Comparing ECEC and aged care funding models

A report for the Australian Childcare Alliance

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dandolopartners

Introduction

There is policy debate underway about the application of 'supply-side' funding models for the early childhood education and care (ECEC) system.

There is currently a significant wave of reform thinking in the ECEC sector. This includes

- Bold changes to preschool delivery in some states and territories
- Substantive and wide-ranging inquiries from the Productivity Commission (PC) and the Australian Competition and Consumer Commission (ACCC)
- Reviews of specific programs like the Inclusion Support Program (ISP)
- Broader reviews likely to impact ECEC, including how children are supported through the National Disability Insurance Scheme and gender equity in industrial arrangements.

A key thread of many of these debates is the adequacy and appropriateness of the Child Care Subsidy (CCS) funding instrument for delivering on the government and community's objectives for ECEC – with clear opportunities for improvement identified by both the PC's interim report and the ACCC.

Some advocates have suggested that a new, supply-side funding model with capped parent fees is a better solution than the iterative improvements indicated by the PC's interim report and recommended by the ACCC. Changing the core funding instrument for the sector is, however, a very substantial change; one that's necessarily disruptive, and that carries both opportunity and risk.

The Australian Childcare Alliance has commissioned dandolopartners (dandolo) to investigate the design, operation strengths and limitations of one of the established supply-side funding models in Australia, the residential aged care funding model.*

This report aims to:

- **Unpack the difference between supply-side and demand-side funding models** – using aged care and ECEC as examples
- **Identify the key challenges experienced in the aged care sector** and explore the role that the funding model has played in creating, mitigating or resolving them
- **Tease out the implications of the aged care experience for the ECEC sector**, including identifying risks and critical design considerations

The report is a contribution to ongoing conversations about potential future directions for policy change in the sector, and is intended as a contribution to deep policy thinking underway across the sector.

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*Note: this report has considered residential aged care only. Our analysis does not include in-home care or other elements of aged care investment.

Executive summary

ECEC and residential aged care operate in similar systems and markets but have taken different approaches to both public funding and co-contributions from individuals / families. The past and current supply-side funding model used in aged care highlight both risks and opportunities for ECEC.

There are distinct similarities in the systems and markets ECEC and aged care operate in.

This means aged care is a useful, Australian-specific case study for exploring the potential implications of supply-side funding for ECEC. Both ECEC and aged care are:

- Receiving substantial subsidies from government, supplemented by user payments
- Supporting a significant proportion of the relevant population
- Characterised by a diversity of provider sizes and types – standalone, small and large providers across not-for-profit, government, small-business and large corporate providers
- Subject to high levels of regulation, reflecting the level of risk and vulnerability of the populations they serve
- Experiencing a wave of reform

The demand-side funding model for ECEC and the supply-side funding model for aged care are have some key differences, particularly in terms of:

- How they regulate price and what / how much consumers pay
- How they account for differences in cost of delivery
- How they determine government funding levels
- How they fund differences in needs between individuals / communities
- How they ensure funding keeps pace with changes in cost of delivery

Aged care offers a cautionary tale for a poorly designed supply-side funding model. As the Royal Commission found, a funding model that did not keep pace with cost or demand undermined the system as a whole.*

Under the previous aged care funding model, the Royal Commission found that the priority of restraining growth in expenditure had been *'pursued irrespective of the level of need, and without sufficient regard to whether the funding is adequate to deliver quality care',* due to inadequate provision ratios, inadequate indexation and explicit measures to achieve budget savings.

The Commission estimated that the combined impacts of low ratios, inadequate indexation and explicit budget saving decisions shortchanged aged care funding by $9.791 billion in 2018-19.

The impact of inadequate funding levels was apparent in the significant system failures observed by the Royal Commission:

- **Older people were not always able to access care when they needed it** – due to inadequate supply of places, particularly in low socioeconomic and regional, rural and remote areas.
- **Many providers were not financially viable** - ~42% of residential aged care providers reported an operating loss in 2018-19 (increasing to ~64% in 2021-22).**
- **Quality of care was severely compromised** – the Commission estimated that at least 1 in 3 people in aged care had experienced substandard care.

While significant reforms to residential aged care funding have now been implemented, challenges remain in setting funding at a level that ensures the sustainability of the sector and supports delivery of high-quality care.

Financial viability issues persist, particularly due to funding shortfalls for daily living and accommodation – contributing to more consolidation and less diversity

Quality is still an issue, with two-thirds of providers still failing to meet mandated levels of care.

Supply growth is inadequate and continues to be well below what is estimated to be required to service future demand.

The recent Aged Care Taskforce report recommends further reforms to the aged care funding system to address these issues.

* Royal Commission into Aged Care Quality and Safety (2021): Final Report: Care, Dignity and Respect
**KPMG (2023): Aged care sector analysis 2023.

Executive summary

There are significant hurdles involved in getting the funding settings 'right' in a supply-side model, and considerable risks to quality, accessibility and market health if they're not set appropriately. ECEC is starting from a lower base than aged care, in terms of system and data maturity.

To prevent the future erosion of aged care funding settings, there is a now a significant administrative infrastructure in place.

- The pricing authority, Independent Health and Aged Care Pricing Authority (IHACPA), requires
  - A significant annual budget from government to operate, with an additional ~$18bn p/a for the existing health pricing authority to take on new responsibilities in aged care.
  - Enhanced IT infrastructure for payment and data collection portals (~$1.4bn).
- The funding model requires extensive and regular financial reporting from providers to support subsidy and pricing advice, including:
  - Monthly submission of claims.
  - Extensive mandated financial reporting on both a quarterly and an annual basis.
  - Reporting on individual homes and whole-of-provider levels.

Getting the funding level 'right' under a supply-side ECEC funding model is a very real challenge.

Aged care was starting from a higher base, in terms of both sector and government knowledge and capability, whereas in ECEC:

- **Government agencies would be starting from scratch** in building the sector-specific knowledge and infrastructure required. Unlike aged care, there's no existing pricing authority with in-house capability to build on.
- **Accurately estimating the costs of delivery in ECEC will be challenging**, as they're not well understood and are known to be variable. Unlike aged care, there's no history of consistent and regular financial reporting across the sector.
- **Ensuring sufficient returns to support capital growth is complex**, but an essential design feature to ensure supply is adequate to meet future demand. The aged care model includes different components for 'care', 'accommodation', and 'daily living' – but this mix looks different in ECEC.
- **Governments will be under ongoing pressure to constrain expenditure** due to broader budgetary considerations and competing priorities over time. Aged care stakeholders are not necessarily confident that the funding increase associated with the new system will be maintained over time.
- **The transition costs are significant and sustained**, as it takes time, sophistication and enduring commitment to get the settings right. The current aged care funding model still requires significant adjustment and development.

If funding levels are set too low, the implications for ECEC are likely to be very similar to those observed in the aged care sector.

Compromised quality

Aged care providers are clearly incentivised to meet – but not exceed – minimum staffing standards. It's clearly difficult to staff over-ratio or make additional investments in quality in a tightly regulated funding model.

Reduced supply and accessibility

Over the last decade, aged care hasn't been sufficiently profitable to drive investment – and there hasn't been enough investment in services to meet future demand.

Reduced market diversity

Some aged care providers have exited the market and more homes are closing than opening. This has been most acute in less profitable markets.

Underinvestment in facilities

Many aged care services have degraded over time as there's not been sufficient revenue to keep them up to date.

Executive summary

The ACCC made sensible and considered recommendations about the role of supply-side funding in under-served ECEC markets. However, if a full supply-side model is applied to ECEC, the experience of aged care provides guidance on the way forward.

The ACCC does not recommend broad application of a supply-side model for ECEC.

They suggest a supply-side model is not necessary or appropriate in the ECEC context, noting:

- **No evidence of widespread excess profits** in the sector
- **Many ECEC markets are well served,** meaning there is strong potential for competitive tension to deliver desired outcomes
- **Maintaining targeting of funding to families most in need of assistance is appropriate**, and represents an efficient use of government funds
- **The risks, transition costs and complexity** associated with switching to a supply-side funding model would be significant.

The ACCC recommendations strike the right balance between reform and due caution by:

- **Targeting application of supply-side funding** only to where it is most needed (in under-served markets), and
- **Retaining elements of the current model, with critical improvements to increase its effectiveness,** including by introducing a credible threat of intervention (e.g., naming and shaming providers who massively increase fees) mitigate excessive price increases and a stronger monitoring role for government.

It may be premature to take the risk of complete system overhaul without first implementing the measures recommended by the ACCC

Given the considerable risks involved in a new funding model, giving the ACCC's recommendations a chance to deliver the desired system outcomes is a sensible approach.

If a supply-side model is to be implemented for ECEC, learnings from aged care funding should be front of mind for policymakers.

There are clear lessons about what works …

- **Fund the system for the level of quality you want, not the level of quality you have** - to ensure desired uplifts in quality are built into subsidy levels and to prevent a 'race to the bottom'.
- **Recognise that it will be costly and time consuming to build the requisite level of sector knowledge and administrative capability for a supply-side model** – noting that ECEC is starting from much further behind than aged care.
- **Focus on getting cost indexation right**– across different cost components and contexts and to ensure the model is 'future proof' and responsive to short and long-term changes in industrial arrangements, real estate markets and other operational costs.
- **Work in collaboration with sector experts to design and implement the new system** – this has worked well in recent aged care processes, and the detailed and nuanced knowledge of the cost of delivery will be critical for identifying and mitigating the risk of perverse incentives and outcomes.
- **Consider the most appropriate mechanism to support capital growth** – this is essential to ensuring future supply meets demand.
- **Build in explicit requirements to pass on wage increases as well as on-costs** – so that additional funding is used as intended.

And cautionary tales about what to avoid …

- **Don't let the system create perverse incentives for providers**– which may negatively impact the overarching system objectives of quality, equity, and access. For example, a supply-side funding model that doesn't account for diverse delivery costs risks incentivising a minimalist approach to staffing, and penalising services that make additional investments in their workforce, in quality improvement and inclusion.
- **Don't take a piecemeal approach** – unlike the staged approach to funding reform in aged care, any supply-side funding model for ECEC should be developed as a cohesive package of subsidies, user payments and system / quality reforms that are designed to work together.

System and market comparison: Why aged care is a useful comparator for ECEC

ECEC and aged care delivery models

ECEC and aged care provide critical, highly valued support to people at each end of the life course. Yet there are distinct differences in the way these services are accessed – from the variability of ECEC demand to the consistency and predictability of demand in aged care – which significantly impact service delivery, and the funding models needed.

ECEC

Long day care (LDC) services provide care and education for young children aged six weeks to five years. Families access long day care services to:

- Enable their children to be cared for while they are working or studying, and
- Strengthen their children's learning and development.

There is significant diversity in when and how much families seek to access ECEC services for their children. Demand for LDC services varies:

- **As children age** – 11.4% of 0–1-year-olds are enrolled in ECEC compared with 89% of 4–5-year-olds.[1]
- **Depending on families work or study needs** – the average attendance per child in 2022-23 was 33 hours per week for LDC.[2] For example, nearly twice as many mothers of 3-5 year olds work full time, compared to mothers of 0-2 year olds.[3]
- **Depending on their eligibility** – changes in work hours and household income impact the number of subsidised hours families can access.
- **If their child is preschool aged** – as some states support preschool attendance through LDCs while others offer preschool through schools.
- **By socio-economic status** – there tends to be a lower proportion of children from lower socio-economic areas enrolled in ECEC.[4]
- **By availability of services** – on average, there are fewer ECEC places available per child as areas become more remote, and there is undersupply in some communities.[5]

This means demand for ECEC is highly variable and can be unpredictable – and funding models need to be responsive to family circumstances that change week on week and year on year and varied occupancy patterns in services.

Residential aged care

Residential aged care provides support and accommodation for older people who:

- Are unable to continue living independently in their own homes,
- Need ongoing help with everyday tasks and
- Have been assessed as needing higher levels of care than can be provided in the home.

While some older people access care on a temporary (respite) basis, most people in the system are receiving full-time, permanent care within a single facility.:

- 84% of exits are due to death and only 6% due to movement to another aged care facility.[6]
- The median length of stay for permanent residential care is around 21 months and has been trending up over time.[7]
- The care needs of an individual may vary over time (as they age, or health conditions deteriorate) – although most people in permanent residential care had high care need ratings in at least one care domain (68% of people for activities of daily living, 68% of people for cognition and behaviour, and 58% of people for complex health care).[8]

The permanent nature of care in residential aged care facilitites makes the volume of places required relatively predictable – although care needs may increase over time, a place is 'fully occupied' as soon as a resident is placed within a service.

Market comparison

There are clear similarities in the systems and markets ECEC and aged care operate in. However, they have distinctly different funding models and provide a useful, Australian-specific basis for comparison.

It's important to understand the market structure and system design to meaningfully compare ECEC and aged care funding models

Funding models both reflect and create the systems and markets in which they operate. Indeed, setting the parameters of a funding model is the most powerful lever government stewards hold to 'set the rules of the game' in which services are delivered and providers operate.

