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Australia's Aged Care Sector: Full-Year Report 2023–24

For the year ending

30 June 2024

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Disclaimer

Parts of this report are based on the results of StewartBrown's *Aged Care Financial Performance Survey*. Although the survey is extensive, it does not provide a complete set of results for all aged care providers operating in the sector.

The authors have used all due care and skill to ensure the material is accurate as of the date of this report. UTS and the authors do not accept responsibility for any loss that may arise by anyone relying on its contents.

Australia's Aged Care Sector: Full-Year Report 2023–24

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Table of abbreviations

ACAR	Aged Care Approval Round
ACCPA	Aged & Community Care Providers Association
ACFPS	Aged Care Financial Performance Survey
ACQSC	Aged Care Quality and Safety Commission
AIHW	Australian Institute for Health and Welfare
BCT	Base Care Tariff
CHSP	Commonwealth Home Support Progamme
DAP	Daily accommodation payment
EBITDA	Earnings Before Interest, Taxes, Depreciation and Amortisation
FTE	Full-time equivalent
FWC	Fair Work Commission
GDP	Gross Domestic Product
IHACPA	Independent Health and Aged Care Pricing Authority
MM	Modified Monash model of remoteness classification
MPIR	Maximum Permissible Interest Rate
NPBT	Net profit before tax
NWAU	National weighted activity unit
RAD	Refundable Accommodation Deposits
UARC	UTS Ageing Research Collaborative
UTS	University of Technology Sydney

Editorial Board Foreword

Welcome to the 2023-24 Full-Year edition of *Australia's Aged Care Sector*.

The highlight of the past few months has undoubtedly been Parliament's multi-party collaboration on aged care policy and program design. The passage of the 2024 Aged Care Bill has been a landmark development and harks back to a decade earlier when the Living Longer, Living Better reforms received broad political and stakeholder support.

Policy reform is quite often a matter of the art of the possible – taking advantage of sometimes fleeting alignments of interests. On this occasion, the efforts of the Minister for Health, Mark Butler, the Minister for Aged Care, Annika Wells MP and the Shadow Minister, Senator Anne Ruston, deserve particular recognition.

The beneficiaries of this collaboration will be older Australians in need of subsidised care services and the providers and workforces that deliver that care. Taxpayers also have reason to hope that the public funding of the sector will be more sustainable over the next several decades while being sufficient to deliver safe, quality care by viable providers.

UARC is pleased to note the Government's agreement to several related reforms that address policy design anomalies, to which we, alongside other key stakeholders, have been drawing attention. These include the introduction of a more granular Base Care Tariff structure (to remove the disparity faced by rural providers, in MM4 especially), a rebalancing of the price weight values for AN-ACC classes, and the introduction of additional co-contributions for non-care services by wealthier aged care recipients.

We also applaud the forthcoming reality of the new, integrated Support at Home program as part of the new Aged Care Act. Nonetheless, the likelihood of the new program achieving a smooth start on 1 July 2025 has long odds, particularly as we await a final detailed price list. The Government needs to make a meaningful investment in ensuring a relatively smooth transition to this program for the sake of the vulnerable cohort of older people who will depend on its services, the providers, and the workforce that delivers the care and support.

As always, the Executive Summary that follows this Preface will provide you with an overview of UARC's analysis of the financial and operational performance of the sector, together with the conclusions about the need for policy and program design that it draws from the research evidence.

I wish to use the remainder of this Foreword to focus on three issues.

First, it is beyond disappointing that a significant number of residential care providers are still failing to deliver the level of care required by their residents as calculated under the care minutes regime, even though they have been fully funded to deliver that care. At the same time, UARC recognises the failings of mandating inputs such as care minutes rather than specifying outcomes, the workforce challenges facing the sector, and the efforts of most providers to meet and in some cases exceed their mandatory obligations.

Our 2023-24 Mid-Year Report optimistically considered the staffing shortfalls to be a temporary aberration and that the unearned surpluses gained from direct care would reduce over the following months. Regrettably, this has not been the case, despite recent public entreaties from Commissioner Anderson and Minister Wells. The Minister's 1 October 2024 letter to the sector closely echoed the analysis that UARC published six months ago. Specifically, the Government needs to ensure that the additional taxpayer funding is actually spent on improving direct care staffing. UARC continues to press the urgency of appropriate and targeted action.

My second musing is on the imminent demise of Aged Care Approvals Rounds (ACAR) and bed licences, another consequence of the new Aged Care Act. While until 1 July 2025, the legal standing of ACAR has but a faint pulse, this reform has been sought for over a decade.

Later in Part 1 of this edition, there is a more fulsome recounting of how we got to this stage. Still, the point I wish to emphasise here is that this reform will enable more forward-looking investors in the residential care sector to provide 24/7 care in the style of accommodation in which people want to live, and in locations of their choice. One can envisage vibrant communities living in independent living units, serviced apartments, and clusters of homes within the broad ambit of retirement village legislation while receiving quality and safe residential care.

Providers will be able to offer a very positive alternative to the stereotypical 'nursing home' that has little favour in the minds of many older people who wish to live full lives while needing complex and continuous care. The challenge will be for both innovative providers and far-sighted bureaucrats to look beyond the medicalised terminology of treating 'sickness' that permeates the wording of the new Act – in itself an overly conservative workaround by the Department to address its Constitutional concerns.

A final topic for this Foreword is also related to accommodation. Our Sector Reports have consistently identified the accommodation business model as the main reason for the significant ongoing losses incurred by residential care providers. While some of the responsibility lies with the Government and taxpayers in inadequately funding accommodation supplements paid on behalf of fully and partially supported residents, the blame also lies in the failure of many providers to set viable prices for their accommodation. The declining investment in new and refurbished aged care homes is leading to a crisis in care availability that cannot await a two-year review. Neither can incoming residents who face unacceptable inequity merely because they cannot afford refundable deposits and must pay a higher equivalent daily price, even after deferred rental payments are introduced. You, dear readers, can expect to hear more from UARC on this pressing matter over the coming months.

May we all travel safely and confidently along the pathway to where aged care services are consumer driven, market-based, proportionately regulated, equitable and sustainably subsidised.

Take care.

Professor Mike Woods (Chair)

On behalf of the Editorial Board and the UTS Ageing Research Collaborative
12 December 2024

Executive Summary

This last year has seen a substantial transformation in the aged care sector, marked by the recent passing of the new Aged Care Act. This legislation introduces critical reforms aimed at enhancing the equity and sustainability of aged care funding and the implementation of the new Support at Home program in 2025.

These developments occur against a mixed backdrop. In 2023-24, residential care homes saw a modest improvement in financial performance, driven by a rise in occupancy and additional direct care funding, while noting that not all are meeting the costs of their mandated workforce targets. There were also improvements in homes' Star Ratings, driven by better resident experience, staffing and compliance. However, warning signs remain, with more than half of homes operating at a loss, many of which are located in regional and rural areas, an increasing reliance on agency staff, and persistent losses for non-care services. At the same time, the viability of home care services continues to decline, with persistent low revenue utilisation and growing reliance on third-parties to deliver services.

Ensuring the financial viability of residential and home care services is essential to maintaining a reliable supply of aged care for older Australians, particularly in regional and rural areas. However, several critical trends highlight risks to the sector's capacity to meet future demand.

Over the last five years, the residential care sector has reported cumulative losses of at least $3.86 billion. This has coincided with a 36.4% decline in building activity, which is likely to result in supply shortages over the next decade. Simultaneously, market concentration has increased, with the 24 largest providers now operating 40.2% of all places and 37.5% of homes. These larger providers generally benefit from lower costs, reducing their risk of financial distress.

Since the introduction of consumer-directed care in 2017, the average net profit before tax of home care providers has remained consistently low, ranging between $2.17 and $4.29 per client per day. A key contributor has been stagnating revenue, whereby providers' nominal earnings have declined despite the growth in available package subsidies.

