as well as the cost to the Commonwealth as the dominant payer for aged care services. Unfortunately, the first-best option for the States and Territories to remove taxes from all aged care providers is practically impossible (and would in any case produce deadweight losses elsewhere in the economy).

The Commission's recommendation was implemented in the 2014 Budget with savings over four years of $652.7 million.[19] The Royal Commission into Aged Care Quality and Safety estimated that this saving represented a 1.2 per cent reduction in expenditure in 2017-18.[20]

The Chair of the Royal Commission into Aged Care Quality and Safety was very critical in his final report of the way in which successive governments had approached the funding of aged care and argued that:

> *The flaws in the current system arise, in my view, to a significant extent from the decisions by successive governments to consider aged care as a form of welfare for the very needy, to be provided to the bare minimum extent required.*[21]

> *The current aged care system and its weak and ineffective regulatory arrangements did not arise by accident. The move to ritualistic regulation was a natural consequence of the Government's desire to restrain expenditure in aged care. In essence, having not provided enough funding for good quality care, the regulatory arrangements could only pay lip service to the requirement that the care that was provided be of high quality.*[22]

He further argued that,

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19 Australia. Treasurer. (2014). *Budget 2014-15: Budget Measures (Budget Paper 2)*, p. 189.

20 Cullen, DJ. (2021). *Expenditure Constraints and Major Budget Measures*. Royal Commission Research Brief. Royal Commission into Aged Care Quality and Safety, p.14

21 Royal Commission into Aged Care Quality and Safety. (2021). Final Report: Care, Dignity and Respect, Vol. 1, p. 12.

22 Ibid., Vol.1, p. 20.

> *… the introduction of independent pricing is critical to restore or to instil confidence and trust between the sector and Government, and to instil confidence in the sustainability of the system in the wider community.*[23]

Moreover, he and Commissioner Briggs recommended (Recommendation 115(4)(b)), that in undertaking its functions, the Pricing Authority should be guided, inter alia, by the following object:

> *… ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services, taking into account the principles of competitive neutrality.*[24]

The Government accepted this recommendation in its response to the Final Report of the Royal Commission.[25] In the context of the Australian Government's acceptance of the Royal Commission's recommendation there is a strong case to reinstate the Commonwealth's compensation to commercial providers for the cost of payroll taxes. In the absence of this, any measures to produce adequate and independent pricing will continue to be distorted by the variation in incidence of taxes.

IMPACT ON PRICES OF DISTORTIONS IN THE COMPETITION BETWEEN NOT-FOR-PROFIT AND FOR-PROFIT PROVIDERS

This section explains mathematically how deadweight losses and other inefficiencies take place where there is a differential tax incidence across the aged care sector.

In aged care, not-for-profit and for-profit firms coexist and compete against each other. For-profit firms are subject to profit taxation and to taxation on their input costs through, for example, payroll taxes and the fringe benefit tax. Not-for-profit firms benefit from exemption from taxation on profit and from some taxes on input costs. However, they can face difficulties in raising capital through equity financing. They also face non-distribution constraints.

In perfect markets, firms seek to maximise profits. In non-perfect markets, firms can have other goals – for example, firms can seek to maximise profits, or revenue, or sales. In seeking

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[23] Ibid., Vol. 1., p. 16.

[24] Ibid., Vol. 1, p. 288.

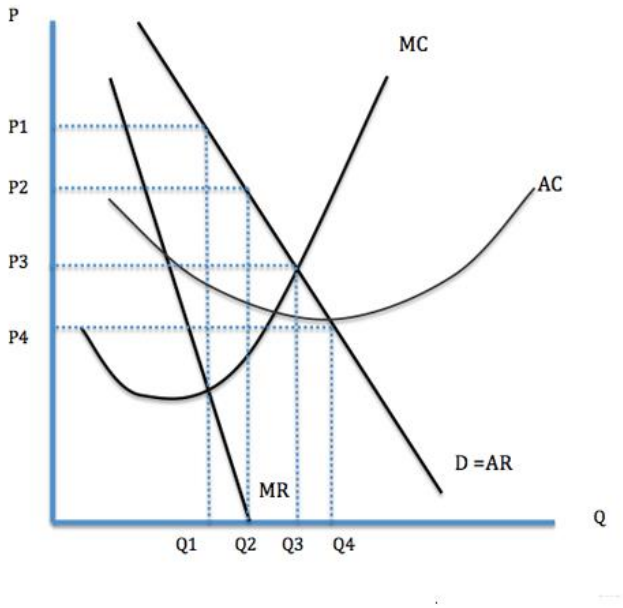
[25] Australian Government. (2021). Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, p.78.

each of these outcomes, firms will strive for technical efficiency but not necessarily for allocative efficiency.