To compare funding models, it's important to understand:

- **The context of the system** – what services are provided, to whom, and what's needed to deliver quality
- **The market structure** – the size and sophistication of providers, the scale they operate at / the extent to which they can realise economies of scale, the general level of organisational maturity of providers, and the drivers / incentives that shape their decision-making.

These factors shape assessments of funding adequacy and inform how funding levels / requirements need to be set to be effective. They also indicate the extent to which risks around fraud, 'gaming the system', and diverse cost profiles need to be taken into account.

There are clear parallels between the ECEC and aged care systems and markets

In addition to both providing essential care and valued support across the community – including for highly vulnerable populations, both ECEC and aged care are:

Substantially subsidised by government, but with a means-tested co-contribution that's proportionate to a household's income / capacity to pay.

- The annual Australian Government contribution to ECEC is $11.6 bn,[9] compared with $17 bn in aged care.[10]

Supporting a significant proportion of the population, including across socio-economic, demographic and geographic communities.

- ECEC serves a larger population, with nearly a million children accessing services in a given year,[11] compared with around 250,000 aged care residents.[12]

Characterised by the diversity of the providers, with a mix of large and small providers from not-for-profit (NFP), small business, large corporate and government sectors.

- There's a similar division of small / standalone, medium and large providers in ECEC and aged care, and a similar mix of NFP, private and government provision – although NFP providers hold greater market share in aged care.

Highly regulated, because of the vulnerability of the people they serve and the high levels of risk they carry – and the importance of quality for achieving intended outcomes.

- There are mandated staffing ratios, qualification requirements and quality standards in both sectors, as well as broader requirements around workplace health and safety / food safety.

Experiencing a wave of reform, driven by significant community concern around accessibility, affordably and quality – and the perception that the system fundamentals aren't adequate for delivering on community expectations.

- There was a Royal Commission into aged care in 2018-21, and substantial inquires into ECEC in 2023/34.

There are some fundamental differences in the way services are provided

In particular:

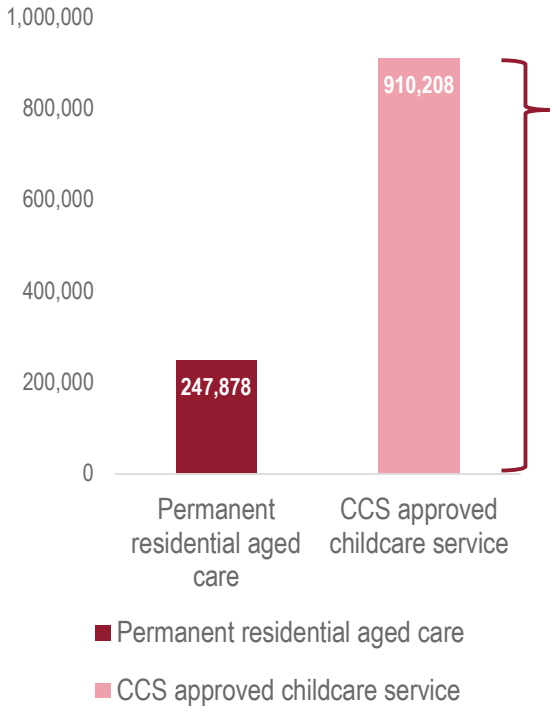
- **Occupancy is much more stable and predictable in aged care** – with residents occupying their places 24/7 while children in ECEC often have highly variable access.
- **Capital outlays in aged care are more substantive** – both sectors need bespoke facilities, but the core capital cost in much higher.

Both of these factors are material when considering the adequacy of the funding model.

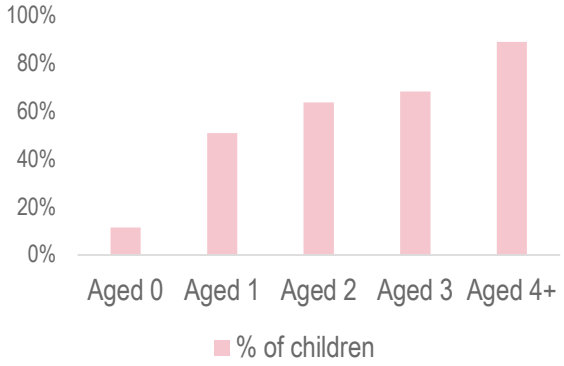
Population reach and expenditure

Both ECEC and aged care support thousands of individuals and families each year, although ECEC has a much larger footprint.

In 2022-2023, the number of children in CCS approved childcare services was 3.6 times higher[13] than the number of people in residential aged care.[14]



The proportion of children attending ECEC increases from around 12% of infants to close to 90% of children aged 4+.[15]



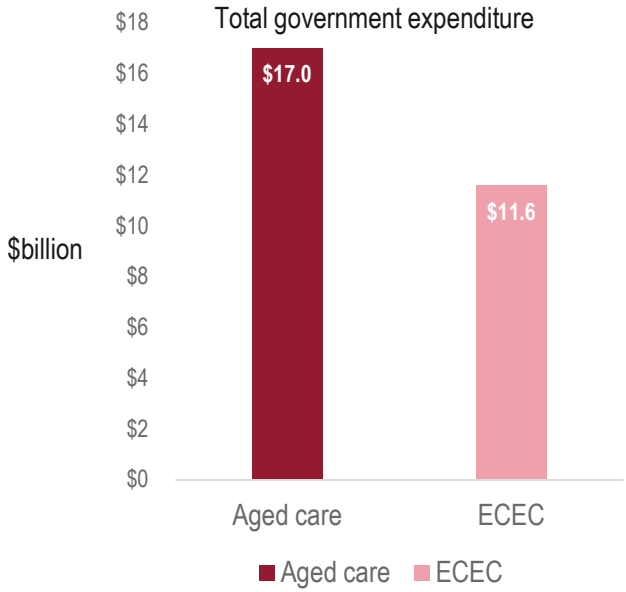
Residential aged care is used by a comparatively small portion of the population

5% of the 65+ population[16]

30% of the 85+ population[17]

Cost of delivery is lower in ECEC, and it receives significantly less government investment.

In 2022-2023, the government invested $5.4 billion dollars more in residential aged care[18] services than in ECEC services.[19]



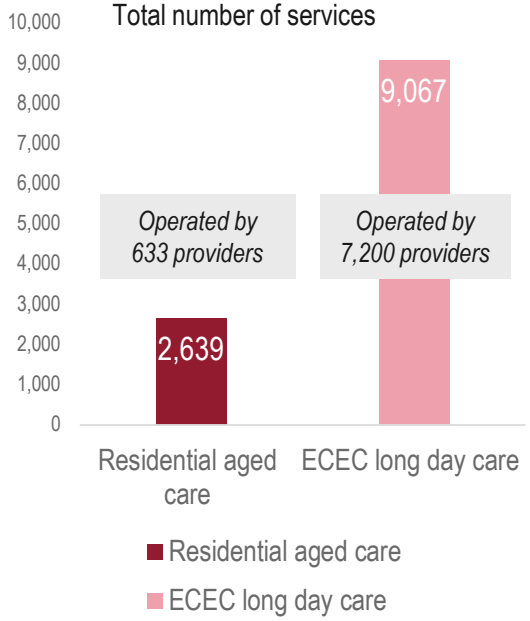
Funding model implications

- There are more families impacted by ECEC funding settings – heightening its political visibility and the level of risk
- Both funding models are uncapped and activity-based, which means the total cost to government is impacted by changes in population growth

Market comparison

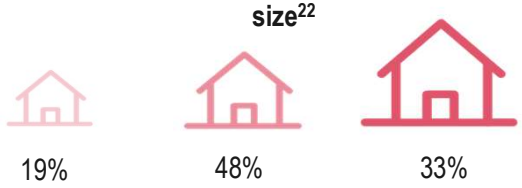
There are significantly more ECEC services in operation than there are residential aged care services, and a higher proportion of single service providers in ECEC. In both sectors, there's a diverse mix of private, not-for-profit and government provision.

In 2022-2023, there were 3.4 times more ECEC long day care services in operation[20] than there were residential aged care services.[21]



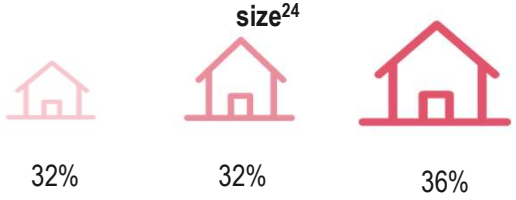
In both aged care and ECEC, around a third of services are owned by large providers, however ECEC has a larger proportion of services owned by single service providers.

Proportion of aged care services by provider size[22]



Small (1 service), medium (2-19 services), large (20 or more services)

Proportion of ECEC services by provider size[24]

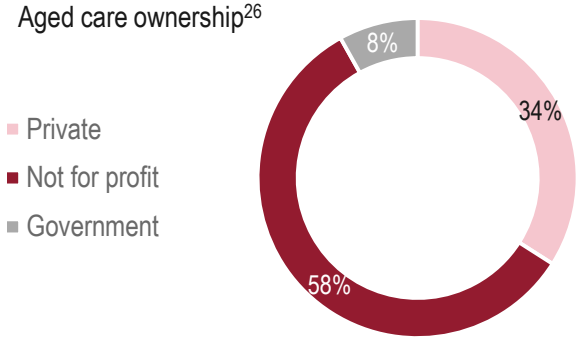


Small (1 service), Medium (2-24 services), Large (25 or more services)

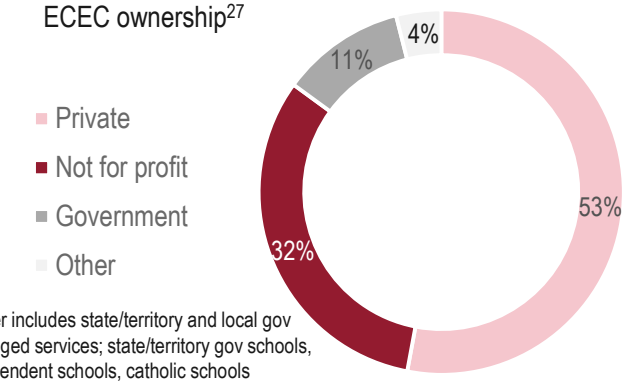
*size is measured differently in each sector

Both sectors are a mixed market, with private, NFP and government provision – although NFP providers have much higher market share in aged care.

Aged care ownership[26]



ECEC ownership[27]



*Other includes state/territory and local gov managed services; state/territory gov schools, independent schools, catholic schools

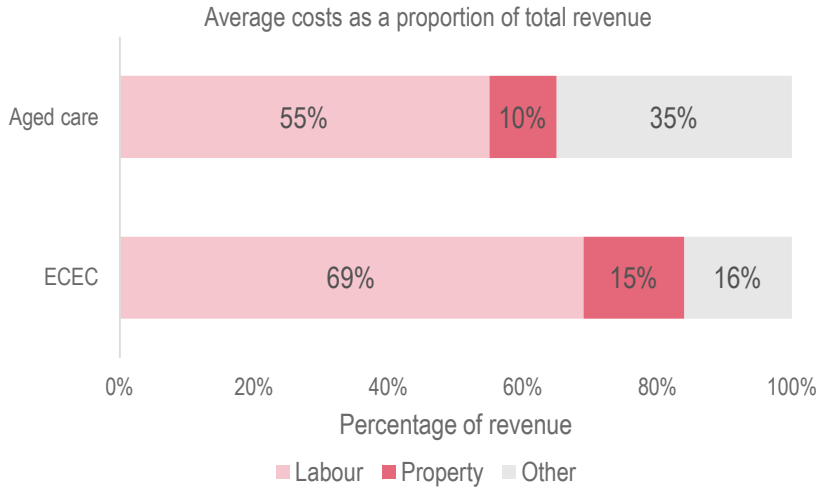
Funding model implications

- Both funding models need to solve for differences in cost of delivery between standalone / single operator services and large networks – each of which has a different cost base and structure. Anecdotally, however, cross-subsidisation is much less common in aged care and each site is more likely to operate as a standalone entity.
- There is similar diversity across both sectors, but there are many more services in ECEC, much greater scope for differences in cost of delivery, and more complexity in building consistency and alignment. The higher proportion of single service / small providers in ECEC creates additional challenges for supporting effective implementation.

Cost structure comparison

For both ECEC and aged care, labour is the most significant cost category, followed by property costs – although ECEC is much more exposed to labour market changes / costs. Across both sectors, the fixed costs of service delivery are high.

Labour and property are the primary cost drivers across aged care[28] and ECEC.[29]



*Other includes regulatory compliance costs, consumables, finance and administration, utilities

Revenue drivers

Across both sectors, revenue and viability is determined by occupancy – with aged care generally aiming for around 92% occupancy at minimum,[30] and ECEC generally needing around 70% occupancy to cover fixed costs.[31]

Profitability

Both sectors currently deliver modest revenue.

