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Mr Nigel Ray PSM and Associate Professor Nicole Sutton
Residential Aged Care Accommodation Pricing Review

Email: accompricingreview@health.gov.au

Dear Mr Ray & Associate Professor Sutton

RE: RESIDENTIAL AGED CARE ACCOMMODATION PRICING REVIEW – SA HEALTH RESPONSE

Thank you for the opportunity to provide a response to the Residential Aged Care Accommodation Pricing Review and for providing advice on the terms of reference for the review.

SA Health has a strong interest in this review as:

- SA Local Health Networks continue to provide Residential Aged Care in a number of rural communities where private and other not for profit providers are not as available.
- The growing needs of the elderly population need to be met, and it is essential that private and not for profit organisations establish efficient and effective operations, and are adequately incentivised to respond to demand changes; and
- We work closely with all residential aged care providers as their services link with the wider health care system, including the hospital system and their capacity to respond effectively impacts the operation of the health sector.

The SA Health response to consultation questions has mainly focussed on its experiences as a provider of last resort but has also put forward a number of principles that we hope can contribute positively to the shaping of new policies governing Accommodation Pricing.

Should you require additional information please contact Denise Ferrier, Acting Deputy Chief Executive, Commissioning & Performance on email denise.ferrier@sa.gov.au

Yours sincerely

DR ROBYN LAWRENCE
Chief Executive

04 / 11 / 2025

Att: SA Health response to the consultation questions from the Residential Aged Care Accommodation Pricing Review

SA Health responses to the consultation questions

From the Residential Aged Care Accommodation Pricing Review

1. **Outline how you think the Accommodation Supplement could be reformed to ensure quality accommodation for residents of low means.**
    - SA Health provides a range of aged care services in rural SA including Residential Aged Care (RAC) for communities that have not been able to have community-based organisations and for-profit organisations establish RAC facilities to meet the requirements of people in need of aged care.
    - SA Health is therefore a provider of last resort in these communities mainly due to the lack of ability to attract other providers purely due to operational and economic reasons. Examples of this include lack of scale in operations, access to key resources and an inability to separately organise and attract the level of capital required to commence the development of RAC facilities. These factors are also linked with residents having low means of contributing at higher levels and this therefore provides further operating risks, particularly as rural incomes are subject to seasonal variation and markets.
    - As a provider of last resort, SA Health services are usually provided at a net cost to the SA Government and investment in facilities is subject to government funding commitments.
    - SA Health believes that competitive neutrality principles should apply across all sectors in a way that ensures operational needs for people living in all communities are met. At the same time, it should incentivise services to consider the growing needs of residents in Residential Aged Care as reflected across community.
    - It must also be noted that there are rural regions that have been successful in opening and operating RAC facilities over many years, and this has been thanks to not only significant government support but community support in the form of significant fund-raising programs.
    - Responses to other questions are aimed at ensuring that the not-for-profit sector and the private sector continue to thrive and meet the needs of our projected growth in aged care demand.
    - SA supports the “Matters for this Review” as outlined on p6 of the Consultation paper, namely:
        - Equity of contribution regardless of income or where they are located
        - Low means residents have access to high quality accommodation in RAC
        - Support the capacity of providers to attract funds and invest in high quality RAC facilities.