Looking to the future, in residential care, the viability of direct care services will likely continue to improve through important changes to the AN-ACC model in 2024-25. In particular, changes to the Base Care Tariff will enhance the viability of many regional and rural homes and revisions to the AN-ACC price weights will increase support for residents with lower care needs.

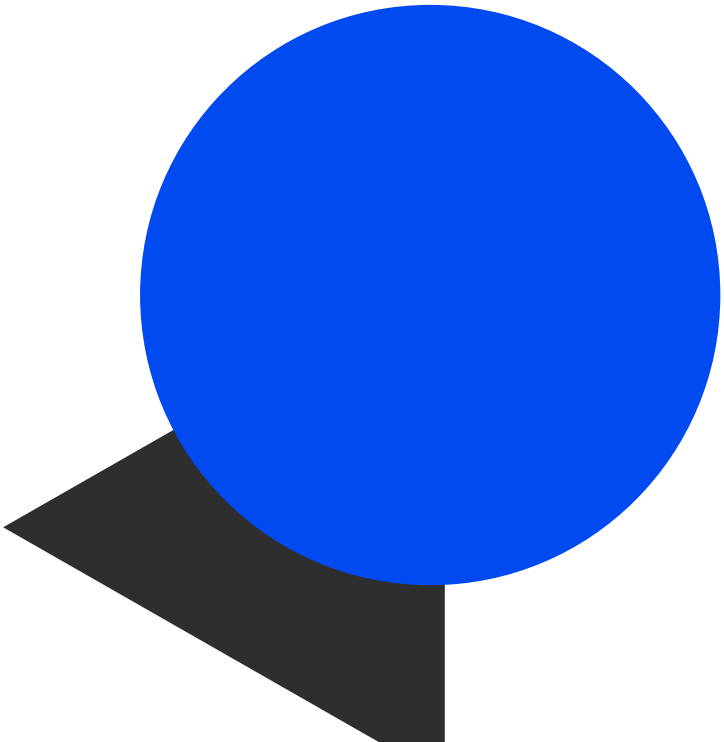
However, policy expectations are hardening that this additional funding is used to deliver higher direct care staffing, noting that homes failing to meet staffing requirements report significantly better financial outcomes, primarily due to reduced staffing costs. As of June 2024, only 40.5% of homes met both their care minute targets, with lower compliance in metropolitan areas and among for-profit providers.

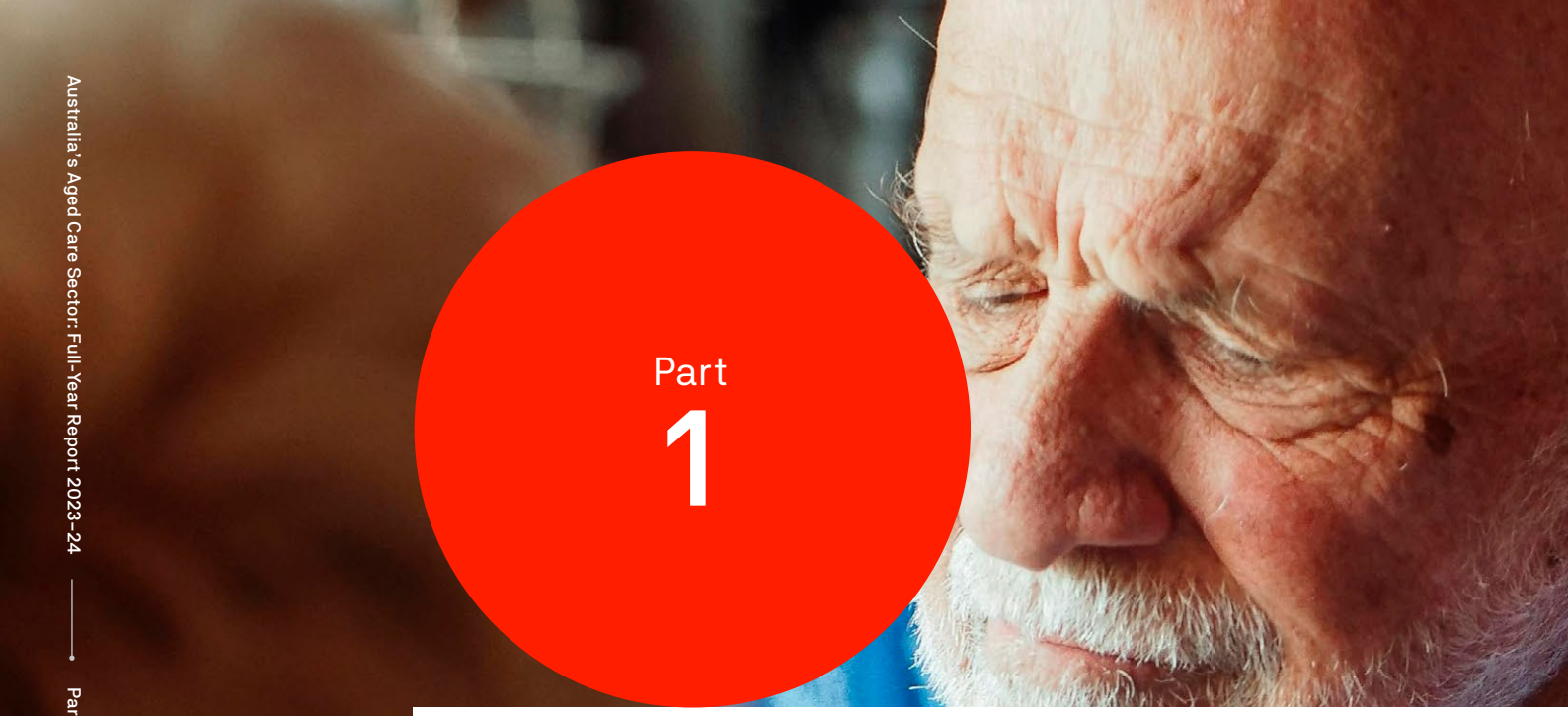
Additionally, the 2024–25 hotelling supplement has been raised to $12.55 per resident per day; however, this remains $3.17 per day below the actual cost of providing everyday living services, raising concerns about the adequacy of funding in this area. Furthermore, accommodation services remain the most significant source of losses. Even after the changes recommended by the Aged Care Taskforce are implemented, the revenue structures for accommodation will require further attention to ensure a sufficient supply of residential places to meet demand.

The future viability of home care providers will depend on the implementation of the defined service list and capped pricing under the new Support at Home program. However, uncertainty persists regarding the cap's impact on care management fees and the pricing of administrative costs within service fees. A key challenge will be determining what qualifies as "legitimate cost variations" while distinguishing these from inefficiencies or poor productivity, particularly given the diverse cost structures across providers.

In the longer term, reforms introduced in response to the Aged Care Taskforce are expected to enhance the equity and sustainability of the aged care system. These include fully funding clinical care services and providing safety-net funding for individuals with low means. Additionally, changes to residential care and the Support at Home program will require wealthier individuals to contribute more towards the costs of independence, everyday living, and accommodation services. These measures are likely to improve the equity and sustainability of the aged care system by reducing existing disparities, improving the viability of residential providers and reducing the rate of growth in government spending.