- In ECEC, the ACCC reports an average profit margin of 9% for large LDC for profit providers, and 6% for not-for-profit providers.[32]
- In aged care, the most recently reported year to date net profit before tax (NPBT) margin was 3% .[33] Provider revenue in the aged care sector has not always been stable – in 2021-22, the NPBT margin was negative 10%.[34]

There is considerable variation in costs in the aged care sector. For example, in services participating in a sector benchmarking report, labour costs were as high 79% for the least profitable quartile of services.

In practice in ECEC, there are range of factors that influence divergence from the average costs in ECEC, including:

- **Services making greater investments in their workforce** – staffing over ratio and employing more qualified and experienced staff
- **Services with historically low property costs** – receiving peppercorn / below market rate rents, or in services in premises they own and have paid off initial investment costs
- **Services with high property costs** – including services in inner metro areas or services carrying high levels of debt they need to service. Rent is linked to licenced places with a set amount per licenced place (ranging from $3,000 to $8,000 per licenced place)
- **New and upgraded services** – bearing both the cost of the build and fit-out, combined with additional expenditure on building team / operational culture and usually lower levels of occupancy. Establishing a new ~100 place service costs $1m to $2m and the cost of updating a playground at a facility of this size varies from $300k - $500k.

The ACCC claims that costs are relatively consistent across the sector,[35] a position that is contested by providers.[36]

Funding model implications

- Both sectors experience high fixed costs and require high levels of occupancy to cover their fixed costs.
- Both sectors are very exposed to changes in labour costs, in part because of regulated staffing levels and highly Award-dependent sectors. This is more acute for ECEC.
- ECEC is much more exposed to the commercial property market than aged care – for example, regular rent reviews that link rental rates to CCS subsidy levels, and/or lending terms benchmarked to expected returns.
- Providers are very exposed to changes in cost of delivery – economies of scale are limited, individual services / providers have limited ability to influence the cost of the core inputs (wages/property), and margins are modest.

Funding model design: How the ECEC and aged care funding models work

Overview of funding model design

This section provides an overview of the ECEC and aged care funding models, and considers the objectives and principles that shape their design

This section:

Outlines different types of funding models …

Description of demand and supply-side funding models

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Describes the core elements of the ECEC and aged care funding models …

ECEC funding model– a demand-side case study

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Residential aged care funding model – a supply-side case study

p. 15

Distills the key differences and similarities …

Comparison of ECEC and aged care funding

p. 16

For each, we provide an overview of:

- The elements of government funding
- How out-of-pocket costs are calculated
- How providers are funded
- Other key elements of funding model operation

And provides an analysis of how each model approaches the various factors government is 'solving for'.

We have developed a framework that captures the core objectives governments navigate – and face trade-offs about – when designing a funding model

It considers critical but competing objectives:

- **Value for money**
- **Accountability**
- **Efficiency**
- **Market health**

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With more detailed analysis of these factors in Appendix

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Funding model design

Demand and supply-side funding models are suited to different system characteristics and different policy outcomes.

Subsidies paid to the service user ('demand-side')

Demand-side funding models generally come in the form of a subsidy paid to households to cover all or some of the costs of accessing a service.

They are often used in systems where there is a market of providers, where price and cost are variable, and where the role of government is to reduce the out-of-pocket cost for service users.

Payments can be made directly to households or be paid to the service providers that households have chosen to use.[37] They're usually either a flat fee or a proportion of the total price.[38]

Demand-side models may be appropriate when…

- Government aims to target the level of subsidies based on individual / household characteristics (such as family income or level of need), or target to certain cohorts and not others.[39]
- There is sufficient demand to support numerous providers competing within a local market.
- Households have adequate information on quality and alternative options to meet their needs.
- Government aims to support choice and market efficiency by encouraging providers to compete by:
  - Providing high-quality services;
  - Offering lower prices; and
  - Being responsive to household needs – for example, the types of care sought, hours of operation or opening new services in areas of high demand.

Examples include:

- ECEC
- NDIS
- Medicare

Subsidies paid to the service provider ('supply-side')

Supply-side funding models involve payments directly to the service provider to cover some or all of the costs of supplying services.

They may take the form of operating subsidies or direct public provision. They also come in several different forms (e.g. activity-based funding that varies with the number/type of services provided, or lump sum block funding).[40]

Providers may be allowed or encouraged to charge a co-payment to households, which is often fixed in dollar terms.[41]

Supply-side models may be appropriate when…

- There is a desire to vary subsidies based on cost differences (e.g. linked to certain cost components or service provider characteristics).[42]
- There is a policy imperative to broadly and directly limit or fix out-of-pocket costs for consumers.[43]
- Governments wish to attach specific conditions to subsidies or target certain areas of need through tailored funding instruments.[44]
- There is a lack of competitive pressure in the market, meaning choice and efficiency benefits of a demand-side model may not be realised.
- If there is a very high cost of supply for a particular market/service type/cohort, and services are likely to be unprofitable or unviable without additional support.[45]
- Services or core infrastructure are directly provided by government.

Examples include:

- Aged care
- Hospitals
- Schools

Some funding models include a mix of both – for example, the ACCC has proposed that ECEC funding remain demand-side where there's an effective and competitive market and introduce a supply-side component for under-served markets and cohorts.[46]

ECEC funding model (demand-side)

The CCS is a demand-side subsidy that is activity-based and means-tested. The cost of delivery is shared between governments and families, with the balance of that share determined by family circumstances. Providers set fees, but government use the hourly rate cap to limit government expenditure and provide a price signal to providers and families.

Australian Government funding is primarily provided through the CCS.[47]

The Child Care Subsidy (CCS) is:

- **Paid directly to providers** based on:
  - Each child's booked hours, and
  - The subsidy level their family is entitled to.
- **Based on a proportion of a benchmark fee** (the hourly rate cap or HRC) or the hourly fee charged by the LDC provider, whichever is lower.
- **Demand driven**, with the total amount spent based on need / eligibility, not a capped funding bucket.

Additional Childcare Subsidy (ACCS) provides 100 hours of subsidised care each fortnight for:

- Households experiencing temporary financial hardship
- Grandparents caring for their grandchild
- Children in out of home care or who are at risk of harm or abuse

Parents transitioning to work are also eligible for the ACCS subject to their activity level and period out of work.

The Inclusion Support Program (ISP) is a supply-side mechanism that helps children with additional needs to participate in ECEC through tailored support and funding to services (subject to application and review by a central body).

There are other funding mechanisms that only apply in some circumstances:

- The Preschool Reform Agreement (PRA) between the Australian Government and states and territories provides 15 hours of preschool in the year before school, and Victoria, NSW and Queensland pass this funding on to LDC services to cover the additional costs of delivering preschool programs.
- Some states and territories provide additional funding for capital investment or to support quality.
- The Australian Government's Community Child Care Fund (CCCF), competitive grants which provide block grants to targeted services.

Long Day Care providers set fees and receive payments from government and families

CCS payments are made directly to the LDC provider, based on fortnightly, usually automated, reporting on bookings from eligible families.

Providers set their own fee, normally determined by the cost of delivering the service and the fee level the local market will tolerate.

Payment is based on bookings for set sessions lengths (10 hours on average) although families are allowed up to 42 days per child of absences – to take into account illness / unavoidable absences

The Minister for Education determines the hourly rate cap, usually updated annually based on CPI.

Households pay the gap between fees set by providers and the level of subsidy they're eligible for

Households are eligible for the CCS when:

- They care for the child a minimum of 2 nights per fortnight
- They are responsible for ECEC fees
- The child meets immunisation requirements
- The child is enrolled in an approved ECEC service.

The number of subsidised hours and level of subsidy depends on:

- **Annual household income** – the maximum subsidy rate of 90% applies for households earning $83,280 or less, with a sliding scale up to a household income of $533,280 or more.
- **Their level of activity** – this includes paid work, volunteering, studying, self-employment and job hunting.
  - 8-16 hours activity entitles a child to 36 hours of subsidised access (fortnightly)
  - More than 48 hours of activity entitles a child to 100 of subsidised access (fortnightly)
  - Additional hours are paid at full cost
- **Number of children** – families with more than one child aged 5 or under may get a higher subsidy for their second child if they earn less than $362,408.

Families pay the gap:

Families make a co-contribution – paid directly to the provider – to cover the difference between the provider's fee and the CCS amount. The size of the gap fee depends on both the level of CCS subsidy and whether the service is charging above the hourly rate cap.

Aged care funding model (supply-side)

Residential aged care is funded through a complex combination of supply-side government funding and capped user fees, with an independent pricing authority providing annual advice to government on subsidy/price levels.

Australian Government funding is provided directly to aged care providers, with the total subsidy being a mix of four key components.[48]

The Base Care Tariff, a fixed payment to providers based on 6 categories reflecting service location and specialisation (homelessness or Aboriginal and Torres Strait Island people)

The AN-ACC subsidy, which is activity-based, and involves 13 categories varied to reflect care needs of individual residents. The AN-ACC is offset by the means tested care fee where applicable - with the amount government pays reduced when individuals are paying more

An initial entry adjustment payment, a one-off payment that reflects the fixed cost of a new resident entering a facility

A range of additional supplements applied to specific purposes/circumstances. These include:

- The hotelling supplement, paid per resident per day to supplement daily living fees.
- Accommodation payments for low means residents, with higher rates for facilities with a higher proportion of low means residents.
- Supplements for specific medical interventions e.g. oxygen, enteral feeding.
- 24/7 nursing supplement, to help smaller facilities meet staffing requirements.

The Independent Health and Aged Care Pricing Authority (IHACPA) provides annual advice to government on subsidy levels and user caps, and also assesses applications from providers to charge certain additional fees.

The Minister for Health and Aged Care sets government subsidy levels and maximum user fees.

Aged care providers have limited flexibility over fees and receive pre-determined payments from government and individuals

Government payments are made directly to providers on a monthly basis, based on activity data collected by Services Australia.

Individual payments are comprised of four components – which are mix of mandatory, means-tested, and opt-in payments. Maximum rates are set by government, and they're paid at different frequencies

The Basic Daily Fee, which is paid by all residents and is set at a maximum rate of 85% of the aged pension

A means-tested care fee, with annual and lifetime caps, which is paid by some residents. Means testing involves a complex formula that includes both income and assets.

Accommodation fees, based on income and assets. Some residents pay this as a refundable lump sum, while others pay as a daily fee. Fees for low means residents are partially or fully offset by government supplements.

Additional service fees, which are opt-in for higher level of accommodation service, but additional costs must be approved by IHACPA.

Individuals must be assessed as eligible for residential aged care by an Aged Care Assessment Team prior to receiving subsidised care. An independent assessor performs an assessment of care needs and submits via an online portal to determine the AN-ACC funding classifications of individual residents.

Funding model comparison

Whilst the funding models are similarly complex, they have key differences relating to how they regulate price, determine eligibility and subsidy level, and account for increased costs.

Key points of similarity

The ECEC and aged care funding models share key similarities, including:

Their level of complexity

Both the ECEC and aged care funding models involve a complex combination of government funding and means-tested fee. In both sectors, it is difficult for users to estimate their out-of-pocket costs.

How targeted they are

This complexity arises from the desire to vary subsidy levels based on individual circumstances, and for the investment to be 'progressive' – increasing according to need.

Being activity based

Funding is aligned with occupancy and providers are paid for the number of residents / children they serve.

Being uncapped

Access to subsidy is based on pre-determined eligibility, but there's no cap on the number of individuals / families who can access it.

A mix of user-pays and government subsidy

Both involve out-of-pocket costs for most users and heavy subsidy from government.

Key points of difference

However, both funding models contain key points of difference that relate to:

How they regulate price

In the aged care sector, the government sets and caps prices (informed by independent advice from IHACPA), whereas in ECEC, providers determine price and government sets indirect price signals via the hourly rate cap.

How they determine funding levels

The aged care funding model is a mix of fixed / core elements and variable / means or needs-tested component – with a substantial independent body monitoring and providing advice to government on changes in cost of delivery and appropriate prices. The subsidy level in ECEC is based on individual circumstances with no core costs covered. The hourly rate cap is indexed to CPI, which does not reflect cost of delivery in ECEC.

How they fund differences in needs and differences in cost of delivery

Aged care has a number of needs-based elements, including independent assessment of needs, loadings based on geography, and supplements for specific needs (such as oxygen use). Apart from the ISP, the ECEC funding model does not explicitly address differences in need or cost of delivery.

How they account for cost increases

In ECEC, if the cost of delivery exceeds the subsidy level (because of inflation, higher prices, reduced government investment), providers are able to increase fees to cover costs – with fee growth ideally constrained by local market conditions. Aged care providers do not have access to a similar 'release valve' because prices are set and capped by government. If their operating costs exceed the subsidy level, they will no longer be financially viable.

The design of the ECEC and aged care funding models represent different approaches to addressing key issues relating to value for money, efficiency, accountability and market health.