As Exhibit 10 illustrates, for a given demand curve, the quantities that a firms will seek to supply depend on their goals:

- Profit maximisation occurs at quantity Q_1, where marginal revenue (MR) equals marginal cost (MC).
- Revenue maximisation occurs at quantity Q_2 , where marginal revenue (MR) equals 0.
- Allocative efficiency occurs at quantity Q_3 , where Price (Average Revenue) or Marginal Utility (MU) equals Marginal Cost (MC).
- Sales maximisation (making maximum sales whilst still making normal profits) occurs at quantity Q_4 , where Average Revenues (AR) = Average Costs (AC).

Exhibit 10: Efficiency and goals



Tax exemptions are granted in pursuit of social objectives. However, it is unclear that not-for-profits are motivated solely by the pursuit of those objectives. The traditional view – see, for example Pauly and Redisch (1973) – is that not-for-profit firms operate under a "sales maximization" objective function as opposed to the "profit maximisation" objective function of for-profit firms. However, other studies indicate that the distinction between for-profit and not-for-profit firms in health care is not clear cut. Eldendburg et al. (1999) find financial performance to be the most significant variable in explaining the turnover of not-for-profit hospital CEOs. Leone and Van Horn (1999) find not-for-profit hospital CEOs engage in earnings management by adjusting earning figures upward or downward toward a target just above zero. Their results support the importance of financial performance in not-for-

profit hospitals leading to the CEOs' earnings management. Baber, Daniel, and Roberts (1999) find changes in top managers pay in not-for-profit organizations is related to changes in direct revenue to the organization's philanthropic objective. Brickley and Van Horn (2000) find the relation between financial performance and CEO turnover and compensation in not-for-profit hospitals is as strong as that in for-profit hospitals. Overall, there is strong evidence that decision-making in not-for-profit hospitals is affected by financial performance (including profits). Weisbrod (1998) argues not-for-profit hospitals are more prone to concern for financial performance facing increased competition from for-profit hospitals – see also Duggan (2000); and Silverman and Skinner (2001).

A recent study (Bai et al., 2021) examined the provision of charity care in 4,663 USA hospitals using 2018 Medicare Hospital Cost Reports. The study found that, in aggregate, nonprofit hospitals spent $2.3 of every $100 in total expenses incurred on charity care, which was less than government ($4.1) or for-profit ($3.8) hospitals. These results suggest that many government and nonprofit hospitals' charity care provision was not aligned with their charity care obligations arising from their favourable tax treatment.

Benchmark Model

In this chapter we expand on the work of Sansing (2000) and Lien (2002) to examine the competitive dynamics of a market in which two firms compete in a homogenous market, where the first firm F_{NFP} operates on a not-for-profit basis and the second firm F_{FP} operates on a for-profit basis.

With the appropriate choice of units, the inverse demand function for the market can, without loss of generality, be specified as:

$$p = d - q \tag{1}$$

where p is the market price and q is the quantity demanded.

Suppose that each firm has a linear production function such that the unit production cost is c_{NFP} for the not-for-profit firm and c_{FP} for the for-profit firm. We assume that demand is such that that each firm can operate without loss. That is, we assume that $d > c_{NFP}$ and that $d > c_{FP}$.

The profits before taxes for the two firms are therefore:

$$\pi_{NFP} = (p - c_{NFP})q_{NFP} = \{d - q_{NFP} - q_{FP} - c_{NFP}\}q_{NFP} \tag{2}$$

$$\pi_{FP} = (p - c_{FP})q_{FP} = \{d - q_{NFP} - q_{FP} - c_{FP}\}q_{FP} \quad (3)$$

We assume that the for-profit firm is subject to a tax on profits (income tax) at rate α and to a tax on labour costs (payroll tax) at rate β. We also assume that that the share of costs that are labour costs (costs subject to payroll tax) is γ and that $0 \leq \alpha,\beta,\gamma < 1$. We also assume that losses generate tax credits.

The profits after taxes for the two firms are therefore:

$$\hat{\pi}_{NFP} = (p - c_{NFP})q_{NFP} = (d - q_{NFP} - q_{FP} - c_{NFP})q_{NFP} \quad (4)$$

$$\hat{\pi}_{FP} = (1 - \alpha)(p - c_{FP})q_{FP} = (1 - \alpha)(d - q_{NFP} - q_{FP} - (1 + \beta\gamma)\check{c}_{FP})q_{FP} \quad (5)$$

where $\check{c}_{FP}$ is the unit production cost before payroll tax for the for-profit firm.