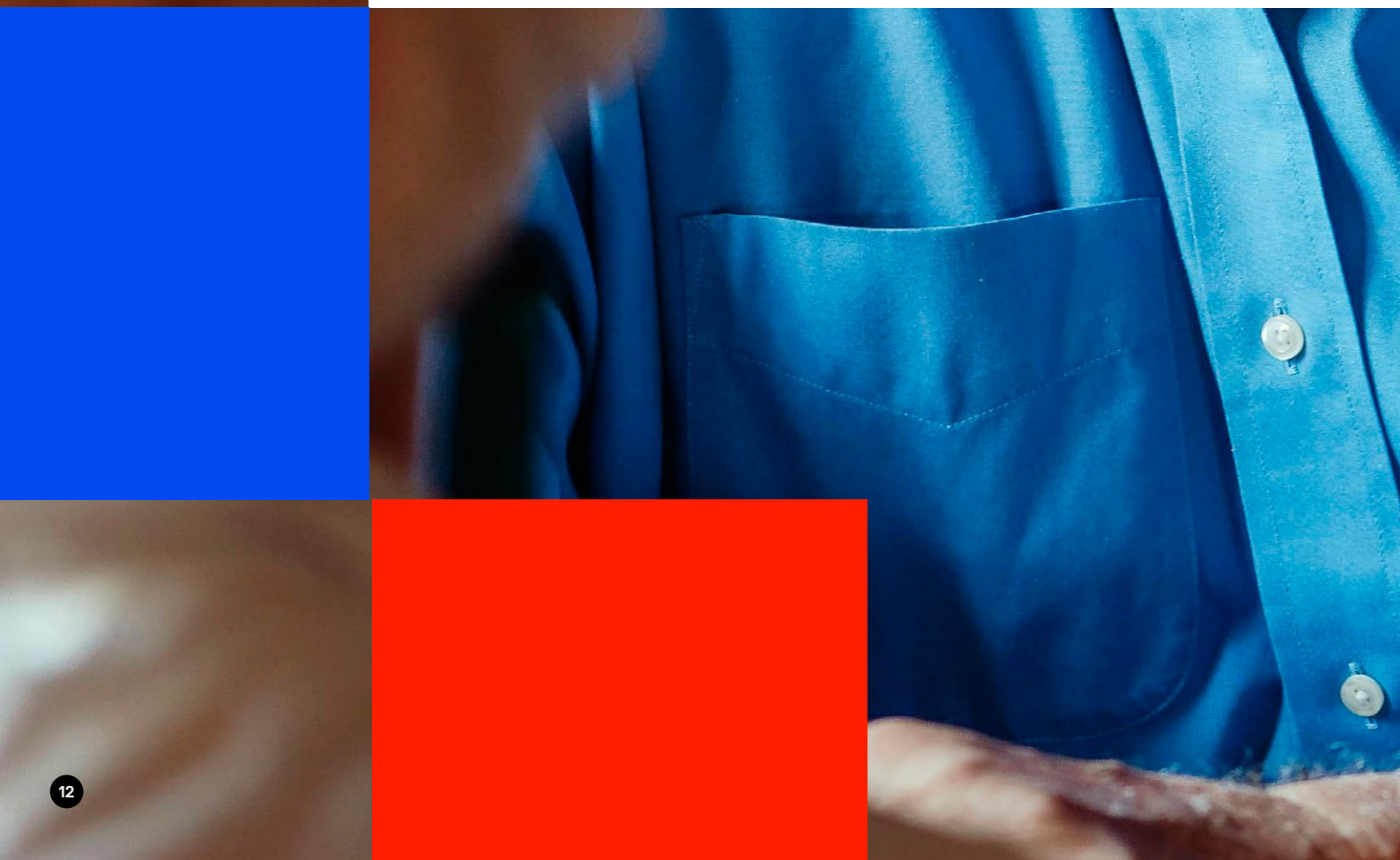
Finally, the abolition of ACAR and the expanded definition of a residential care home under the new Aged Care Act provide a foundation for giving older people greater control and flexibility to receive care across a broader range of accommodation settings tailored to their needs and preferences. However, the realisation of this potential will depend on how the Government interprets the new Act and its willingness to collaborate with innovative providers committed to meeting the evolving expectations of their consumer base





Part
1

Analysis and commentary



Part 1 of this report provides analysis and commentary on many of the most pressing reforms and issues across the Australian aged care sector.

Drawing on the expertise of members from across the UTS Ageing Research Collaborative, this section includes original research and policy analysis, informed by a wide variety of evidence sources, including from the Department of Health and Aged Care, StewartBrown, and the Australian Institute of Health and Welfare.

Key topics in this edition include:

- Financial viability across the aged care sector
- Economies of scale in residential care
- Changes in residential care funding for 2024-25
- Aged Care Taskforce response
- Pricing Support at Home
- Direct care staffing
- Recent trends in Star Ratings
- The abolition of ACAR

Financial viability

Financial viability across the aged care sector

Key messages

- Since 2019-20, the residential care sector has lost at least $3.86 billion. Persistent losses have coincided with a 36.4% slowdown in building activity, which is likely to lead to supply shortfalls in the coming decade.

- Stagnating revenue has undermined home care provider viability. In nominal terms, while the average value of package subsidies has increased by 24.9% since 2016-17, the average revenue earned has fallen by 7.0%.

- Ensuring the financial viability of residential and home care services is critical to safeguarding the reliable supply of aged care to older Australians, particularly outside major metropolitan centres.

Financial viability concerns remain at the forefront across Australia's aged care sector. The Department of Health and Aged Care's (the 'Department') latest figures indicate that more than a third (34.1%) of residential aged care providers are operating at a loss, as are a quarter (23.3%) of home care providers.[1]

The Department's sector-wide statistics are reflected in the detailed analysis of StewartBrown's annual data presented in Part 2 of this report, which show that for the 2023-24 financial year:

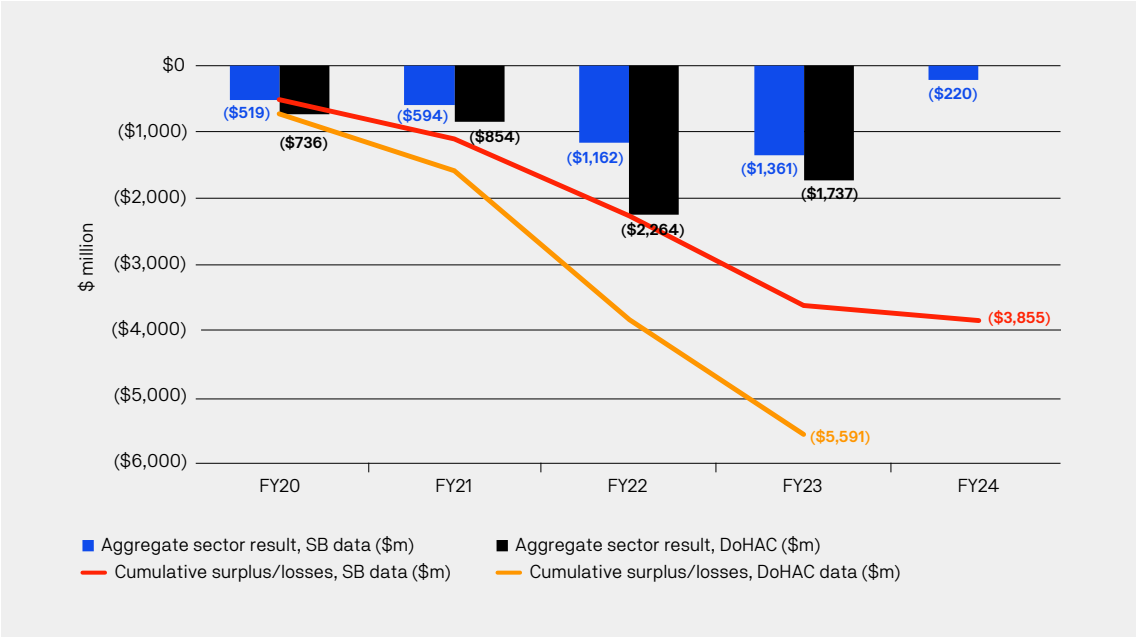
- The average financial performance of approved providers remains low, with a median EBITDA of just 3.3%.
- More than half (51.3%) of residential aged care homes operated at a loss, with an average deficit of $3.07 per resident per day.
- Home care providers' financial performance continues to decline, with an average Operating Result of just $1.11 per client per day (median equivalent to $2.82 per client per day).