Funding model design considerations

Governments navigate numerous and often competing objectives in designing funding models that are fit-for-purpose for achieving their overarching policy objectives.

There are four overarching objectives governments seek to balance when crafting a funding model.

Funding model design elements

Value for money Does the funding model ensure value for money for government?	***Government value**: whether the funding model enables the outcomes it is investing in to be achieved efficiently* ***Constraints on spending**: mechanisms to constrain spending growth and ensure predictability in expenditure*
Efficient administration How big is the administrative burden and who bears it?	***Government**: scale and cost of the administrative burden for government* ***Providers**: scale and cost of the administrative burden for providers* ***Families**: scale and cost of the administrative burden for families*
Accountability How effectively does the model create accountability mechanisms?	***Levers**: the extent to which the funding model creates levers to influence provider behaviour / desired outcomes* ***Data and insight**: capacity of the system to track outputs / outcomes and to monitor fraud and compliance*
Market Health To what extent does the model support a healthy market?	***Sustainability**: ensuring financially viable providers* ***Supply and provider diversity**: creating sufficient incentives for adequate levels / diversity of supply in mainstream and thin markets* ***Profit:** mechanisms to ensure any profits are reasonable and proportionate* ***Workforce**: sustaining a high-quality workforce*

These collectively enable the overarching policy intent.

For example, the draft National Vision for ECEC articulates four key policy principles:

Equity
All people are supported to succeed, regardless of their circumstances and abilities.

Affordability
Participation is within the means of all families.

Quality
Services are culturally appropriate for their community, deliver on expected quality standards, and meet individuals' needs.

Accessibility
Geographic or cultural barriers to attending a high-quality service are removed.

But there are there are necessarily trade-offs to be made between these objectives.

For example, there are trade-offs between:

- Gathering robust data and insight through the models' operation and reducing administrative burden
- Constraining government spending growth and the financial sustainably of providers

We unpack how these trade-offs are navigated in the ECEC and aged care funding models on pp. 40

Funding model design trade-offs

The new aged care funding model gives government more direct control of how the system operates but has required a sharper articulation of what constitutes 'value for money' for government, greater investment in the administrative architecture, and closer monitoring of market health. Both models prioritise targeting on the basis of need or household circumstances over simplicity and efficient administration.

Value for money p. 41

Does the funding model ensure value for money for government?

We found:

- The new aged care funding approach requires real clarity about what government is buying and the level of funding needed to achieve it – and that this is less clear in ECEC.
- In ECEC, government controls price and expenditure indirectly via market mechanisms – this may mean government is more exposed to provider decisions about fees.
- In aged care, independent advice on the cost of delivery creates a clear imperative for funding to keep pace with cost and demand – although potentially limits the flexibility government has to control spending. However, IHACPA only provides advice to government – its decisions are not binding as they are in health.

Efficient administration p. 42

How big is the administrative burden and who bears it?

We found:

- In both ECEC and aged care, eligibility and means testing mechanisms create complexity. This means families can struggle to:
  - Estimate the actual out of pocket costs they'll pay,
  - Navigate the systems required to develop accurate estimates, and
  - In the case of ECEC, keep systems updated to match changes in entitlements.
- The systems are costly to administer. They require expensive enabling technology and in the case of the IHACPA, a large establishment and operational budget.

Accountability p. 43

How effectively does the model create accountability mechanisms?

We found:

- Both models contain comprehensive data collection mechanisms to track system operations. However, the use of these mechanisms to provide system insights and inform decision-making is much more mature in aged care.
- The aged-care model directly influences provider behaviour by controlling fees and access to subsidies. However, there are still issues with ensuring that funding provided is used for its intended purpose.
- The ECEC funding model does not fully leverage the levers at its disposal to incentivise quality and price.

Market Health p. 44

To what extent does the model support a healthy market?

We found:

- The aged care funding model directly influences / controls service viability and profit (by limiting subsidy to actual cost of delivery and allowing small margins only).
- In contrast, the ECEC influences provider behaviour, viability and profit much more indirectly – via price signals, market competition, and the price sensitivity of families.
- Both models have traditionally encouraged a diversity of supply, although there's considerable market consolidation underway in aged care and increasing growth of for-profit provision in ECEC.
  - Despite this, aged care has not fully recovered from a period of low funding and reduced supply – the supply of residential care places continues to be well below what is required to meet increased future demand.
  - There is growing consolidation across both sectors, with large providers growing faster and the growing risk of providers who are 'too big to fail' in aged care.
  - There has been significant growth in for-profit market share in ECEC.
- Service viability remains fragile in both sectors due to constraints on revenue (for aged care) and difficulty keeping pace with actual costs (ECEC).

Key findings – getting the funding settings right

Overview of key findings

This section provides an overview of the key findings from our comparison of ECEC and aged care funding models

We outline the consequences of setting funding too low under the previous aged care model …

Risk of setting funding levels too low

p. 21

… and unpack the challenges of getting funding model design right.

The challenges of setting the 'right' level of funding for aged care

p. 22

Aged care viability, quality and supply over time

p. 23

What's needed to set subsidy levels well

p. 24

Constraints in ECEC

p. 25

Implications of a poorly-set supply-side funding model in ECEC

p. 26

Risk of setting funding levels too low

The findings of the Aged Care Royal Commission clearly demonstrate that setting supply-side funding levels too low can fundamentally break the system as a whole.

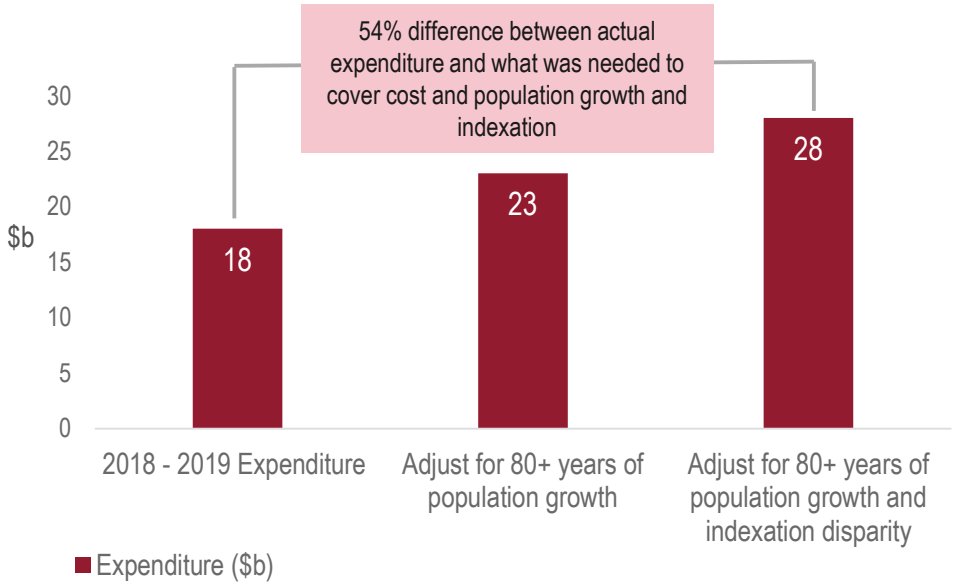
The aged care system was significantly underfunded over many years

Under the previous aged care funding model (also a supply-side model), the Royal Commission found that the priority of restraining growth in expenditure had been *'pursued irrespective of the level of need, and without sufficient regard to whether the funding is adequate to deliver quality care'*.[49]

In particular, the Commission noted that expenditure had not kept up with costs and demand due to:

- The rationing of access through inadequate provision ratios,
- Failure to match indexation with changing provider input costs and population growth, and
- Explicit measures to achieve budget savings.[50]

The Commission estimated that the combined impacts of provision ratios and inadequate indexation **shortchanged aged care funding by $9.791 billion** in 2018-19.[51]



Aged care offers a cautionary tale for inadequate funding. A funding model that did not keep pace with cost or demand undermined the system as a whole.

The impact of inadequate funding levels was apparent in the significant system failures observed by the Royal Commission:

Access

Older people were not always able to access care when they needed it – due to inadequate supply of places, particularly in low socioeconomic and regional, rural and remote areas.

Viability

Many providers were not financially viable - ~42% of residential aged care providers reported an operating loss in 2018-19. The exit of unviable providers led to greater market concentration and increased risk of providers that are 'too big to fail.'[52]

Quality

★☆☆☆☆

Quality of care was severely compromised – the Commission estimated that at least 1 in 3 people in aged care had experienced substandard care.[53] This ranged from:

- Inadequacies in routine care (for example, nutritious food, availability of registered nurses, regular wellbeing checks), to
- Extreme cases of mistreatment such as physical and sexual abuse and overuse of restrictive practices.

Aged care was no longer meeting community expectations and created significant wellbeing risks, including:

- *Increased use of restrictive practices* - providers would sometimes misuse physical or pharmacological restraints in place of other more resource intensive interventions. For example, one provider revealed that 71% of its residents received psychotropic medication and 50% were physically restrained.[54]
- *High rates of malnutrition* - average food budgets were $6 per resident per day, around 50 per cent of the estimated level required to provide quality food. Between 22% and 50% of older people living in residential aged care were malnourished.[55]

The challenges of setting the 'right' level of funding for aged care

While significant reforms to residential aged care funding have now been implemented, challenges remain in setting funding at a level that ensures the sustainability of the sector and supports delivery of high-quality care.

There have been significant reforms to the funding model fundamentals

The challenges in aged care were significant enough to require:

- A two and half year long Royal Commission resulting in five volumes of findings
- A dedicated Taskforce to determine implementation priorities and directions
- An investment of $26.8 billion across the 2021-22 and 2023-24 budgets to implement increased subsidies, a 15% wage increase, and higher mandated care minutes.[56]

Key funding model design changes include:

- A new activity-based funding model that links payments to the volume and nature of care each provider offers – the AN-ACC funding model.
- Annual advice to government on subsidy and price levels by the IHACPA.
- An increase in financial reporting requirements by providers.

These changes were implemented in 2022/23. While it is too early to know if the new model is fully effective, there are ongoing challenges identified by the Taskforce. These highlight the complexity in getting funding settings 'right', and the time it can take to turn a broken system around … even after multiple government reviews and substantial investment in administrative infrastructure.

But the issues have not been quick to resolve and there are ongoing challenges with viability and quality

The most recent data shows the financial position of the sector has improved significantly since the implementation of the new funding model.

- 64.6% of providers report a positive year-to-date financial position in Quarter 2 2023-24 (measured by net profit before tax), almost doubling the previous year's result.[57]

However, the recent Aged Care Taskforce report (released March 2024) identified ongoing issues with some elements of the funding model impacting viability:

- Many providers still making substantial losses in the areas of daily living and accommodation.[58]
- Shortfalls in care-related funding levels for rural and remote services, particularly in large rural and regional towns.[59]

In addition:

- Only 58% of residents were serviced by profitable providers, meaning the impacts of unprofitable providers are still be borne by a significant proportion of residents.[60]
- Many providers are using surplus direct care funding (resulting from staff shortages) to cross-subsidise losses they incur for everyday living and accommodation expenses.[61]

Significant challenges with quality and supply also persist:

- Nearly 2/3 of providers are still failing to meet mandated levels of care, largely due to ongoing workforce shortages.[62]
- The growth in supply of residential care places continues to be well below what is estimated to be required to service future demand.[63]

These trends are unpacked further on p. 23

There's also further funding model redesign work to be done

The Aged Care Taskforce has recommended a greater role for means-tested resident co-contributions in non-care funding components – recognising that while care costs have improved, there are ongoing issues with accommodation costs.[64] This:

- Reflects a view that it's not reasonable or feasible for government to cover the full cost of aged care, especially when residents have capacity to pay.
- May create a 'release valve' that allows providers to grow their revenue if government funding settings become / remain insufficient to cover their costs.
- May improve financial viability in the future.

The Taskforce's recommendations – yet to be adopted by government – include:

- Higher income residents making a greater contribution to the Basic Daily Fee.
- Flexibility for higher income residents to negotiate a higher Basic Daily Fee to cover additional services or amenities, allowing providers to diversify their offerings and obtain additional revenue.
- A package of measures to improve the availability of accommodation revenue, including increases to the maximum daily bed rate, and ability of providers to retain a portion of accommodation fees each year.

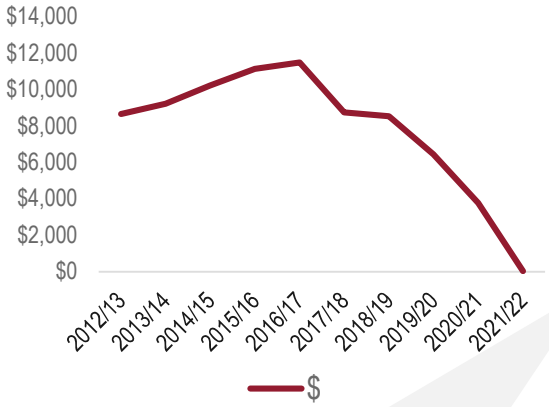
Estimates suggest Australia will need to increase aged-care spending by $10 billion a year to fully implement the Royal Commission's recommendations[65]

Aged care viability, quality and supply over time

Despite subsidy increases, aged care profitability declined markedly over the same period, largely due to increasing costs outstripping revenue and COVID-19 impacts. This has impacted on the quality of care delivered and continues to dampen supply.