2. **Should the value of the Accommodation Supplement be universal or tiered such as by location or proportion of residents or other basis?**
   - It is recognised that the Accommodation Supplement can meet the objective of equitable distribution of public funding for all people in aged care regardless of income levels.
   - The option of further "Tiered" payments should be considered carefully as it should be recognised that from 1 November 2025, new residents are required to contribute the 2% RAD retention (for up to five years) as a legislated new revenue for RAC facilities.
   - Where there are populations with residents who cannot contribute to RAD and therefore not contribute to RAD retention, this will create a "tiered" difference of income that RAC facilities can generate. SA Health argues that this is inequitable to several of its public RAC facilities when compared to benefits that other providers servicing income advantaged populations receive.
3. **Should the Higher Accommodation Supplement be staggered over time, so that as the accommodation facilities age the supplement is reduced (with the full value payable again after a new renovation)?**
   - Providers should be incentivised to ensure that building infrastructure is managed effectively and where redevelopment is required that plans are put in place to ensure these are undertaken or steps are taken to manage replacement builds.
   - The payment of a supplement even when varied to recognise asset life stages does not in itself ensure that there is incentivisation of renovation and replacement builds. The decision to commit to further investment and the risks that are taken on in construction and over future income and operational levels are equally important.
   - It is recognised that higher upfront payments provide a higher rate of initial return on investment and therefore de-risks investment decisions and contributes positively to investment estimates.
4. **How suitable is the current incentive structure to encourage providers to accept low means residents (a discount on the Accommodation Supplement based on a single threshold of 40% supported residents)? How could those incentives be preserved or enhanced?**
   - It is recognised that the fees' structure (outlined on p8 of the consultation paper) provides further income for all patients in their care e.g. 33% more for services that were significantly refurbished or newly build on or after 20/04/2012. This is approximately $6,000 per patient per day for every patient that meets the 40% threshold and therefore promises to provide an incentive to take on low means residents.
   - Low income is linked to lower health status and the risk of greater chronic illness particularly as people age and this may therefore contribute to lower cognition and mobility categories that come with higher aged care costs.

- Whilst demand for aged care placements is continuing to remain strong this provides RAC facilities with the ability to pick and choose their preferred patients, there is therefore the continuing risk that high-cost low means residents could continue to be referred to default public RAC facilities.
- It may take some time for RAC facilities to adjust to:
  - The incentive fee structure for low means individuals where a 40% threshold can be obtained
  - The competing alternative of RAD retention 2% (up to $15,000 per annum in the first year) and how this is best balanced from a revenue maximisation perspective noting benefits of the RAD in providing further benefits (interest, etc)
  - The attendant problem of maintaining equity for all in an environment where there is continuing high demand for RAC accommodation.
- SA has further work to do to understand its RAC population.

5. **How can the Accommodation Supplement be reformed to support an uplift in the quality of accommodation?**
   - This would require understanding what an acceptable quality of accommodation is and an understanding of the condition of the assets and their ongoing maintenance, redevelopment and replacement.
   - Some of these accommodation factors will be linked to local level conditions and community needs.
   - The Accommodation Supplement would also need to retain its currency in terms of the real growth in building and construction costs that are being experienced in the building sector.

6. **Outline how the Accommodation Supplement pricing impacts on incentives for capital investment in residential aged care.**
   - The Accommodation Supplement does not incentivise capital formation in several of SA's rural areas where SA Health provides RAC facilities by default. Put simply there are other factors at play including scale, access to resources and other factors at play that prevents alternative providers from establishing RAC facilities.

7. **In what ways could the Accommodation Supplement be reformed to better incentivise capital investment in residential aged care?**
   - Steps to increase revenue certainty and to reduce administration complexity could provide increased transparency and reduce risks and focus providers on developing the business case for continued capital investment.

8. **To what extent are the current rates of the Accommodation Supplement sufficient to cover providers' capital and operational costs relating to accommodation?**
   - In 2024-25, SA Health generated less than $5m of Accommodation Supplements and this is insufficient to cover the building depreciation expense (i.e. to replace the existing asset). As previously commented, there are several factors besides accommodation revenue contributing to this variance.

9. **How does the costs of providing accommodation vary across different operating environments, such as differences in location?**
    - Building contractors will usually price in staff accommodation and travel costs as well as accounting for differences that occur in freight and cost of obtaining supplies and associated labour.
    - Operational costs in rural locations are subject to scarcity of available resources in the location that the RAC facilities are operating. Agency staff are often called upon to work shifts at far higher costs.

10. **What factors should be considered in setting an equivalence mechanism and rationale for each?**
    - Scale factors could be determined by the number of resident beds.
    - Remoteness measures would likely capture cost disadvantage measures but may also double count scale factors.
11. **What is an appropriate rate of return on lump sum for providers? Is this an appropriate level for setting an MPIR?**
    - SA notes the discussion on page 14 and 15 of the consultation paper and:
        - Supports that pricing models should be stable to provide income certainty for providers and to improve equity between RAD and DAP payers
        - Supports pricing models that establish administrative efficiency in billing for all RAC residents.