Aged care services experiencing sustained periods of financial distress are at greater risk of closure, which may undermine reliable access to services for older people, particularly those living outside major cities.

The cumulative effect of sustained losses in residential care is illustrated in Figure 1. Based on the figures reported in StewartBrown's 2023-24 *Aged Care Financial Performance Survey* (ACFPS), UARC estimates that providers lost in aggregate $220 million in 2023-24,[2] bringing the residential care sector's losses since 2019-20 to at least $3.86 billion.

These estimates are likely conservative and understate the total losses experienced across the sector once all homes are included, including those with service disruptions and operated by local and state governments. Sector-wide figures reported by the Department show that in prior years, the sector has encountered even larger losses (see Figure 1), which is likely to be the outcome again for FY24.[3]

Figure 1: Cumulative sector losses in residential aged care sector



1. Department of Health and Aged Care (2024), *Quarterly Financial Snapshot for the Aged Care Sector – Quarter 4 2023–24*.
2. This figure has been estimated assuming 223,691 operational places in Australia as of 30 June 2024, with an occupancy rate of 87.8%.
3. Department figures represent the results from all residential providers, which include all residential aged care homes, including those with operational issues. These have been compiled from results reported in: Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector 2022-23*.

Financial viability constraining capital investment

One of the concerns arising from residential care's consistently poor financial returns is the potentially adverse impact on investment in new and refurbished capital infrastructure. A recent provider survey by the Aged & Community Care Providers Association (ACCPA) indicated that more than half of providers (57%) lacked confidence in their organisation's ability to attract capital for building refurbishments or new builds.[4]

The sector has experienced a marked slowdown in building activity over the past four years. Statistics reported by the Department show that in 2019–20, total expenditure on completed or in-progress construction projects, including new builds, rebuilds, and upgrades, was $5.66 billion. By 2022–23, this figure had fallen 36.4% to $3.60 billion. Compounding this issue is a notable decline in homes' intentions to undertake upgrades or rebuilds and a decrease in building approvals.[5]

Given the significant lead times required for new infrastructure to become operational, this recent decline in building activity poses a risk of supply shortfalls in meeting the demand for residential care over the next 5–10 years. While the expansion of the Home Care Package program may enable more individuals to age in place, the prevalence of complex health conditions requiring 24-hour care, coupled with growth in the population aged 80 and above, is nonetheless expected to drive increased demand for residential care. As detailed in Part 2 of this report, the average occupancy rate of existing homes has now returned to almost pre-pandemic levels at 92.6%, meaning that older people may already face challenges finding available places in their local areas. Furthermore, according to the Department's forecasts, Australia will need an additional 100,000 residential care places within the next decade.[6]

There is some hope that forward-looking providers will make good use of the retirement village provisions in the new Aged Care Act to expand supply. Still, inevitably, there will be some delays in its full integration into the supply chain as the Department and Government grapple with and clarify the many precedents it will set. Given this, improving the level of capital investment in residential care remains a critical and urgent priority.

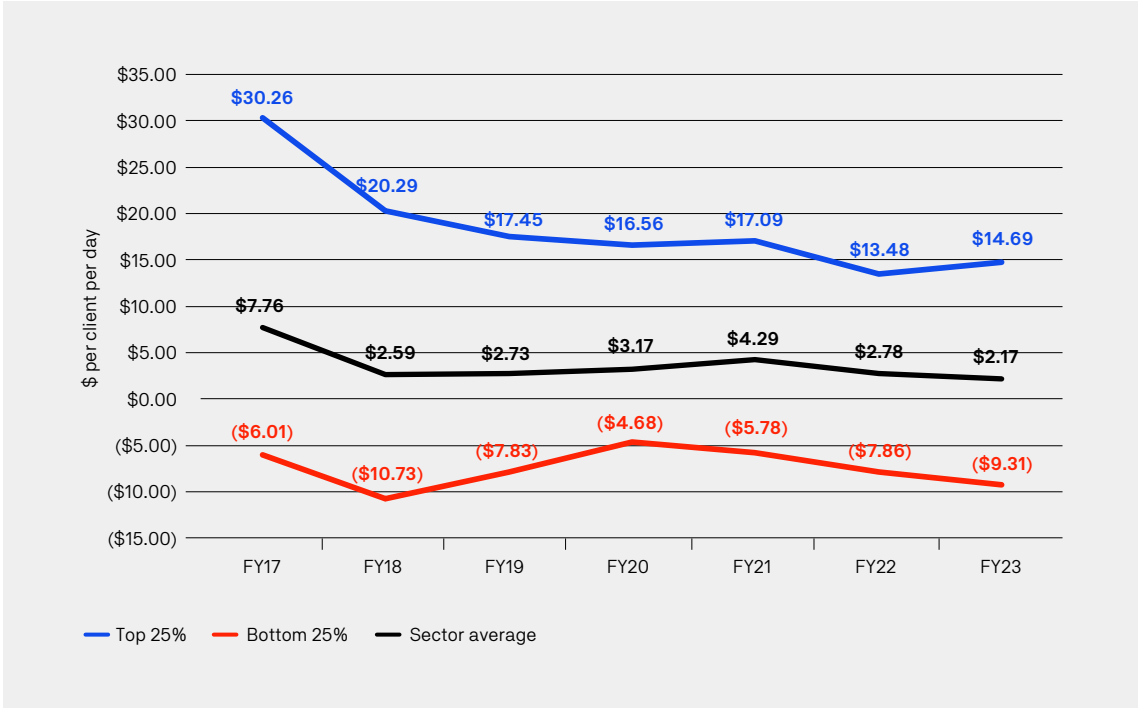
4. ACCPA (2024), *State of the Sector Aged Care Report 2024.*
5. Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector 2022-23*, p.111-113.
6. Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector 2022-23*, p.127.

Stagnation of home care provider revenue

Unless the poor financial returns for home care providers improve and workforce availability constraints relax, the sector will likely face significant challenges in delivering sufficient supply to meet the growing demand anticipated under the new Support at Home program.

As of March 2024, 59,751 people were waiting in the National Priority System for a home care package, with 9-12 months delays for a level 3 package.[7] In response to these pressures, the Government has committed additional funding to increase the number of available packages and aims to reduce the wait times through a new prioritisation mechanism.[8] However, this will only be possible if there is a sufficiently viable provider market to meet the demand and a sufficiently sized and skilled workforce to deliver the services.