Note, if losses do not generate tax credits then the after tax profit for the for-profit firm is strictly:

$\hat{\pi}_{FP} = \pi_{FP} - \alpha \max(\pi_{FP}, 0)$.

However, given the assumption that demand is such that each firm can operate without loss, profit maximisation for the firm after taxes on profit is the same as profit maximisation before taxes on profit.

Profit maximisation for the for-profit firm occurs where the first and second order conditions obtain:

$$\frac{\partial \hat{\pi}_{FP}}{\partial q_{FP}} = (1 - \alpha)(d - q_{NFP} - 2q_{FP} - (1 + \beta\gamma)\check{c}_{FP}) = 0 \quad (6)$$

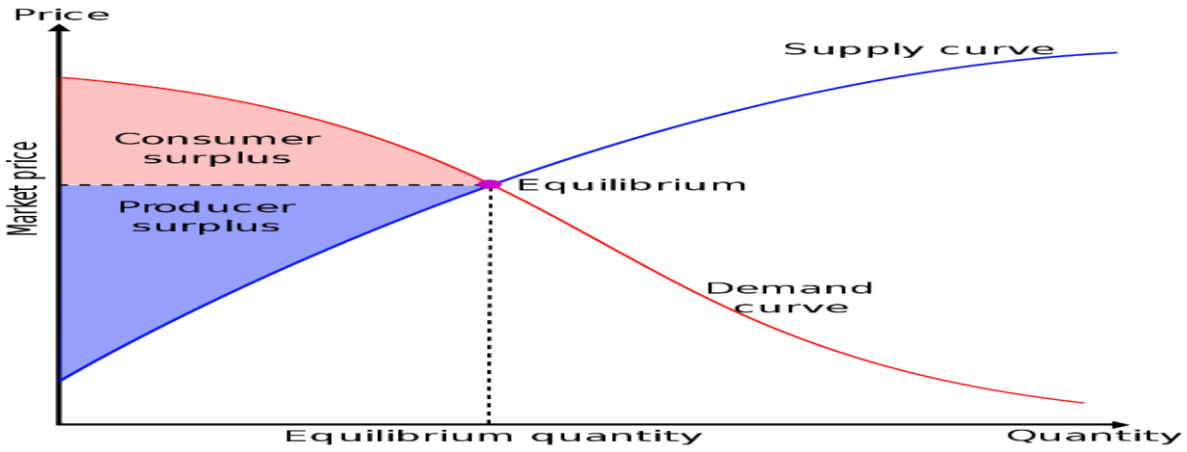
$$\frac{\partial^2 \hat{\pi}_{FP}}{\partial^2 q_{FP}} = -(1 - \alpha) < 0 \quad (7)$$

We note that the second order condition is trivially satisfied as $\alpha < 1$.

Now consider the not-for-profit firm. We assume that the not-for-profit firm in the model seeks to maximise both its own profit and the overall consumer surplus, where for a given quantity q the consumer surplus (see Exhibit 11) is defined as:

$$CS = \int_0^q (d - z)dz - (d - q)q = \frac{(q_{FP} + q_{NFP})^2}{2} \quad (8)$$

Exhibit 11: Consumer Surplus and Producer Surplus at Equilibrium



Moreover we assume that the not-for-profit firm values the overall consumer surplus relative to its own profit by a factor ω. That is, that the firm seeks to maximise the objective function:

$$V = \{d - q_{NFP} - q_{FP} - c_{NFP}\}q_{NFP} + \omega CS \tag{9}$$

This is maximised when the first and second order conditions are met:

$$\frac{\partial \pi_{NFP}}{\partial q_{NFP}} = d - q_{FP} - 2q_{NFP} - c_{NFP} + \omega(q_{FP} + q_{NFP}) = 0 \tag{10}$$

$$\frac{\partial^2 \pi_{NFP}}{\partial^2 q_{NFP}} = -2 + \omega < 0 \tag{11}$$

We note that the second order condition is satisfied when $\omega \leq 2$. That is, the second order condition is only satisfied of the not-for-profit firm weighs its consumer surplus less than twice as much as its own profit. (Note, this apparently arbitrary constraint on altruism is an artefact of the choice of units in the initial linear demand function.)