    - SA also recognises and supports the points provided (on p15) that summarises costs and benefits and solutions proposed by reviews undertaken by the Aged Care Taskforce, Royal Commission, and Aged Care Financing Authority.
    - SA notes the current MPIR is 7.61% (from 1 October 2025) and that it is legislated to include a margin to top-up the General Interest Charge so that it reflects market interest rates. It is recognised that at current levels this could be an expected earning rate for loan arrangements covering approved RAD purposes.

12. **How does this change with economic conditions? Does the MPIR link to the General Interest Charge represent an appropriate way of adjusting equivalence in line with economic conditions?**
    - It is recognised that the MPIR can increase or decreasing consistent with national monetary policy and the demand for capital in the prevailing economic conditions.
    - As it is adjusted quarterly it will move consistent with official national monetary policies.
    - The MPIR that is linked to the General Interest Charge is therefore supported by government policy that applies in other areas of the national economy.

13. **Would a Weighted Average Cost of Capital be an appropriate equivalence mechanism? If so, how should this be derived?**
    - The Weighted Average Cost of Capital may have relevance for private sector providers and to some extent not for profit RAC providers particularly if they need to compete within their organisations to access capital or via the open market.
    - For default providers such as SA Health where financing business cases rely on government funding the measure is not relevant except to highlight the cost to the taxpayer to establish operational equivalence with other providers across the RAC sector.

- The WACC is a traditional measure that only focusses on the cost of obtaining capital to finance net assets. It does not measure further capital factors such as maintenance and the whole of life for assets including refurbishment and replacement.

14. Is there a case for an equivalence range rather than a single point of equivalence defined by the MPIR and why? How might this work?

- The use of the MPIR is established to reflect movements in rates that apply in the broader economy would only set a threshold or a price for investment. The MPIR does not specifically establish the WACC is linked to further financing concepts including risks to capital or the reliability of returns.
- In the Consultation Paper at p15 there is brief mention that Macquarie University noted some issues with the WACC approach, and this should be reviewed further.

15. Should the government introduce a mandated minimum accommodation payment that prevents providers receiving less revenue from non-supported residents than they do from supported residents?

- It is recognised that the situation described is an unintended consequence of the fees models that have been established to provide non supported residents with choice regarding the use of the financial assets they have contributed to RAC facilities.
- These unintended consequences would likely need to be remedied in a way that is balanced against other costs and benefits of the current system and current impacts between the Commonwealth, providers and non-supported residents.

16. What are the advantages and disadvantages of moving the MPIR-related fluctuations in pricing from the DAP to the RAD?

- The key disadvantage with the RAD is that it is established at the commencement of the resident being accepted into care. It is therefore a contracted amount that is calculated based on a resident's available assets, the assessed contribution and the MPIR and is capped.
- Follow-on calculations for the contributions to the Accommodation Supplement therefore reference the original RAD calculation and this may contribute to variations in the level of income being generated by RAC facilities.
- This uncertainty that arises from the initial interest rate that was applied is a risk borne by the RAC facilities.
- It should be noted that SA's RAC facilities face income uncertainty especially as rural incomes rise and fall due to changes in the prices of commodities.

17. Would setting DAPs as the default make accommodation pricing easier to understand for prospective residents and their families?

- Using the DAP as the default (and not providing the option of RADs being available) would improve operational simplicity and increase transparency for RAC facilities and residents alike.

18. Are there other relevant factors to consider in relation to setting the DAP as the default payment type?

- If systems change to accept DAP as the default, administrative procedures and guidelines would need to change to amended administrative systems so that policy objectives could be achieved (e.g. how it may impact on the RAD balance).

19. Do you think the DAP should be set as the default payment type? Why?

- The following factors are relevant in supporting the DAP as the preferred payment type:
    - Administrative ease for RAC facilities
    - Increased income certainty
    - Equivalence of the calculation of the Daily Accommodation Fee across all residents
    - A RAC facility or agreement to pay a RAC facility could still provide benefits to RAC providers based on the means of residents. Residents and their estate would still have access to the residual deposit once they leave.