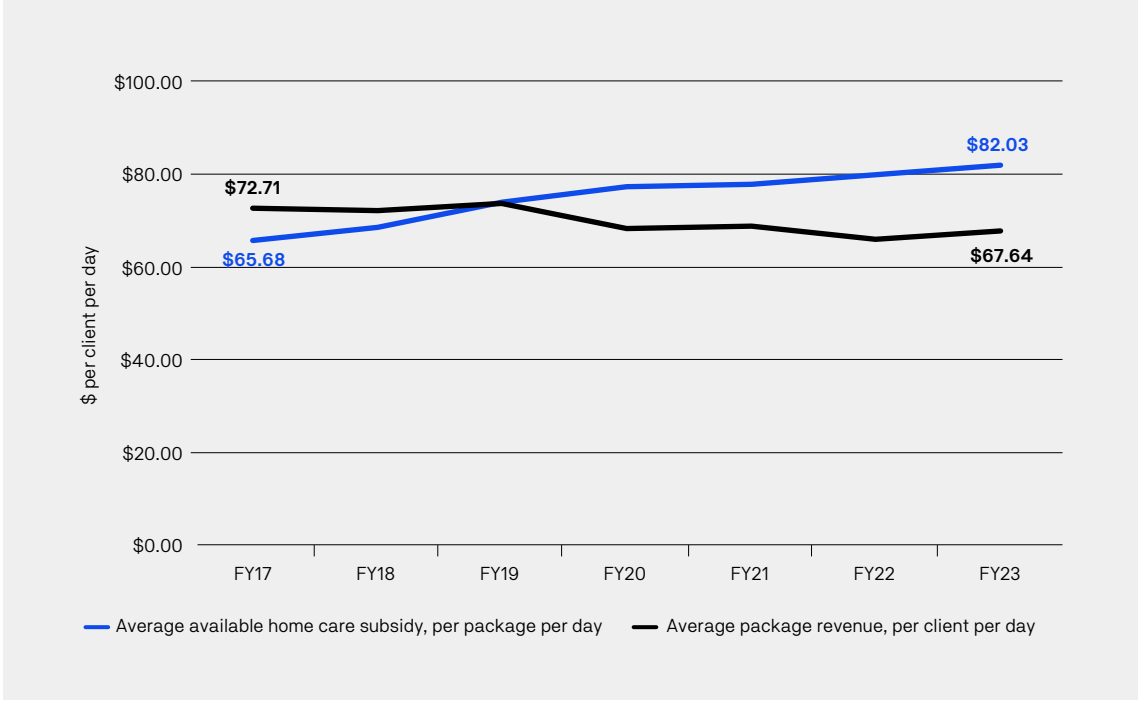
Figure 2: Home care providers' average net profit before tax, per client per day, by quartile



Since the introduction of consumer-directed care in 2017, the average net profit before tax has remained consistently low, ranging between $2.17 and $4.29 per client per day (see Figure 2).[9] Recent data from StewartBrown indicates an even poorer financial outcome in 2023–24 (i.e. $1.11 per resident per day, see Part 2). Moreover, these averages obscure the extent of viability challenges across the sector. As shown in Figure 2, the poorest-performing quartile of providers (the 'bottom 25%') has operated at a loss since 2016–17, with average deficits worsening since 2019-20.

7. Department of Health and Aged Care (2024), *Home Care Packages Program Data Report, 3rd Quarter 2023-24.*
8. Department of Health and Aged Care (2024), *Support at Home program handbook Program details for 1 July 2025.*
9. These figures have been collated from sector statistics published in annual reports by the Department of Health and Aged Care, Department of Health and the Aged Care Financing Authority.

Figure 3: Available home care package subsidy and realised package revenue, per client per day

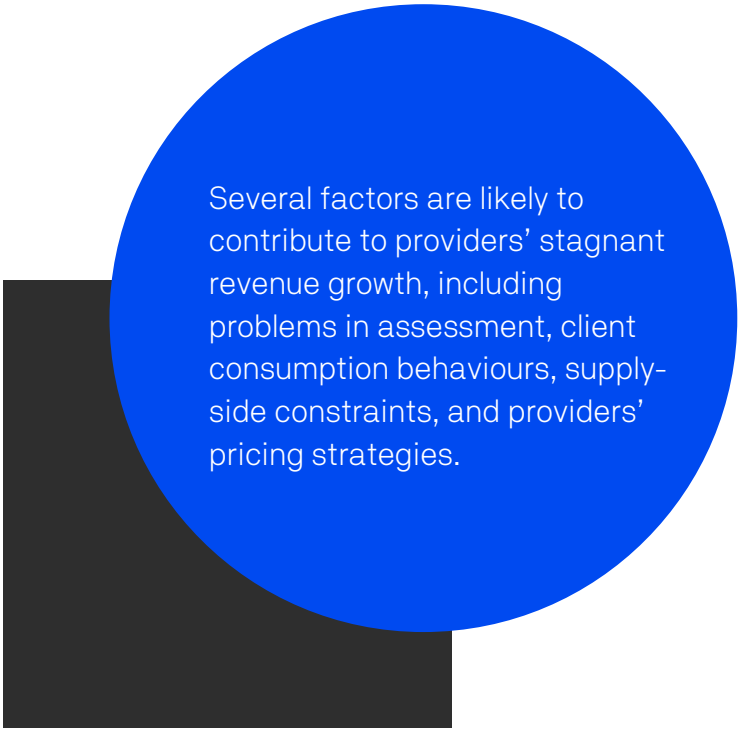


The prolonged revenue stagnation is a key factor contributing to home care providers' financial struggles. UARC estimates that since 2016-17, the average value of package subsidies has steadily increased by 24.9% in nominal terms, primarily due to annual indexation increases (see Figure 3).[10] However, the average revenue home care providers earn per client per day over the same period has fallen by 7.0%.[11] This divergence between the value of package entitlements and the actual revenue earned has led to the accumulation of unspent funds estimated to total $3.6 billion as of June 2024.[12]

10. The average subsidy value has been calculated based on a weighted mix of home care clients in packages, by level, for each year, multiplied by the value of package subsidy, by level, as published in the *Schedule of Subsidies and Supplements for Aged Care* by the Department of Health and Aged Care. For reference, the equivalent figure for 2023-24 is estimated at $91.44, having increased to reflect Stage 2 of the FWC aged care work value case.
11. Average package revenue figures have been collated from sector-wide statistics published in annual reports by the Department of Health and Aged Care, Department of Health and the Aged Care Financing Authority.
12. Department of Health and Aged Care (2024), *Quarterly Financial Snapshot Aged Care Sector, Quarter 4 2023-24.*

Several contributing factors are likely to cause providers' stagnant revenue growth and low utilisation. For example, low utilisation may arise from problems in assessment, whereby clients are assigned a package that does not align with their needs or if there are reassessment delays if their needs change. Alternatively, it could reflect client consumption behaviours, such as when individuals save up their package to pay for equipment, home modifications, or future care needs. It could also reflect providers' supply-side constraints, particularly in terms of workforce, which may limit the availability of service offerings that align with individuals' needs in the areas where they live. Furthermore, revenue will stagnate if providers keep prices low as a competitive strategy.

Some of the features of the new Support at Home program (detailed later in Part 1) are designed to address some of these factors. For example, introducing quarterly budgets and dedicated funding for equipment and home modifications budgets should gradually reduce the amount of unspent funds.[13] In addition, more granular classification levels, reduced wait times and more efficient reassessment processes will also improve the alignment between individuals' needs and entitlement levels. However, it is less clear how the new program will address the other causes of stagnant revenue growth, particularly providers' supply adequacy and competitive pricing strategies.



13. In the new Support at Home program, participants will only be able to accrue a maximum of $1000 or 10% of their quarterly budget (whichever is higher) from one quarter to the next.

Economies of scale in residential care

Key messages

- Market consolidation in residential aged care continues. In 2023-24, the 24 largest providers operated 40.2% of all operational places and 37.5% of all residential aged care homes.