Provider profitability declined significantly from 2016 to 2022 – but is expected to improve this financial year[66]

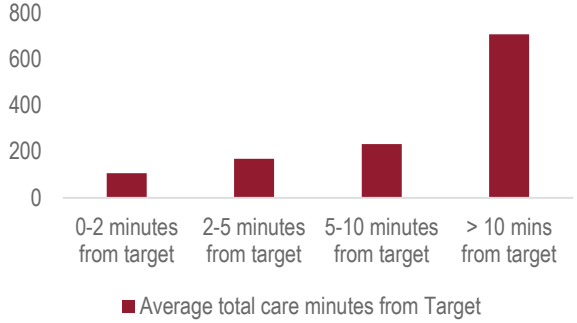
Residential care provider average earnings per resident*



While data is not yet available for 2022-23, it is expected this will show an improvement in provider average EBITDA, as indicated in the quarterly financial snapshots.

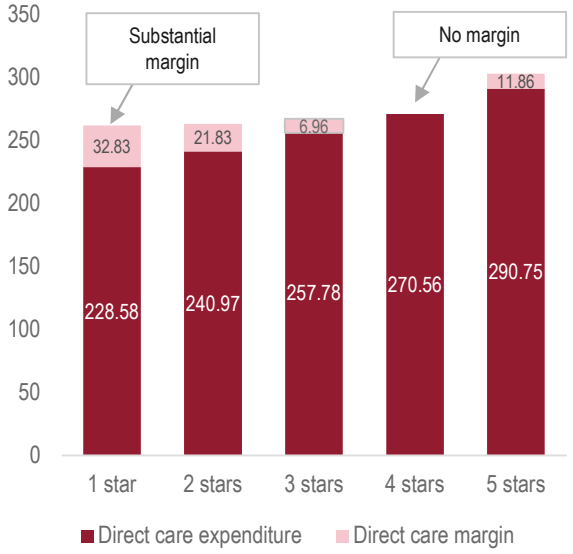
* before EBITDA per resident per annum.

While total care minutes* have been increasing, nearly 30% of services are a significant distance from meeting their targets[67]



*care minutes refers to the amount of care residents receive from registered nurses, enrolled nurses, and nursing assistants.

Providers are making more profit when they don't meet their staffing targets[68]

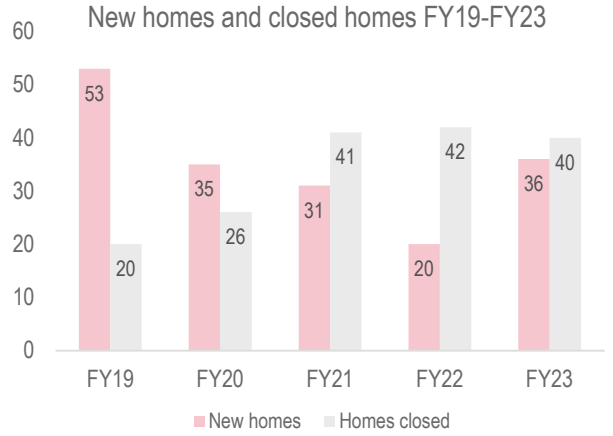


The supply of residential care places continues to be well below what is required to meet increased future demand

Over the next 40 years, the number of Australians aged 65 years and over will more than double, and those aged 85 years and over will more than triple.[69]

But the supply is not growing fast enough to meet this future demand. Since 2015, the number of homes in operation has declined (due to the closure of smaller homes), yet the number of available places has increased. Whilst growth in the number of available places is positive, it is hampered by the closure of facilities.

More homes have closed than opened over the last three years[70]



The total number of places has grown, however, as smaller homes have been replaced by larger facilities

What's needed to set subsidy levels well

The new aged care funding model is better equipped to make sure subsidy levels reflect costs of delivery but involves a comprehensive administrative apparatus. This requires significant investment from government, imposes a substantial burden on providers, and is still under development – and does not necessarily guarantee a positive outcome.

In the aged care sector, setting the right subsidy levels and price requires significant administrative infrastructure supported by...

A pricing authority

IHACPA advises government on subsidy levels and price

The pricing authority, IHACPA, requires a significant annual budget from government to operate.

In 2022-23, IHACPA's budget doubled to $36m[71] to carry out its pricing role in the aged care sector. Aged care responsibilities were given to an existing pricing authority with experience in a similar sector (albeit in a sector that had significant data maturity and built on ~20 years of unit-costing from the Victorian health system). Nonetheless, it has taken time for IHACPA to stand up its aged care function, build the necessary sector expertise and data sophistication. It is still using interim methodologies while this capability develops.

IHACPA undertakes extensive consultation and modelling to inform the advice it provides to government on subsidy levels and user payments caps.[72] This includes:

- Extensive public consultation
- Regular costing studies, which gather cost and activity data from a wide range of providers with different geographic, demographic and individual characteristics using a sampling framework
- Development of interim aged-care specific cost indexation methodologies until detailed cost data is available
- Consultation with an advisory committee.

.. as well as an additional $1.4bn investment in upgraded IT infrastructure for the My Aged Care Service and Support / Provider portals[73]

Detailed reporting from providers

Providers inform this advice through detailed reporting

The funding model imposes a considerable burden on providers to support subsidy and pricing advice through extensive reporting, including:

Monthly submission of claims forms to Services Australia, setting out the details of each resident they are claiming a subsidy for in that month.[74]

Annual reporting to inform the Aged Care Financial Report consisting of:

- Info on income / expenses, labour costs and hours
- Balance sheet, income / cash flow statements and movement schedules for financial statements
- Segment Report and survey of Aged Care Homes
- Annual Prudential Compliance Statement.[75]

Quarterly reporting to inform the Quarterly Financial Report consisting of:

- Viability and prudential compliance questions
- Year to date financial statements, at the approved provider level
- Residential care labour cost and hours reporting, at the facility level
- Quarterly food and nutrition report for each approved residential aged care service.[76]

Despite the work of IHACPA and significant levels of financial reporting, the right subsidy level and price is still not guaranteed because…

- The sector is still building the system capability to accurately reflect costs. The 2023-24 IHACPA advice was based on an interim indexation methodology due to a lack of recent cost data.
- Whilst providers can apply to have higher fees granted for discrete, opt-in services, the approval process is slow, and is not subject to indexation.
- IHACPA only provides pricing *advice* to government, compared to its price *determination* role for hospital funding.
- Aged care stakeholders hold a concern that the uplift in funding associated with the new funding model will not be maintained over time.

Constraints in ECEC

Getting funding level 'right' under a supply-side ECEC funding model is a very real challenge. The sector is starting from a lower base, in terms of data maturity and understanding of the cost of delivery – and the transition costs are significant.

Government agencies would be starting from scratch in building the sector-specific operational knowledge, data capture and IT / administrative infrastructure required to support a supply-side model for ECEC.

- Aged care benefits from a more mature starting-point for data capability, consistency in financial reporting, and a pricing authority with experience in a similar sector.
- IHACPA inherited an established hospital pricing framework (from Victoria) when it was established, and has in-house know-how expertise it can apply to its new responsibilities in aged care. Nonetheless, it costs $18m a year to deliver aged care pricing.[77]

Accurately estimating the cost of delivery in ECEC will be challenging, as they're not well understood and are known to be variable

- ECEC costs are highly variable and occupancy can be unpredictable. Cost of delivery varies due to the significant diversity in provider type and size, significant differences in property costs / market rent, and high degree of variability in occupancy levels (day to day, week to week).
- There is limited / inconsistent public financial reporting in the sector, and a lack of agreed norms for how different types of cost are counted (for example, distribution of head office quality / inclusion support costs).

Ensuring sufficient returns to support capital growth is complex, but an essential design feature to ensure supply is adequate to meet future demand.

- ECEC providers have very different needs / approaches to property costs – including differences in the level of debt being carried, different exposure to commercial rent arrangements, and different levels of ambition about growth.
- A funding model that meets these different contexts is challenging.

Governments will be under ongoing pressure to constrain expenditure due to broader budgetary considerations and competing priorities over time.

- There's no guarantee that the funding model will keep pace with the actual costs of delivery over time.
- Currently, aged care stakeholders and investors are unsure if the funding model settings are sufficient for ensuring adequacy / viability over time.

The transition costs are significant and sustained, as it takes time, sophistication and enduring commitment to get the settings right. The current aged care funding model still requires significant adjustment and development. The primary focus to date has been on the care cost component, but other elements of the funding model have yet to be resolved and all elements needed for viability are not yet in place – the sector is still awaiting decisions from government on key elements of the reform.

- The long time-frames for implementation are despite aged care's comparative advantages – they were already operating under a supply-side model, they had a more mature data infrastructure and financial reporting basis, and an established pricing authority.
- In 2014 the Productivity Commission predicted that a new funding model in ECEC would be *'extraordinarily disruptive'*.[78]

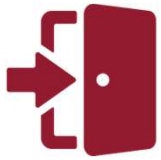
Implications of a poorly-set supply-side funding model in ECEC

The experience in the aged care sector serves as a cautionary tale of the risks associated with implementing a supply-side funding model in the ECEC sector

If funding levels are set too low, the real-world consequences for ECEC are likely to be very similar to those observed in the aged care sector

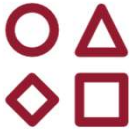
Compromised quality

Aged care providers are clearly incentivised to meet – but not exceed – minimum staffing standards. It's clearly difficult to staff over-ratio or make additional investments in quality in a tightly regulated funding model.



Reduced supply and accessibility

Over the last decade, aged care hasn't been sufficiently profitable to drive investment – and there hasn't been enough investment in services to meet future demand.



Reduced market diversity

Some aged care providers have exited the market and more homes are closing than opening. This has been most acute in less profitable markets – i.e. higher cost rural and remote locations and those serving more vulnerable populations

Underinvestment in facilities

Investment in premises is necessarily lumpy – with large early outlays and periodic large investments. Many aged care services have degraded over time as there's not been sufficient revenue to keep them up to date.

Key findings – policy goals

Overview of key findings

This section provides an overview of the key findings from our comparison of ECEC and aged care funding models

This section explores the impact of the aged care funding model on key policy priorities.

Complexity and equity

The trade-off between simplicity and complexity – and what this means for equity

p. 29

Price and affordability

The trade-off between controlling price / affordability and responsibility for system health

p. 30

Quality

The relationship between funding settings, workforce, and quality of provision

p. 32

Equity

Funding model design that enables equitable access and avoids perverse incentives

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Complexity and equity

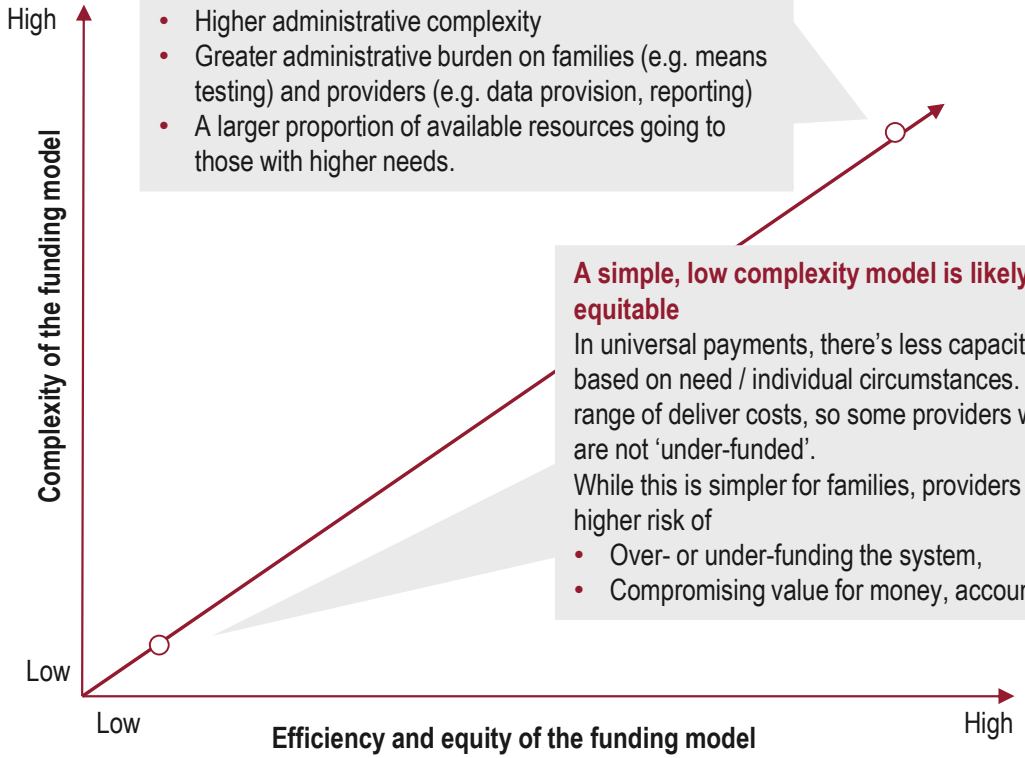
Advocates of supply-side ECEC funding and capped fees argue that this will significantly reduce the complexity of the system for families, but there are trade-offs between simplicity, efficiency and equity.