We now consider a Cournot-Nash equilibrium in which each firm chooses its optimal production level assuming the other firm maintains its current production level. Solving the two first order conditions simultaneously requires:

$$q^*_{NFP} = \frac{(1+\omega)d - 2c_{NFP} + (1-\omega)(1+\beta\gamma)\check{c}_{FP}}{(3-\omega)} \tag{12}$$

$$q^*_{FP} = \frac{(1-\omega)d + c_{NFP} - (2-\omega)(1+\beta\gamma)\check{c}_{FP}}{(3-\omega)} \tag{13}$$

Moreover, we note that:

$$\frac{\partial q_{FP}^{*}}{\partial \omega} = \frac{(-2d + c_{NFP} + (1 + \beta\gamma)\check{c}_{FP})}{(3 - \omega)^2} \leq 0 \tag{14}$$

as we have assumed that demand is such that that each firm can operate without loss, and that:

$$\frac{\partial q_{NFP}^{*}}{\partial \omega} = -2\frac{\partial q_{FP}^{*}}{\partial \omega} \geq 0 \tag{15}$$

That is, as the not-for-profit firm becomes more altruistic, it expands its production level to enhance consumer surplus.

We also note that:

$$\frac{\partial q_{FP}^{*}}{\partial \alpha} = 0 \tag{16}$$

$$\frac{\partial q_{FP}^{*}}{\partial \beta} = \frac{(1 - \omega)\gamma\check{c}_{FP}}{(3 - \omega)} \tag{17}$$

$$\frac{\partial q_{FP}^{*}}{\partial \gamma} = \frac{(1 - \omega)\beta\check{c}_{FP}}{(3 - \omega)} \tag{18}$$

That is, the equilibrium production level of the for-profit firm is not affected by the rate of tax on profits. It is, however, affected by the rate of tax on labour inputs and by the labour share of costs.

If the not-for-profit firm values the consumer surplus more highly than its own profit, then any increase in the rate of tax on labour costs will decrease the production level of the for-profit firm.

Similarly, if the not-for-profit firm values the consumer surplus more highly than its own and the for-profit firm is subject to tax on its labour input costs, then any increase in the share of its costs attributable to labour will decrease the production level of the for-profit firm.

We now examine the effect of any expansion in production by the not-for-profit firm on the for-profit firm by considering a stochastic inverse demand function such that:

$$p = d - q + \varepsilon \tag{19}$$

where ε is a zero-mean random variable representing a demand shock.

We assume both firms make their production decisions prior to the realization of the demand shock.

As demand is stochastic, profit for the for-profit firm is also stochastic and given by:

$$\hat{\pi}_{FP} = (p - c_{FP})q_{FP} = \{d - q_{NFP} - q_{FP} + \varepsilon - (1 + \beta\gamma)\check{c}_{FP}\}q_{FP} \tag{20}$$

We now consider the for-profit firm's response to the demand shock.

The requirement for a continuing positive profit for the for-profit firm is that:

$$\varepsilon > q_{NFP} + q_{FP} + (1 + \beta\gamma)\check{c}_{FP} - d \tag{21}$$

and so the expected after tax profit is:

$$\begin{aligned} E(\hat{\pi}_{FP}) = {} & \{d - q_{NFP} - q_{FP} - (1 + \beta\gamma)\check{c}_{FP}\}q_{FP} \\ & - \alpha \int_{z}^{\infty} (d - q_{NFP} - q_{FP} + \varepsilon - (1 + \beta\gamma)\check{c}_{FP}) f(\varepsilon) d\epsilon \end{aligned} \tag{22}$$

where $f(\varepsilon)$ is the probability distribution function of ε and:

$$z = q_{NFP} + q_{FP} + (1 + \beta\gamma)\check{c}_{FP} - d \tag{23}$$

The objective function of the not-for-profit firm is not affected by the demand shock. So the demand shock only directly affects the for-profit firm's production decision. That is, for a given output level by the for-profit firm, the not-for-profit firm's production is the same with or without demand shock. However, as demand shock induces the for-profit firm to change its production level, strategic interactions between the two firms then lead the not-for-profit firm to adjust its production level as well.

We now find the resulting Cournot-Nash equilibrium. To maximize $E(\hat{\pi}_{FP})$ the optimal production level, q^*_{FP}, has to satisfy the following first and second order conditions:

$$\frac{\partial E(\hat{\pi}_{FP})}{\partial q_{FP}} = 0 \tag{24}$$

$$\frac{\partial^2 E(\hat{\pi}_{FP})}{\partial^2 q_{FP}} < 0 \tag{25}$$

That is:

$$\{d - q_{NFP} - 2q_{FP} - (1 + \beta\gamma)\check{c}_{FP}\} - \alpha \int_{z}^{\infty} (d - q_{NFP} - 2q_{FP} + \varepsilon - (1 + \beta\gamma)\check{c}_{FP}) f(\varepsilon) d\epsilon = 0 \quad (26)$$

$$-2(1 - \alpha) + \alpha\{q_{NFP} + q_{FP} + (1 + \beta\gamma)\check{c}_{FP} - d\} f(z) < 0 \quad (27)$$