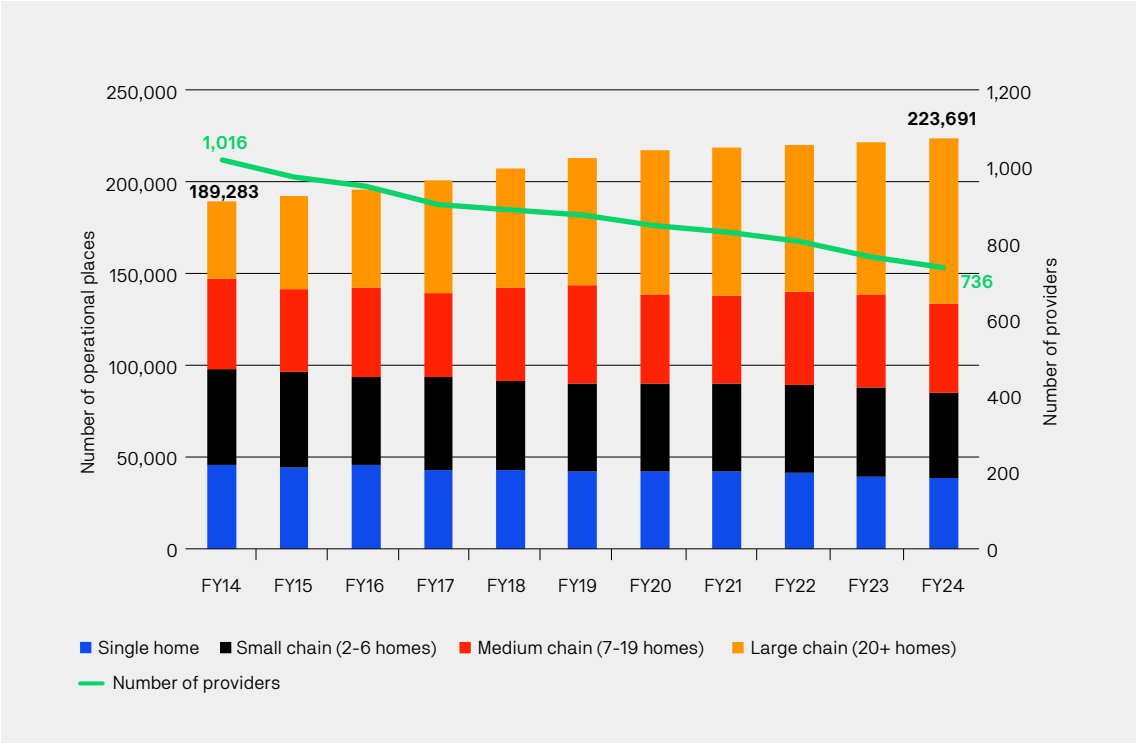
- Larger providers report lower operating expenses as a percentage of operating revenue than their smaller counterparts, driven by lower direct care, everyday living, accommodation and staffing expenditures.

- While generally, homes expend more on staffing to achieve higher staffing Star Ratings, homes of large chains can achieve higher staffing Star Ratings without necessarily incurring a higher rate of direct care staffing spending.

UARC's last full-year report (2022-23) provided initial evidence of market consolidation and economies of scale in residential aged care homes. This section provides updated evidence focusing on the most recent period (2023-24), given the recent pricing and operational services changes.

Despite continued demand for residential aged care in the past decade, the number of providers offering residential aged care services continues to fall. Figure 4 shows that in the last decade, the total number of operational places has grown 18.2% from 189,283 in June 2014 to 223,693 in June 2024. At the same time, the total number of providers has fallen by 27.6%, from 1,016 to 736.[14]

Figure 4: Number of residential operational places, by provider scale

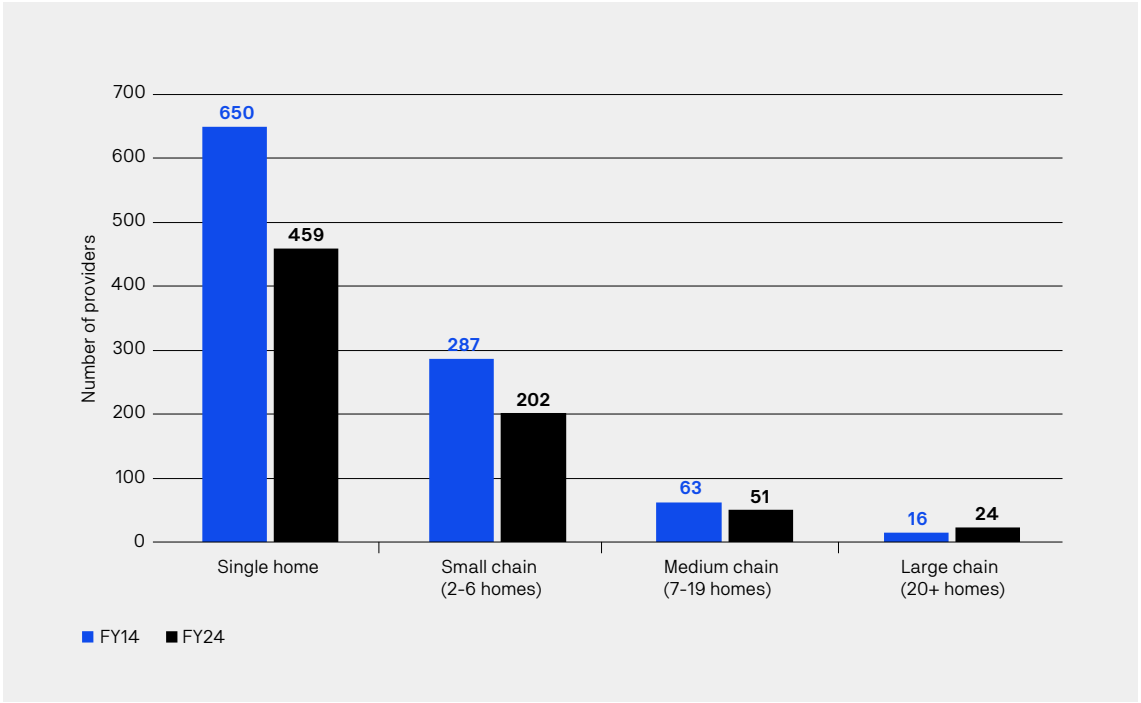


The changing composition of the residential provider market is illustrated in Figure 5. This shows that most exits in the last decade have been from single-home providers (a net decrease of 191 providers) and small chains operating 2-6 homes (a net decrease of 85 providers). In contrast, the number of large chain providers operating 20 or more homes has increased since 2013-14.[15]

As a result, the residential care market has consolidated, with very large providers continuing to increase their market share (see Figure 4). For example, in 2023-24, the 24 largest providers operated 40.2% of all operational places and 37.5% of all residential aged care homes.[16] By comparison, single-home operators have a 17.2% share of operational places and 17.5.% of homes.

14. Department of Health and Aged Care (2024), *Aged Care Service List (30 June 2024)*, Australian Institute of Health and Welfare.
15. Data compiled from annual reports issued by the Department of Health and Aged Care, the Department of Health and the Aged Care Financing Authority, and the Aged Care Service Listing.
16. Department of Health and Aged Care (2024), *Aged Care Service Listing (30 June 2024)*.