There are trade-off between simplicity, efficiency and equity when designing a funding model

A highly efficient model is more complex to navigate and administer – and can be more equitable

Funding is tailored to suit the highly varied contexts of services and the needs of the populations they serve. This results in:

- Higher administrative complexity
- Greater administrative burden on families (e.g. means testing) and providers (e.g. data provision, reporting)
- A larger proportion of available resources going to those with higher needs.



A simple, low complexity model is likely to be less efficient and less equitable

In universal payments, there's less capacity to target and configure funding based on need / individual circumstances. Funding levels need to suit a wider range of deliver costs, so some providers will be 'over-funded' to ensure most are not 'under-funded'.

While this is simpler for families, providers and administrators, it comes at a higher risk of

- Over- or under-funding the system,
- Compromising value for money, accountability and system efficiency.

The aged care funding model shows that a supply-side model does not necessarily mean a less complex system

… the aged care model is highly complex to drive efficiency

- There are multiple categories of government subsidy and user payments combined, some universal and some means tested
- There are also multiple classifications within subsidy and user categories to tailor funding to need (for example, 13 care categories, a myriad of specific purpose supplements)

… but the trade-offs of this efficiency are borne by:

- **Families**, who find it hard to navigate the system and understand total cost
- **Government**, through administering highly resource intensive annual price setting and monthly payments
- **Providers**, who must cope with a higher administrative burden of reporting and data collection

Influencing price and affordability

The ability to control price and affordability for families and government is another desired outcome for policymakers, but a supply-side funding model is not necessarily the most efficient or effective way of achieving this.

The aged care model has achieved tight control of price and affordability.

Prices are tightly regulated, there is a limited set of additional services that providers can charge higher fees for, and out-of-pocket costs are directly regulated.

There are drawbacks to approach.

These include:

- **Significant sector viability issues when funding settings did not keep pace with changes in cost of delivery and demand**. The new role for transparent independent pricing advice will improve this challenge going forward – although it limits the flexibility government has to control spending.
- **The tight caps on out-of-pocket costs / user fees is under review** – as its not viable for government to bear the full costs of services, especially when many have the capacity to contribute. The Taskforce has recommended greater co-contributions for accommodation and everyday living costs.[79]

The ECEC model has less direct mechanisms for controlling price and affordability.

This has some key limitations:

- As a more indirect price control measure, the HRC has not been particularly effective at restraining fee growth or government expenditure.
- The ACCC observed that benefits to families of increased subsidy levels have tended to be eroded by fee increases over time.[80]

However, the ACCC has also noted there is limited evidence of systemic excessive profit in the sector, and that costs have grown faster than inflation.[8]

- This suggest that price increases are at least in part a function of the failure of subsidy settings to keep pace with the cost of delivery.

A supply-side funding model is not necessarily the only or best solution to improving price and affordability in ECEC.

There are other, less disruptive solutions to address these issues:

- While supply side funding may be appropriate in targeted markets, broad introduction of a supply-side funding model would result in significant upheaval for the sector.
- Other measures recommended by the ACCC are likely to improve price and affordability outcomes, including:
  - Reforming the HRC, including by more closely aligning it with the costs of delivery and improving its effectiveness as a price signal to consumers;
  - A stronger role for governments to monitor providers' prices, costs, profits and outcomes; and
  - A credible threat of intervention to place downward pressure on fees (e.g., naming and shaming providers who massively increase fees)[82]

Market consolidation

A shift to greater private for-profit provision and market consolidation has been a feature of the aged care sector in recent years, potentially indicating the funding model is not well equipped to support a diversity of provider types and sizes

The size and diversity of aged care providers has changed over the decade

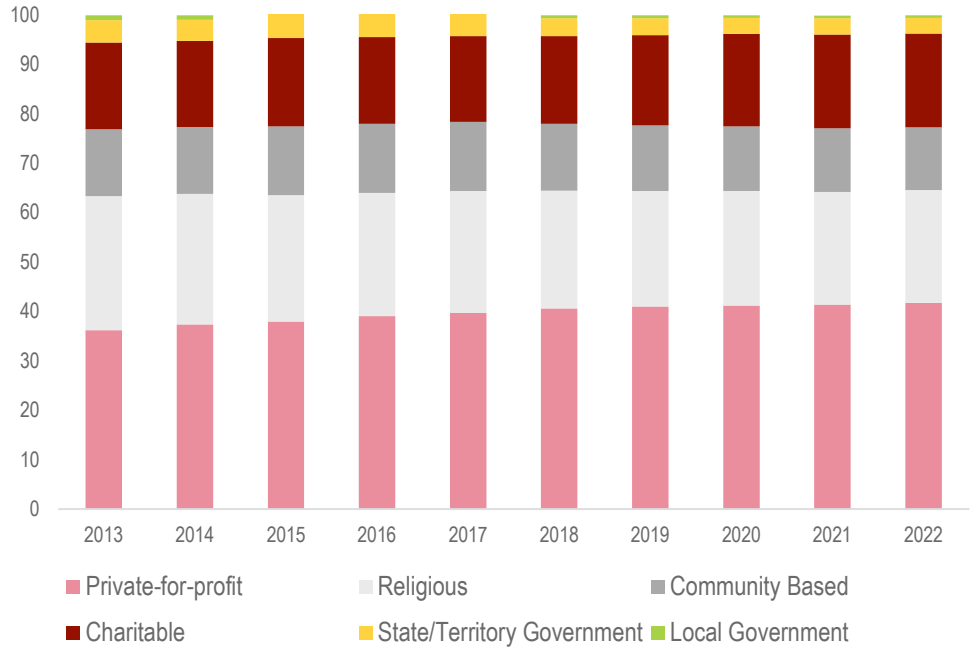
Provider diversity

- **The proportion of private for-profit ownership of residential aged care places has grown** from 37.4% to 40.7% since 2014.
- **The proportion of places owned by religious, community based, and government have declined** over the same period.[83]

Provider size

- **The number of providers of residential aged care has decreased over time,** from 873 in 2015 to 551 in 2023.
- **The average places per provider have increased** from 220 in 2015 to 335 in 2023, indicating significant increases in scale.[84]
- Aged care stakeholders suggest that consolidation has been necessarily for viability – especially given increased administrative costs.

There has been a gradual increase in for-profit provision in aged care over the decade



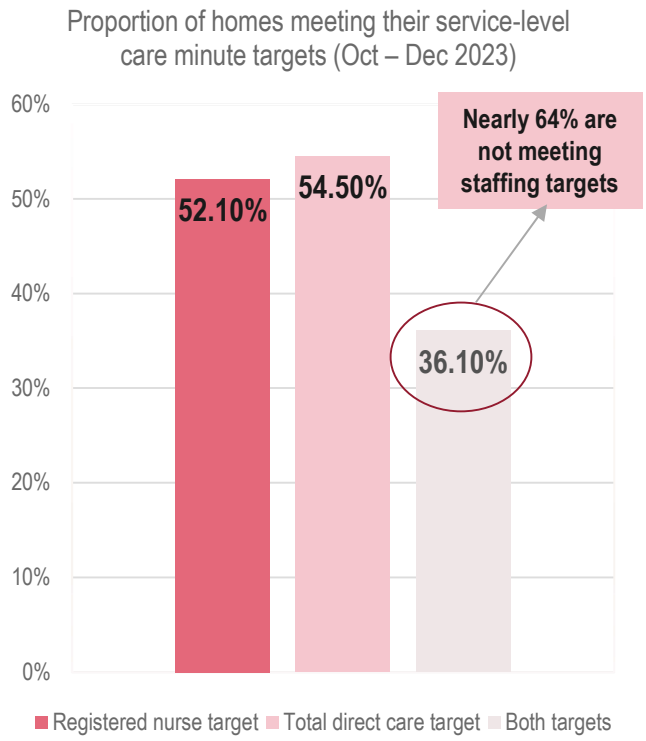
These trends are expected to continue - 75% of new beds opened in FY23 were by private providers, with four providers being responsible for 32% of the total.[85]

Impacts on quality

Under the previous aged care funding model, capacity to provide quality care was significantly eroded. The new funding model has not fully addressed these issues or created a sustainable base for future quality improvement.

The majority of aged care homes are not meeting targets for the amount of direct care provided.[86]

In large part, this is because an additional 25,000 workers are required to fully deliver the staffing targets, and wage increases have not solved workforce attraction and retention issues alone.[87]



Aged care is experiencing a range of ongoing workforce and quality challenges.

Implicit incentives to underspend on labor costs / disincentives for investing in additional staff.

The segment of the market achieving the greatest margins are those receiving the lowest quality ratings for staffing (1 and 2 stars). They may be understaffed because of genuine staffing shortages, but there's an implicit perverse incentive built into the model.

Homes rated highly on staffing earn less margin from direct care

- 4 Star homes spend 100% of their direct care funding and receive no margin
- 1 Star homes spend an average of 87% of their direct care funding, and earn a margin averaging $32.82 per resident per day.
- 4 Star homes spend twice as much on registered nurses than 1 Star services ($65.66 and $36.14 per resident per day).[88]

Funding levels are based on the current cost of delivery – not what's needed for the future or for the aspirations held by the sector (and the Royal Commission) for quality.

Stakeholders report that funding levels have recovered but are not adequate for transforming the quality of care provided in the sector in the future.[92]

Wage increases aren't being passed on to full or to the whole workforce.

Mechanisms to ensure that providers pass on 15% wage increase to staff have been ineffective. Government intends to publish quarterly reports on whether providers are passing on the full rate, there is concern that staff on enterprise agreements will not be able to discern how much a provider received in funding and the dollar amount owed to them.[89]

There's also an increased use of agencies to deliver care – with nearly 40% of direct care costs attributable to third parties.[90]

The absence of a specific provision for allied health in the AN-ACC is leading to an exodus of allied health staff from the aged care workforce.

Specific and targeted measures are required to ensure ongoing access to allied health care, such as physiotherapy, which the Royal Commission identified as critical to ensuring the mobility and independence of older people.[91]

The key risk of this approach for ECEC is the explicit penalties for staffing over-ratio or making additional investments in workforce.

Impacts on equity

Although the aged care funding model contains robust equity provisions, the model continues to create incentives to prioritise residents with lower care needs, and shortages continue in regional and remote areas

There are reasonably good equity provisions embedded in the aged care funding model, including…

- **Means testing,** including assets and incomes and explicitly linking fees to capacity to pay.
- **Independent assessment of individual health needs** to ensure that there is impartial review of health and subsidy levels account for the cost of meeting these needs.
- **Multiple base loadings** for priority cohorts and accounting for service size.