Let $\tau = \frac{\alpha}{1-\alpha}$ and $(z) = \int_{z}^{\infty} \varepsilon f(\varepsilon) d\epsilon$. Then, because H(z) is always positive as $E(\epsilon) = 0$, the first order condition can be rewritten as

$$\{d - q_{NFP} - 2q_{FP} - (1 + \beta\gamma)\check{c}_{FP}\} - \tau H(q_{NFP} + q_{FP} + (1 + \beta\gamma)\check{c}_{FP} - d) = 0 \quad (28)$$

And so:

$$d - q_{NFP} - q_{FP} - (1 + \beta\gamma)\check{c}_{FP} = q_{FP} + \tau H(q_{NFP} + q_{FP} + (1 + \beta\gamma)\check{c}_{FP} - d) > 0 \quad (29)$$

That is, the second order condition is always satisfied as both terms are negative in the left hand side of equation (27).

For the not-for-profit firm, to maximize $E(V)$ the optimal production level, q^{*}_{NFP}, has to satisfy the following first and second order conditions:

$$\frac{\partial E(V)}{\partial q_{NFP}} = 0 \quad (30)$$

$$\frac{\partial^2 E(V)}{\partial^2 q_{NFP}} < 0 \quad (31)$$

That is:

$$d - q_{FP} - 2q_{NFP} - c_{NFP} + \omega(q_{FP} + q_{NFP}) = 0 \quad (32)$$

with the second order condition again trivially satisfied,

The Cournot-Nash equilibrium is derived by solving equations (28) and (32) simultaneously. From equation (32) we have:

$$q_{NFP} = \frac{(d - (1 - \omega)q_{FP} - c_{NFP})}{(2 - \omega)} \quad (33)$$

And substituting this into equation (28) gives:

$$\{\mathrm{d}-\mathrm{q}_{\mathrm{FP}}-(1+\beta\gamma)\check{\mathrm{c}}_{\mathrm{FP}}\}+\frac{(\mathrm{c}_{\mathrm{NFP}}-d-\mathrm{q}_{\mathrm{FP}})}{(2-\omega)} -\tau\mathrm{H}\left((1+\beta\gamma)\check{\mathrm{c}}_{\mathrm{FP}}-\mathrm{d})+\frac{(d+\mathrm{q}_{\mathrm{FP}}-\mathrm{c}_{\mathrm{NFP}})}{(2-\omega)}\right)=0 \tag{34}$$

The solution to this equation is $\mathrm{q}^{*}_{\mathrm{FP}}$ and $\mathrm{q}^{*}_{\mathrm{NFP}}$ is then fond by substitution into equation (33).

We can now examine the impact of the tax rates and the relative preference for consumer surplus of the not-for-profit firm on the market equilibrium.

First, let:

$$m=\{(1+\beta\gamma)\check{\mathrm{c}}_{\mathrm{FP}}-d\}+\frac{(d+\mathrm{q}_{\mathrm{FP}}-\mathrm{c}_{\mathrm{NFP}})}{(2-\omega)} \tag{35}$$

Then by comparative static analysis we know that:

$$\frac{\partial \mathrm{q}^{*}_{\mathrm{FP}}}{\partial\tau}=\frac{-(2-\omega)H(m)}{(3-\omega)-\tau m f(m)} \tag{36}$$

and, since $m=\ -\mathrm{q}_{\mathrm{FP}}-\tau H(m)$ and $H(m)>0$, we have $\frac{\partial \mathrm{q}^{*}_{\mathrm{FP}}}{\partial\tau}<0$, which implies that $\frac{\partial \mathrm{q}^{*}_{\mathrm{FP}}}{\partial\alpha}<0$.

That is, the for-profit firm will tend to produce less as the profit tax is increased.

Similarly:

$$\frac{\partial \mathrm{q}^{*}_{\mathrm{FP}}}{\partial\beta}=\frac{-(2-\omega)\gamma\check{\mathrm{c}}_{\mathrm{FP}}(1-\tau m f(m))}{(3-\omega)-\tau m f(m)}<0 \tag{37}$$

That is, the for-profit firm will tend to produce less as the tax on labour inputs is increased. At the same time the not-for-profit firms output will tend to increase as the tax on labour inputs for for-profit firms increases.