Figure 5: Number of residential care providers, by scale

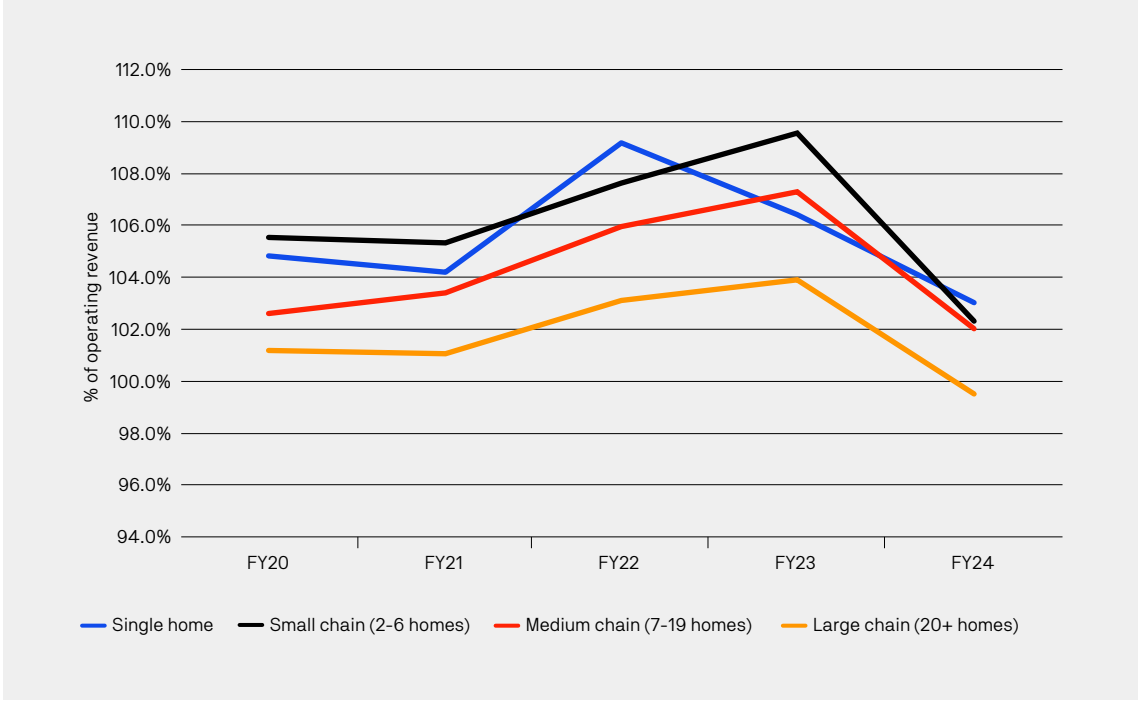


These consolidation trends have been attributed to merger and acquisition activity, whereby large providers are expanding to improve their economies of scale and, in some cases, ensure access is maintained for regional and rural communities. At the same time, small and medium providers are exiting due to ongoing issues around financial viability and regulatory burdens.[17]

To investigate this issue further, UARC conducted a detailed analysis of the relative expenditure patterns of residential aged care homes by provider scale category.[18] The primary metric for this analysis is homes' expenditure as a percentage of operating (recurrent) revenue, which provides insight into their relative cost efficiency in delivering services and their financial sustainability in maintaining adequate margins.[19]

17. KPMG (2024), *Aged care market analysis 2024*.
18. This analysis was conducted using 5 years of the StewartBrown residential care data (2019-20 to 2023-24).
19. Considering whether scaling influences the results, on average, homes operated by large chains generated higher operating revenue ($396.60 per resident per day) compared to single, standalone homes ($385.90 per resident per day) with small ($390.10 per resident per day) and medium chains ($394.10 per resident per day) generating amounts between those ranges. While homes operated by medium chains reported the highest operating expenses ($401.50 per resident per day) followed by homes operated by small chain ($399.20 per resident per day), single homes still incurred higher operating expenses ($397.30 per resident per day) compared to homes of large chains ($393.30 per resident per day).

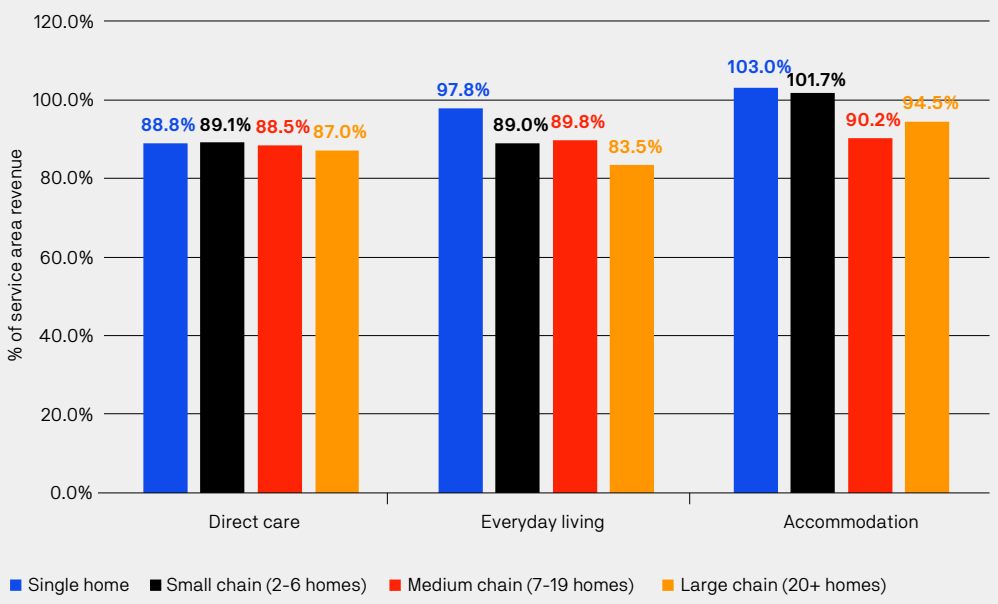
Figure 6: Operating expenses as a percentage of operating revenue, by provider scale



As shown in the five-year trend in Figure 6, on average, large chain homes consistently report lower operating expenses as a percentage of their operating revenue across all periods. While the performance of single, small chain and medium chain homes fluctuates between years, medium chain homes generally exhibit lower operating expenses relative to their revenue compared to single homes and small chains.

This trend persisted in the most recent financial year (2023–24). While providers of all sizes, on average, improved their relative cost efficiency, homes operated by large chains continued to report the lowest expense-to-revenue ratio at 99.5%. In contrast, homes operated by smaller providers (those managing between 1 and 19 homes) still had operating expense ratios exceeding 100% of revenue, indicating negative operating margins. This reinforces the view that homes operated by larger providers enjoy financial advantages, which may reduce their risk of financial viability challenges.

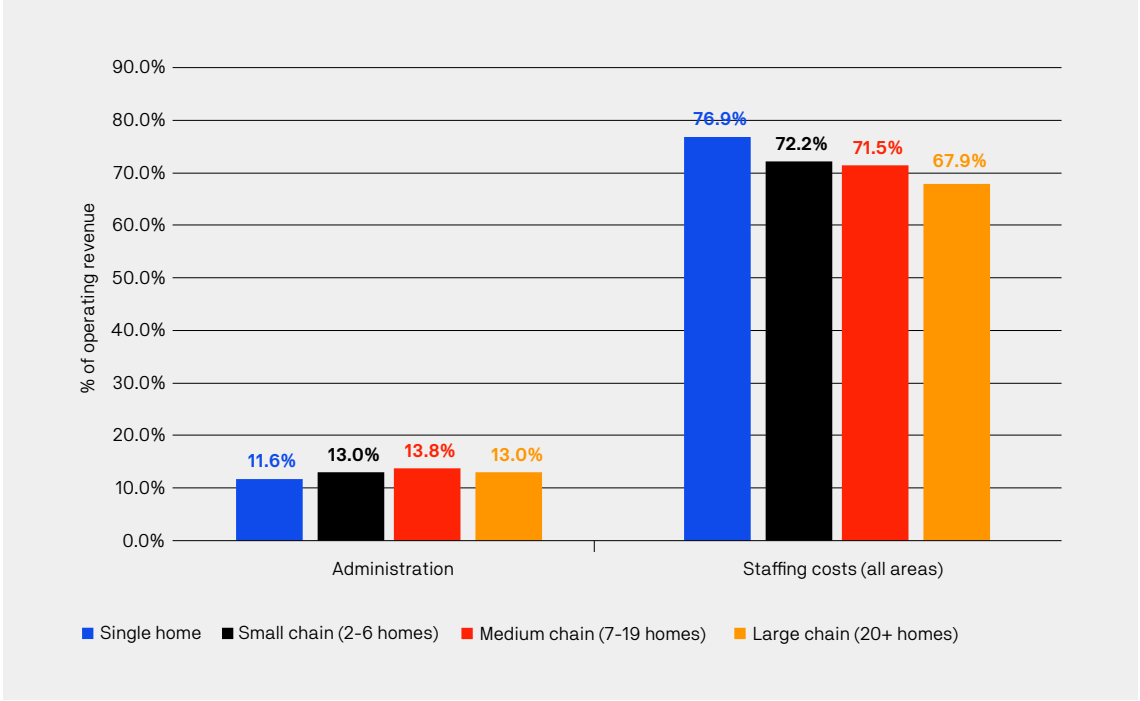
Figure 7: Operating expenses as a percentage of service area revenue, by service area, by provider scale



To understand the drivers of the results, Figure 7 reports the disaggregated operating expense ratios for each service area for 2023-24, i.e. operating expenses for each service area scaled by the operating revenue for that service area. Note that these service area expenses do not include the allocation of administrative costs, which are analysed separately below.