However, issues remain within the funding model which compromise the equity of provision because…

- **The model creates incentives for 'cream skimming', which is the selection of residents based on expected profitability**. Although residents who require more care generate larger subsidies, there is evidence of providers avoiding high-need residents because increased subsidies may not cover the increased cost of mandated care for this cohort.[93]
  - Homes are consistently more profitable when residents have capacity to pay substantial bonds and have low to moderate care needs.[94]
  - There are also concerns from the sector that the model fails to take account of some specific care needs, such as mental health challenges or a history of drug or alcohol use.[95]
- **There are not sufficient incentives for delivery in regional, rural and remote areas**. There are fewer residential aged care places per 1000 people in regional, rural and remote areas than in major cities. Since 2014, residential aged care services have been decreasing at a faster rate in remote Australia (12.5%) than in major cities (5.5%) and regional areas (7.8%).[96]
  - Homes in the bottom quartile of financial performance are more likely to be based in non-metro areas.
- **The 'one-size fits all approach' to aged care provision is not ensuring equitable access for people with diverse experiences and need**s. Although the Aged Care Act identifies nine groups of people requiring 'special provisions,' the final report of the royal commission into aged care identifies 'numerous access issues' for these groups.[97]

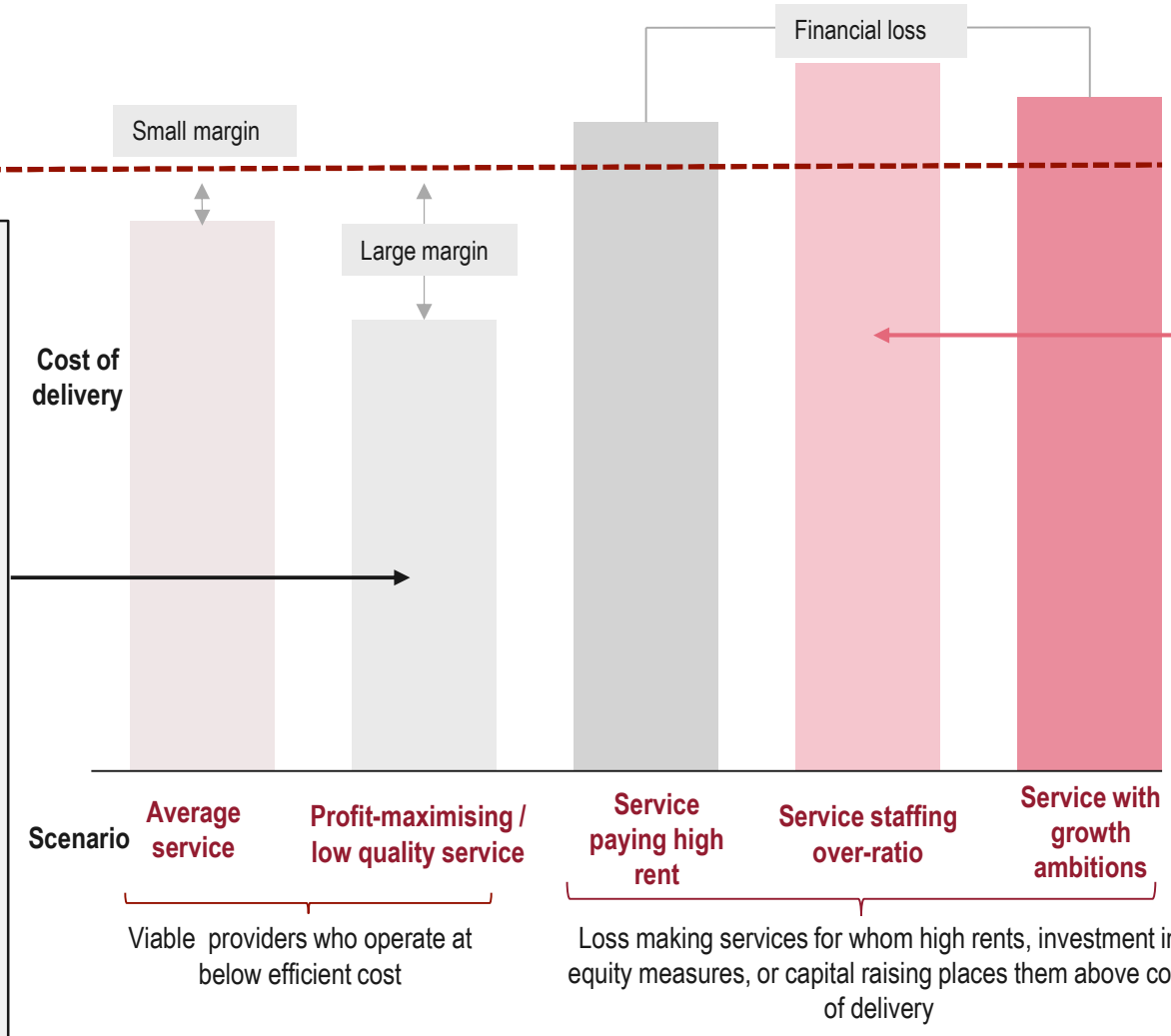
To be fit-for-purpose in the ECEC sector, a supply-side funding model would need to include explicit loadings for equity cohorts and active incentives for high quality provision in disadvantaged communities and regional and remote areas.

Implications and impact

The risk of perverse incentives

A supply-side funding model that did not take into account diverse delivery costs in ECEC would risk incentivising a minimalist approach to staffing, and penalising services that make investments in their workforce that drive quality early learning.

A supply-side funding model that did not take account of diverse costs of delivery in ECEC may incentivise cost-cutting and penalise investments in quality



Case study: A service with low occupancy that needs to minimise expenditure

This service tightly optimise their staffing arrangements and additional costs, so:

- Only 50% of educators hold a Diploma.
- Staff are less experienced, employed at the bottom of the Award bands.
- Their Educational Leader meets the 2 hour a week requirement but has no additional time.
- Incursions only provided to children who pay extra.
- No additional administrative support is provided, so teachers and educators take on a greater administrative load.

Case study: An Exceeding service that invests in its team

This service is an established, high-quality service. They:

- Have a high performing leadership team – with a Director, Assistant Director, Educational Leader and a team of Room Leaders who work collaboratively, enabled by regular time off the floor.
- Ensure the Educational Leader is 'off the floor' 3 days a week.
- Employ mostly Diploma-qualified educators
- Pay 5% - 15% above award.
- Employ administration and finance support, so the Centre Director has more time to support and lead the team.

Note: The graph of profit- and loss-making services is based on indicative scenarios.

Implications of inappropriate funding settings

If government gets the funding settings wrong for ECEC, then a transition to a supply-side funding model could adversely compromise the quality and equity of care, resulting in perverse impacts that could take years to undo.

Funding based on the average cost of delivery is unlikely to be sufficient for services:

- **With high rent or property costs**, particularly in inner city areas, those taking on new mortgages, or transitioning from peppercorn to market rates.
- **That invest in their workforce**, including by employing more experienced staff, investing in a full Educational Leader role, preferring more Diploma than Certificate qualified staff, and providing more time off the floor for professional learning, coaching and team reflection.
- **Making a big equity or inclusion investment** i.e. by staffing over-ratio, employing family engagement / allied health or other support staff, providing the majority of a child's nutritional needs, providing additional professional supervision / support for staff or investing in additional quality or inclusion measures.
- **Offering additional programs valued by their community**, including incursions, longer / more flexible days, cultural experiences, etc.
- **Services building capital** to finance expansion and growth of new / expanded supply, or to finance renovation or updating of older premises .

The higher costs of delivery for these providers are currently accounted for by higher parent fees in high-cost areas, cross-subsidisation across services to finance equity investments, and consistent, stable and moderate margins that attract investors and enable growth.

The key risk of a supply-side funding model for ECEC is a model that does not take into account the differences in cost of delivery – or the cost of delivering quality early learning in diverse contexts.

To avoid these effects on quality and equity, a supply-side funding model in the ECEC sector would need to:

Ensure the base settings are 'quality adjusted' and reflect the full cost of delivering high-quality early learning – not the minimum required to meet base-level NQF settings.

For example, like the quality-adjusted funding settings in hospital pricing, assumptions on cost of delivery could be based on knowl high-quality, high-equity services.

Include needs-based loadings to encourage and adequately fund equity and inclusion investments.

This would need to take into account the range of additional costs required to support high-equity services, including recognising the 'multiplier effect' of a high proportion of children / families with additional needs or complex life circumstances.

Offer an alternative funding mechanism to support capital growth. *Especially if the base-level funding does not include a sufficient margin to enable services to fund maintenance or growth costs.*

Consider the ability to charge additional fees for approved 'value add' components, consistent with the aged care approach.

However, equity considerations are critical here, and 'base funding' should include provision of core elements of delivery, such as minimum nutrition requirements, consumables (like nappies), and incursions for all children (not only those who have paid extra).

ACCC recommendations

The ACCC's recommendations to retain and improve demand-side funding for adequately served ECEC markets, apply a mixed model to under served markets, and supply-side funding to unserved markets are reasonable.

In its final December 2023 report,* the ACCC did not recommend broad application of supply-side model. Broad application of supply-side funding is not necessary or appropriate in the ECEC context, noting:

- **The ACCC found no evidence of widespread excess profits** in the sector.
- **Many ECEC markets are well served, meaning there is strong potential for competitive tension to deliver desired outcomes.** A demand-side model, if functioning well, can support choice for consumers, allocative efficiency and cost effectiveness for government.
- **Maintaining targeting of funding to families most in need of assistance represents an efficient and appropriate use of government funds,** particularly in a constrained revenue environment. If additional funding is available to the system, this would be better spent on areas and cohorts most in need.
- **The risks, transition costs and complexity** associated with switching to a supply-side funding model would be significant and long-lasting, as observed in the aged care sector.

The ACCC recommendations strike a reasonable balance between reform and due caution by:

- **Targeting application of supply-side funding to where it is most needed,** where the demand-side model is not able to achieve the desired outcomes (under-served and unserved markets).
- **Retaining strong elements of the current model, with improvements to increase its effectiveness,** including by maintaining demand-side funding in adequately served markets, and:
  - Reforming the HRC, including by more closely aligning it with the costs of delivery and improving its effectiveness as a price signal to consumers;
  - Building in a stronger role for governments to monitor providers' prices, costs, profits and outcomes; and
  - Creating credible threat of intervention to place downward pressure on fees.

*ACCC (2023): Childcare Inquiry Final Report, found at https://www.accc.gov.au/inquiries-and-consultations/childcare-inquiry-2023/december-2023-final-report

Real costs and risks

Universal application of a supply-side funding model for ECEC would be a complex and costly exercise that would require many years to implement. The risks of getting the funding settings wrong are high.

There are trade-offs between designing a simple vs an efficient and equitable funding model.

A simple fixed-fee, supply-side funding model comes at the cost of reduced efficiency and equity.

- It may be less efficient – to make sure most needs are met, some services need to be 'over-funded'
- It may be less equitable – as cost is not aligned with capacity to pay and there's less targeting of funding.

This could also increase cost to government over time.

More control over price means more responsibility for understanding cost – and significant administrative work to get this right.

Estimating the cost of delivering ECEC is challenging due to the highly variable and unpredictable nature of costs, and ensuring sufficient returns to ensure capital growth is complex.

Significant investment in a pricing authority and supporting IT infrastructure would be required, and the administrative burden on providers would grow.

It would also take many years to implement, causing significant disruption to the sector.

ECEC is starting from much further behind than aged care – it doesn't currently have the maturity nor underlying capability in system-wide costing or reporting to support the establishment of the necessary administrative infrastructure for a supply-side funding model.

Time and effort spent adapting to a new funding model might be better spent on investing in equity and inclusion and systemic reforms to lift the consistency of quality.

There is a significant risk that funding levels will be set too low.

This is a risk because of the difficulty in accurately estimating costs in such a complex system, and the ongoing pressure on Government to constrain expenditure due to broader budgetary considerations and competing priorities over time.

There's no guarantee that the funding model will keep pace with the actual costs of delivery – compromising the ability of the system to deliver its intended policy goals.

Given these challenges …

A funding model that's not well-designed could have pronounced impact on the ECEC market

This could contribute to:

- **Declining quality** – especially if there is a 'race to the bottom' or explicit incentives to reduce expenditure on more qualified / experience teachers and educators or exclude children with additional needs.
- **Market exit and contraction** – a reduction in the diversity of the sector, resulting in less competition on quality and less choice for families.
- **Insufficient supply growth** – further reducing accessibility of places.

It may be premature to take this level of risk and system overhaul without first implementing the measures recommended by the ACCC

Given the considerable risks involved in a new funding model, giving the ACCC's recommendations a chance to deliver the desired system outcomes may be a sensible approach.

Considerations for implementing a supply-side ECEC model

If a supply-side model is to be implemented for ECEC, learnings from aged care funding should be front of mind for policymakers.

There are clear lessons about what's needed for an effective design process …

- **Fund the system for the level of quality you want, not the level of quality you have** – basing funding parameters only on current costs fails to factor in desired uplifts in quality into the subsidy levels. This can stifle progress and innovation and lead to quality stagnation or decline.
- **Recognise that it will be costly and time consuming to build the requisite level of sector knowledge and administrative capability for a supply-side model** – the level of data sophistication, administrative infrastructure and sector knowledge will need to significantly increase, and this will take dedicated time and resources.
- **Focus on getting cost indexation right** – aged care funding suffered from inadequate indexation over many years. Getting indexation right requires detailed consideration of different cost components, variations between different contexts, and the development of tailored indexation rates, ultimately based on the collection of detailed cost data over time.
- **Work in collaboration with sector experts to design and implement the new system** – getting the design of the funding system and the funding levels right will require working together with the sector. Consulted members of the aged care sector have positively remarked upon the level of consultation built into the IHACPA price setting process, and the collaborative nature of the recent Aged Care Taskforce process.
- **Consider the most appropriate mechanism to support capital growth** – the aged care model in its current form is not generating sufficient levels of profitability to deliver the capital growth required to meet future demand. Policy uncertainty also makes it difficult to raise capital to fund capital investment. Consideration should be given to the best way to support capital growth in the unique ECEC property market.
- **Build in explicit requirements to pass on wage increases** – an attractive aspect of supply-side funding is the ability to directly fund wage increases, however this must be supported by robust accountability measures to ensure increases are passed on to the workforce.

And cautionary tales about what to avoid …

- **Don't let the system create perverse incentives for providers** – the funding system must be carefully designed – in combination with the regulatory system – to ensure providers aren't incentivised to game the system (e.g. 'cream skimming) to the detriment of overarching system objectives of quality, equity, and access.
- **Don't take a piecemeal approach** – the aged care experience shows the difficulties in changing certain elements of the funding system in isolation, which is now leading to cross-subsidisation between care and accommodation/daily living funding lines. Any supply-side funding model for ECEC should be developed as a cohesive package of subsidies and user payments that are designed to work together.