This is because, from equation (33):

$$\frac{\partial \mathrm{q}^{*}_{\mathrm{NFP}}}{\partial\beta}=\frac{\partial \mathrm{q}^{*}_{\mathrm{NFP}}}{\partial \mathrm{q}^{*}_{\mathrm{FP}}}\frac{\partial \mathrm{q}^{*}_{\mathrm{FP}}}{\partial\beta}=\left(\frac{\omega-1}{2-\omega}\right)\frac{\partial \mathrm{q}^{*}_{\mathrm{FP}}}{\partial\beta} \tag{38}$$

which is negative if $\omega>1$ and positive if $\omega<1$. That is, if the not-for-profit firm values the consumer surplus more than its profitability then it will decrease production as the profit on

taxes and the tax on labour inputs increases. Whereas, if the not-for-profit firm values the consumer surplus less than its profitability then it will increase production as the profit on taxes and the tax on labour inputs increases.

If we look at the total production at equilibrium of the two firms then we see that:

$$\frac{\partial(q^*_{NFP}+q^*_{NFP})}{\partial\beta} = \frac{\partial q^*_{NFP}}{\partial\beta} + \frac{\partial q^*_{FP}}{\partial\beta} = \left(\frac{1}{2-\omega}\right)\frac{\partial q^*_{FP}}{\partial\beta} < 0 \qquad (39)$$

That is, regardless of the weight that the not-for-profit firm gives to the consumer surplus, the overall production of the two firms will decrease as the tax on labour inputs increases, leading to an increase in the market price.

EFFICIENCY

The effect outlined in the previous section – a higher price as for-profits withdraw from the market occurs even where the for-profit and not-for-profit firms are as efficient as each other. The upwards pressure on price is exacerbated when not-for-profit firms are less efficient than for-profit firms.

A significant number of studies have been conducted of the relative efficiency of for-profit and not-for-profit residential aged care providers. A full list of sources for this section is provided in the bibliography.

Exhibit 12 illustrates the results of the 10 most significant international studies of non-Australian systems. On average, these studies show that for profit nursing homes have a higher technical efficiency (83.7 per cent) than not-for-profit nursing homes (72.9%). That is, for-profit nursing homes can, on average produce the same level of output as a not-for-profit nursing home with 14.9 per cent fewer resources.

Exhibit 12: Literature Review: Relative Efficiency of for-profit and not-for-profit firms in aged care

Source	Average technical efficiency For-profit firms	Average technical efficiency Not-for-profit firms
Anderson 1999	90.1%	72.5%
Anderson 2003	77.0%	74.0%
Chattopadhyay 1994	92.0%	71.0%
Chattopadhyay 1996	94.5%	80.8%
Nordquist 1994	70.4%	62.3%
Nyman 1990	94.7%	88.3%
Ozcan 1998	84.0%	80.3%
Rosko 1995	82.1%	71.0%
Fizel 1992	62.0%	48.0%
Knox 2007	90.3%	80.5%

There have also been two major studies of the efficiency of Australian nursing homes. The first was commissioned in 2002 for the Australian Government's Review of Pricing Arrangements in Residential Aged Care. The second was commissioned in 2020 for the Royal Commission into Aged Care Quality and Safety.

The Review of Pricing Arrangements in Residential Aged Care found that on average for-profit nursing homes has a higher level of technical efficiency (89.0 per cent) than not for profit nursing homes (84.0 per cent).[26] The difference was starker when the median efficiency scores were analysed – 94.0 per cent for for-profit homes and 84 per cent for not-for profit homes. That is, the median for-profit nursing home produce the same level of output as the median not-for-profit nursing home with 11.9 per cent fewer resources. The Review noted that there was no evidence that the cost effectiveness was increased at the cost of quality of care.

The analysis undertaken for the Royal Commission found that the overall efficiency of nursing homes was about 88.4 per cent on average with for profit homes 5.8 per cent more efficient on average then not-for-profit homes. This equates to an average efficiency score for for-profit homes of 92.5 per cent compared to 86.5 per cent for not-for-profit homes.[27]

Implications for funding

Over the last four years total expenditure (public and private) on aged care has grown from $28.4 billion in 2019-20 to $38.8 billion 2022-23, with about 95% of this expenditure on direct care services. Over the same period, Australian Government expenditure has grown from $21.5 billion in 2019-20 to $29.7 billion 2022-23. Over the next four year, the growth in expenditure is projected to be even higher, with Australian Government expenditure on aged care estimated to be $41.8 billion by 2026-27. Overall, total expenditure on aged care per annum will grow by $16.4 billion or 42 per cent in the next four years (see Exhibit 13**Error! Reference source not found.**).[28]

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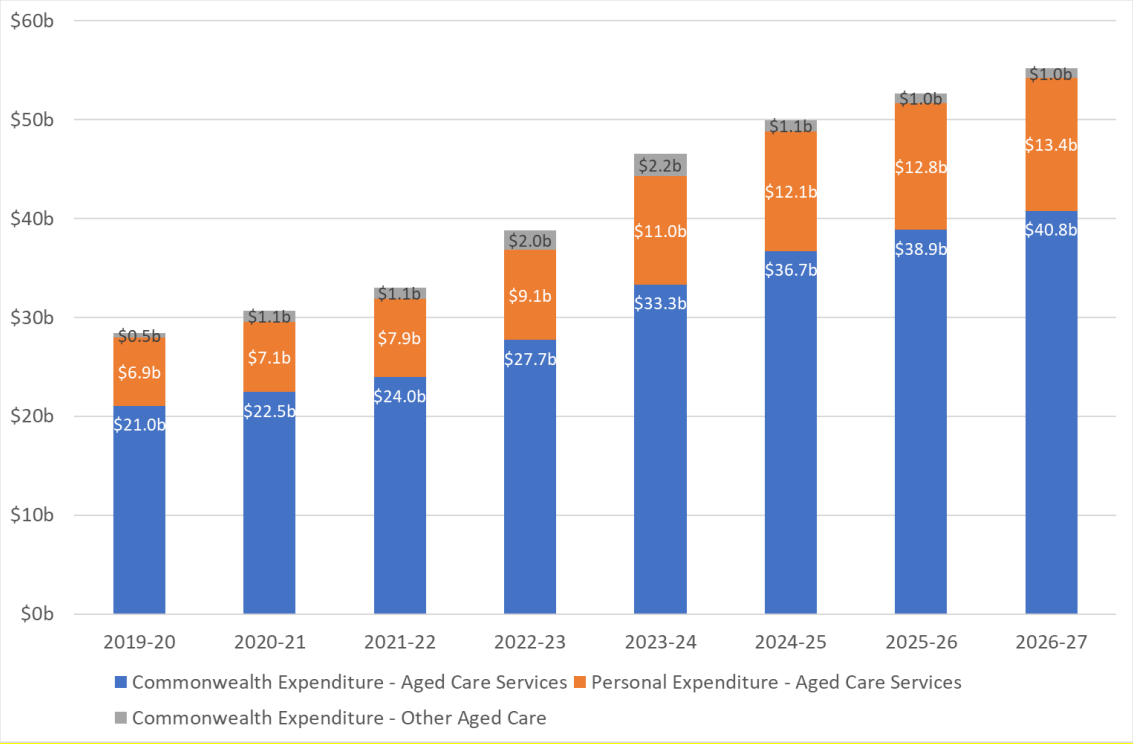
[26] Hogan WP. (2004). *Review of Pricing Arrangements in Residential Aged Care*. Canberra: Department of Health, p. 75.

[27] Royal Commission into Aged Care Quality and Safety. (2020). *Technical Supplementary Report 2: Cost Frontier Analysis of Australian Residential Aged Care Facilities*. Research Paper 9, p. 60.

[28] Historical public expenditure is drawn from the Productivity Commission's Reports on Government Services (see Productivity Commission, 2023).

Historical private expenditure is derived from Aged Care Financing Authority (2021) and Health and Aged Care (2022, 2023).

Exhibit 13: Aged Care Expenditure 2019-20 to 2022-23 and Estimated Expenditure 2023-24 to 2026-27



Assuming that the efficiency estimates for residential aged care that are discussed above are applicable across the entire aged care sector, then if for-profit providers were to vacate the field, the total cost of delivering the same level of aged care services would increase by at least 5.8 per cent (minimum Commission estimate). This would equate to an additional expenditure of $9.0 billion over the next four years with most of the burden of this cost falling on the Australian Government rather than individuals. If, more conservatively, for-profits were to decide to maintain their current level of service provision but not invest in the growth in the sector then total costs would be $1.4 billion higher over the next four years than they would be if for-profits maintained their current market share.

An alternative way of looking at these numbers is as follows:

- Since commercial firms are 5.8 per cent to 11.9 per cent more efficient than not-for-profit firms, average costs in the sector (assuming a market share of 40 per cent for for-profit providers) is between 3.1 per cent and 7.1 per cent higher than it would be if all services were delivered by for-profit providers.

Expenditure forecasts for Australian Government expenditure on aged care are derived from the Portfolio Budget Statements of the Department of Health and Aged Care (2023, pp. 96-7) and the Department of Veterans Affairs (2023, p. 46).

Forecasts for private expenditure for aged care were estimated from current expenditure shares.