Appendix – detailed analysis of the funding models

Value for money

Resetting the aged care funding model has required clear articulation of government's policy goals and clarity about the level of investment needed to achieve them; this is less clear in ECEC.

	Early childhood education and care	Aged care	Key insights
The funding model aims to achieve value for money by …	**Constraints on spending**: The ECEC funding model is demand-driven (there are no caps on the number of families who can receive subsidies), but: • There are limits on the amount of subsidy a family can access, linked to income and level of activity, • The HRC sets a ceiling on the amount of provider fees government will subsidise, and • It's expected that local market competition will help drive down prices.	**Government value**: The new aged care funding model seeks to directly link the quantum of funding provided with the efficient cost of delivery, requiring a clear view of what government aims to 'buy' and what efficient delivery is. **Constraints on spending**: Several mechanisms for constraining spending are built into the model: • Means-testing helps strike a balance between the share of costs borne by government and individuals. • The maximum level of user fees is regulated by government, and eligibility for subsidies is independently assessed. • The Minister retains final decision-making on subsidy levels.	• The new aged care funding approach requires real clarity about what government is buying and the level of funding needed to achieve it – and that this is less clear in ECEC. • In ECEC, government controls price and expenditure indirectly via market mechanisms – this may mean government feels exposed to provider decisions about fees. • In aged care, independent advice on the cost of delivery creates a clear imperative for funding to keep pace with cost and demand – and potentially limits the flexibility government has to control spending. However, IHACPA only provides advice to government – its decisions are not binding as they are in health.
Known challenges include …	**Government value**: The ACCC noted that its difficult to assess the health of the ECEC market given the key objectives and priorities of the system are not always clear.[97] **Constraints on spending**: Government has limited ability to influence fees and therefore changes in out-of-pocket costs for families can be unpredictable. The Hourly Rate Cap is not considered to be especially effective at restraining fee growth or government expenditure.[99] The ACCC has recommended establishing a credible threat of stronger regulatory responses and more transparency about fees to support family decision-making.[100]	**Government value**: Under the previous funding model, funding levels were set too low to meet policy objectives or community expectations. Accommodation and daily living funding is still considered to be insufficient in many cases.[101] **Constraints on spending**: After a period of significant under-funding, the new Independent Health and Aged Care Pricing Authority (IHACPA) provides data-informed advice on the cost of delivery, including service location/size/specialisation and independently assessed care needs. Although the Minister retains decision-making authority, this creates significant external pressure for subsidy levels to reflect the genuine costs of delivery – potentially limiting the level of control government has over increases in expenditure.	

Efficient administration

Both models impose a significant administrative burden on families and providers in exchange for receiving / benefiting from the subsidy

	Early childhood education and care	Aged care
The funding model aims to achieve efficient administration by …	**Government**: MyGov provides a portal for managing system users and payment to providers, and core CCS ITS processes are relatively automated. **Providers**: Government manages the system for assessing family eligibility / subsidy levels, with relatively efficient and automated transmission of data between services and the CCS IT system. **Families**: Three key design features intend to reduce the administrative burden on families - the HRC as a price signal, the fee calculator to estimate cost, and Starting Blocks to locate available services.	**Government**: Online portals streamline communication with providers and monthly collection of data and payments. Data for the quarterly and annual financial reporting is collected by the Department of Social Services via an online template. **Providers**: Providers can view the AN-ACC status of residents and make claims for subsidies through online portals managed by government, with income tested reductions processed automatically. Payments are processed in advance based on past payments with reconciliation provided the following month, creating greater predictability in revenue. **Families**: Fee calculator and My Aged Care website supports estimation of fees and selection of service. Regulated user pricing limits costs, and a means (income/asset) assessment determines whether individual will have to pay means tested care fee and some/all accommodation costs.
Known challenges include …	**Government**: There is limited publicly available information about the administrative burden of operating the CCS, beyond substantial setup costs. **Providers**: The complexity of the funding model means many families rely on providers to help them navigate the CCS, especially in culturally diverse or disadvantaged communities.[102] Service revenue is based on utilisation, which requires active financial management from providers. **Families**: The activity test is the most significant source of administrative burden for families engaging with the CCS. Activity and income changes vary subsidy levels and make it difficult for families to estimate costs. Costs can be unpredictable, and families need to frequently update their details on MyGov.[103] Changes to a child's bookings require updates to their provider contract.[104]	**Government**: Administering supply-side funding model is costly for government. The IHACPA 2022-23 budget for hospital and aged care pricing functions was $36m, around double the level required in the previous year when only hospital pricing was required. There were also significant costs in setting up the IT system. **Providers**: There is a significant reporting burden (monthly submission of claims and quarterly / annual financial reporting) and complexity navigating interaction between regulatory requirements and funding (care classifications, subsidy levels and care minutes). **Families**: User payments include a mix of fixed, means tested and opt-in fees across different aspects of provision (accommodation, care and other costs). This makes it difficult to understand and compare care costs. The Aged Care Taskforce acknowledged the need to make co-contributions '*fairer, simpler and more transparent*'.[105]

Key insights

- In both ECEC and aged care, eligibility and means testing mechanisms create complexity. This means families struggle to:
  - Estimate the actual out of pocket costs they'll pay,
  - Navigate the systems required to develop accurate estimates, and
  - In the case of ECEC, keep systems updated to match changes in entitlements.
- The systems are costly to administer. They require expensive enabling technology and in the case of the IHACPA, a large establishment and operational budget.

Accountability

The aged care funding model is much more explicit in its use of levers to ensure accountability for outcomes and influence provider behaviour than ECEC.

	Early childhood education and care	Aged care	Key insights
The funding model aims to achieve meaningful accountability by …	**Levers**: Beyond base-level provider-approval requirements, there is limited explicit use of the funding model to influence provider behaviour. **Data and insight**: Government monitors system outputs, and controls for fraud by collecting data on: • Family income and work hours to confirm eligibility and accurate subsidy allocation • Attendance and session details to ensure children are attending services for which subsidies are claimed It also collects data on financial performance of large providers to provide visibility of profits and revenues.	**Levers**: Model influences provider behaviour and outcomes by: • Regulating user fees and requiring permission to charge higher or additional service fees • Controlling access to public subsidies by approval and accreditation of aged care providers • Independently assessing individual resident care requirements, to support appropriate classification of residents for funding purposes. • Conducting independent and transparent pricing processes, including cost studies. **Data and insight**: Data is collected through reporting by providers on financial performance and direct care minutes. Detailed technical documentation on subsidy calculation is published to provide transparency of price-setting process.	• Both models contain comprehensive data collection mechanisms to track system operations. • However, the use of these mechanisms to provide system insights and inform decision-making is much more mature in aged care. • The aged-care model directly influences provider behaviour by controlling fees and access to subsidies. However, there are still issues with ensuring that funding provided is used for its intended purpose. • The quality monitoring system in ECEC appears to be more comprehensive and effective, but the ECEC funding model does not effectively leverage the levers at its disposal to incentivise quality and price.
Known challenges include …	**Levers**: The ACCC and PC have noted the benefits of more active stewardship of the ECEC system and market. Key issues include that approval of provider permits to enter market or expand offerings is not conditional on NQS ratings, few incentives for higher quality provision, or for delivery in thin markets. **Data and insight**: Whilst data collection practices are comprehensive, they are not always designed to inform effective decision-making. For example: • Financial reporting doesn't cover whole market • There's no public reporting of supply or demand, leading to asymmetries in access to this information across the system • There's limited public monitoring of system outcomes	**Levers**: Despite the controls built into the model, there are still issues with ensuring funding is used for its intended purpose, with only half of all providers meeting or exceeding either of their care targets, despite being funded to raise their level of staffing to achieve this. **Data and insight**: Data collection practices for IHACPA are still developing and require further refinement to optimise their value for decision-makers. For example, the IHACPA's 2023-24 pricing advice is based on interim methodologies to calculate cost and wage changes due to a lack of recent cost and activity data.	

Market health

The aged care funding model directly controls for service viability and profit, whereas the ECEC model influences these indirectly through increasing demand for services and families' sensitivity to price. Both models have design elements that seek to encourage diverse supply, responsive to demand.

	Early childhood education and care	Aged care	Key insights
The funding model aims to achieve a healthy market by …	**Viability:** Subsidies increase the affordability of ECEC which increases demand, leading to higher enrolment rates and more stable revenue streams. **Supply and provider diversity:** The funding model is 'provider agnostic'. Modest but stable revenue settings have incentivised market growth and new providers into the market. The funding settings create scope for providers to tailor their service offering to meet demand patterns. **Profit:** Families' price sensitivity places pressure on providers to keep prices down to remain competitive, restricting excessive profit margins.[106] ECEC markets are highly localised and the ACCC found little variance in fees within local markets, although prices vary more between markets.[107] **Workforce:** The funding model does not explicitly address workforce matters.	**Viability:** Calculation of subsidy levels is based on actual cost of delivering care supports services, with in-depth processes for indexation / aligning funding settings with cost increases. **Supply and provider diversity:** The activity-based approach responds to market demand. Variations to the Base Care Tariff and provision of care to specific cohorts addresses supply in thin markets. 'Provider agnostic' design supports a range of provider types. **Profit:** Care related subsidies are set to reflect costs and minimise excessive profits – with thin but relatively set margins built into the design. Providers (with approval) can increase revenue through user fees for discretionary accommodation costs (for example, higher-end facilities and amenities). **Workforce:** There is a direct mechanism to account for wage-related costs and pass on wage increases to staff.	• Aged care funding model uses a supply-side subsidy to directly control for service viability and profit (by limiting subsidy to actual cost of delivery). • In contrast, the ECEC demand-side subsidy indirectly influences viability and profit by increasing demand for services and enhancing families' price sensitivity to control for profit. • Both models contain design elements that aim to encourage a diversity of supply responsive to demand.

Market health

Both funding models are contributing to a reduced level of market diversity and are not incentivising supply in thin markets. Service viability remains fragile, and failure to pass on wage increases is compounding workforce shortages.

Known challenges include …

Early childhood education and care

Viability: Indexation has not kept pace with actual costs (which have increased faster than CPI)[108] but provider viability has remained stable – except in thin markets where demand isn't sufficient to meet fixed costs of delivery.[109]

Supply and provider diversity: Supply has grown most in urban areas and through for-profit provision – contributing to inadequate supply in thin markets and a reduction in market diversity.[110] Demand places for 0-2s exceeds supply as higher costs of delivery are not recognised in the funding model and increased supply is not incentivised as a result.[111]

Profit: The ACCC found no evidence of excessive profit. The sector has low margins with relatively stable long-term returns.[112] Large LDCs are profitable on average, and margins are not excessive in aggregate over the period 2018-22.[113] Comparatively, approx. 25% of LDC providers structured as companies earn little to no profit or generate a loss.[114] Margins are higher for for-profit providers in major cities and more advantaged areas.

Workforce: There are issues with attracting and retaining a quality workforce, in part because base-level funding does not fully cover the cost of optimum workforce conditions or professional development. There's no simple mechanism to pass on wage increases via the CSS.

Aged care

Viability: Despite subsidy increases, around 35% of providers still operate at a loss due to constraints on revenue, particularly in the areas of daily living and accommodation.[115]

Supply and provider diversity: The funding model is incentivising consolidation, with fewer but larger providers. This poses risk of dependence on large, low-quality providers that are 'too big to fail.'[116] Funding does not adequately cover higher costs of delivery in some rural and remote areas, with metropolitan providers significantly outperforming regional and rural provider in terms of profitability. This may exacerbate provision gaps in thin markets. Supply is not growing at a fast enough pace to meet the future demands of an ageing population.

Profit: The model doesn't constrain profit in all cases, with instances of providers operating below staffing levels (and using excess care funding to cross-subsidise other parts of the business)[117] and exploiting care classifications to select residents based on profit margin.[118]

Workforce: Following an extended period of underfunding and low wages, workforce shortages in the aged care sector are acute, with an annual workforce shortfall of around 35,000[119]. The model doesn't adequately ensure providers pass on full wage increases[120] or employ sufficient staff to meet care minutes[121], with nearly two-thirds of providers still failing to meet mandated levels of care.

Key insights

- The aged care funding model Both models encourage a diversity of supply and delivery models that are responsive to demand.
  - Despite this, aged care has not fully recovered from a period of low funding and reduced supply – supply is not growing fast enough to meet future increased demand.
  - There is growing consolidation across both sectors, with large providers growing faster and the growing risk of providers who are 'too big to fail' in aged care.
  - There has been significant growth in for-profit market share in ECEC.
- Service viability remains fragile in both sectors due to constraints on revenue (for aged care) and difficulty keeping pace with actual costs (ECEC).

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