- This equates to an effective subsidy to the not-for-profit sector of between $1.6 billion and $3.3 billion per annum in 2023-24.

This level of inefficiency will increase as for-profit providers vacate the field, or do not invest in the required expansion of supply.

If, alternatively, the Australian Government was to address the disincentive imposed by the differential cost of payroll tax for for-profit providers then, based on an effective payroll tax rate of 4 per cent and a 40 per cent market share for the for-profit sector, the cost of the additional payroll tax subsidy would be $2.5 billion over the next four year – which is less than half the increase in costs that will occur if for-profits do not take part in the expansion of the sector and less than a quarter of the increase in costs that will occur if for-profits vacate the field.

Importantly, levelling the playing field should increase the appetite for competitive capital investment into commercial aged care, which will over time reduce the market share of not-for-profits. This is efficient because as noted above, any increase in payroll tax supplement for an increase in for-profit share will be more than compensated by the productivity gain of replacing a not-for-profit with a for-profit provider.

The principal consequences of relatively lower efficiency of not-for-profit providers, coupled with growth in Commonwealth expenditure, are that costs will rise by a higher-than-necessary rate, while efficiency in the sector will be held back. Both these would be corrected by Commonwealth compensation of payroll taxes for commercial providers.

Solutions

There are five potential solutions to the problems caused by the payroll tax differential between for-profit and not-for-profit aged care providers.[29]

1) **Removal of all State and Territory payroll taxes in the aged care sector, to remove the observed disparities.**

   This option is the lowest-cost option to the Commonwealth.

   However, it will inevitably be viewed as a charge to State and Territory treasuries, which will be unappealing to those governments.

   As a further observation, there is an increased economy wide deadweight loss from the marginal economic burden of taxation (see discussion below) where this increases the distortionary exemption from payroll taxes, though the specific deadweight loss in the aged care sector is removed. This is common to all proposed solutions.

2) **Removal of all State and Territory payroll taxes in the aged care sector, with compensation to the states and territories by the Commonwealth.**

   This option addresses the objections that the state and territory treasuries might have to option 1.

   It has a higher apparent cost for the Commonwealth than the status quo and option 1 and a similar apparent cost to options 3, 4 and 5.

   However, as we argue in this paper, the reduction in the efficiency of Commonwealth aged care funding that flows from the differential tax treatment of different providers is a hidden cost already inherent in the system that is higher than the cost of compensating providers for the tax differential.

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[29] It would e possible for the Commonwealth to choose to compensate only residential aged care providers and not home care providers. The argument for this is that while some home care firms may have labour expenses which place them below the payroll tax threshold, this is never the case for residential care providers. This proposal is not supported as:

- It would be highly complex in the case of businesses with integrated home and residential care services to decide how much of the payroll tax impost to compensate.
- It would prefer labour allocation to residential services, which would be market-distorting and a source of inefficiency.

3) **The Commonwealth makes an additional payment, on top of the usual aged care subsidies and supplements, to aged care providers to the value of payroll taxes collected from their aged care businesses.**

   As discussed above, this option was used by the Australian Government between 1987 and 1999 through the Other Costs Reimbursed Expenditure arrangements.

   While the direct costs and industry effects of this option are identical to option 2, payment to providers is preferred over that option as it presents lower risks of gaming and should therefore have a lower overall deadweight loss.

4) **The Commonwealth makes an additional payment, on top of the usual aged care subsidies and supplements, to aged care providers who incur a payroll tax liability equal to the average impact of payroll taxes on those aged care providers who are subject to them.**

   As discussed below, this option was used by the Australian Government between 1999 and 2014 when a payroll tax supplement (set at a fixed percentage of average care subsidies) was paid to providers who had a payroll tax liability.

   The difficulty with this approach is that it does not recognise the complexity of the payroll tax arrangements and the differences between states. Some not-for-profits can be eligible to require payroll tax on some of their employees – which is why they sometimes show a small payroll tax liability – it would be unfair to allow these providers access to the full average supplement. Similarly, some for-profit providers are now so large that they have effectively exhausted the payroll tax free threshold and are paying a higher effective rate of payroll tax than smaller for-profit providers.

5) **The States and Territories remove the payroll tax exemptions for not for profit providers of aged care services.**

   This is undesirable, and in any case would violate strong political constraints.

Option 3 is strongly preferred as the most efficient way to address the distortions that the differential imposition of payroll taxes has on the efficiency of the aged care sector. As argued above, this approach is preferable to the status quo as it improves the overall efficiency of the sector sufficiently (by reducing the average price paid and the indirect subsidy to the not-for-profit sector) to offset the cost of the payroll tax supplement.

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