This demonstrates that large chain homes generally have lower average expense-to-revenue ratios than homes operated by smaller providers across most service areas. The differences by provider scale are particularly pronounced in everyday living services. For example, in 2023-24 single homes had an average expenditure (excluding administration) of 97.8% of their everyday living revenue. In contrast, this rate was significantly lower for small chains (89.0%), medium chains (89.8%), and large chains (83.5%).

Figure 8: Administrative and staffing expenses as a percentage of revenue, by provider scale



The one area of expenditure in which single homes appear to have a cost advantage is, perhaps unsurprisingly, administration (see Figure 8). In 2023-24, their administration expenses averaged 11.6% of total operating revenue, lower than homes operated by chains of all sizes (13.0%-13.8%). This pattern likely reflects relative differences in the additional coordination complexity of an organisation operating across multiple services and locations rather than a single-site.

Across all service and expense areas, there is a clear scale-related trend in the relative rate of staffing costs as a percentage of operating revenue (Figure 8). Single homes, on average, spend 76.9% of their revenue on staffing; this rate declines to 67.9% for homes operated by large chains.

Several factors could influence the observed differences in staffing expenditure. On the one hand, larger providers may achieve genuine cost efficiencies by negotiating favourable external agency contracts, investing in better systems, implementing more efficient rostering practices, or reducing reliance on overtime. On the other hand, these differences might also reflect variations in direct care staffing levels across the sector, which could have unintended or adverse effects (see Direct Care Staffing section). It is important to assess cost efficiencies in the context of whether homes are delivering comparable levels of care to ensure that reduced costs do not compromise care quality.

Figure 9: Direct care labour costs as a percentage of direct care revenue, by staffing Star Rating

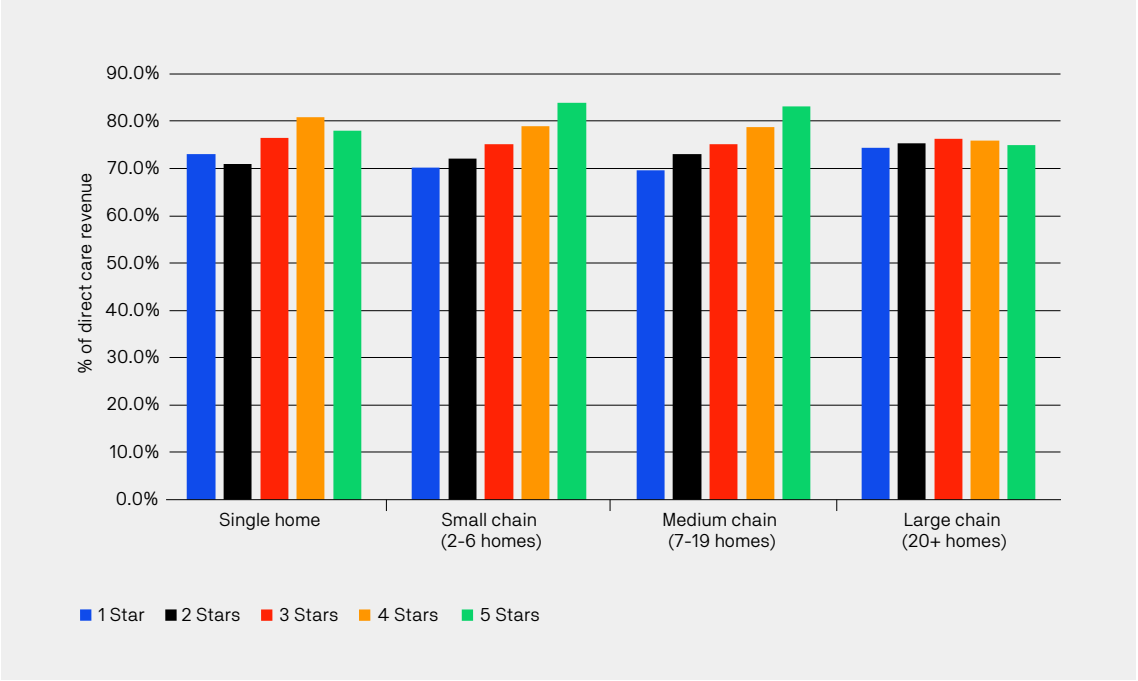


Figure 9 presents homes' average direct labour costs as a percentage of direct care revenue (for 2023-24) grouped by provider scale and staffing Star Rating (for quarter 4 of 2023-24).[20] This shows that most homes need to spend more on direct care labour as a proportion of their direct care revenue to achieve higher staffing Star Ratings. However, the exception to this pattern is homes operated by larger providers. There is consistency in the rate of direct care labour spending by these larger providers, with the range of costs between 74.4% and 76.4% across all the stars. The results suggest that homes of large chains can achieve higher staffing Star Ratings while maintaining a relatively similar rate of direct care staffing spending, potentially reflecting more efficient staffing models.

20. The staffing Star Rating is assigned based on the extent to which homes meet and exceed service-level registered nurse and total direct care minute targets. Data on the staffing star rating is from: Department of Health and Aged Care (2024) *Service-level care minutes performance in residential aged care (from October 2023).*

Changes in residential care funding for 2024-25

Key messages

- The AN-ACC funding model is the largest single area of Government spending on aged care, accounting for $13.0 billion in 2022-23.
- The AN-ACC base price has been increased, based on advice from IHACPA, to $280.01 for 2024-25, with more funding to meet the new minimum care minute requirements and implement Stage 3 of the Fair Work Commission aged care wage case.
- The introduction of a more granular Base Care Tariff structure is expected to improve the financial viability of aged care homes, particularly those in medium rural towns (MM4).
- The price weights for each variable AN-ACC class have been revised, resulting in an uplift in the variable funding for residents with lower care needs and relatively lower variable funding for residents with higher care needs.
- The 2024-25 hotelling supplement has been increased to $12.55 per resident per day. However, there are concerns that at this price, everyday living revenue will still be $3.17 per resident per day below the actual cost of delivering services.

In September 2024, the Government announced an additional $5.8 billion of funding for residential care over four years from 2024-25.[21] Most of this additional funding ($4.8 billion) stems from changes to the AN-ACC funding model for residential care, with the remainder relating to increases in the hotelling supplement.

It is important to note that these changes are in addition to the proposed reforms announced as part of the response to the Aged Care Taskforce. The implications of those reforms will apply from 1 July 2025 when the new Aged Care Act comes into force and are addressed later in the Sustainability section in Part 1.

Overview of the AN-ACC funding model

The AN-ACC funding model determines aged care homes' revenue for direct care services, including clinical care, nursing, and assistance with personal tasks such as eating, bathing, and mobility. In 2022-23, the annual subsidy for these services was $13.0 billion, making it the largest single line item in the Government's aged care funding portfolio and 53.8% of residential providers' total revenue.[22]

Under AN-ACC, which started in October 2022, homes' direct care funding for permanent[23] residents comprises three components:

1. A fixed component subsidy or 'base care tariff' (BCT), which reflects each home's geographical location (denoted by its Modified Monash classification[24] or 'MM') and specialisations for homelessness or remote Aboriginal and Torres Strait Islander persons;
2. A variable component subsidy, which is determined by the classification of the homes' residents into different AN-ACC classes based on their care needs;[25] and,
3. A one-off transition payment for each newly admitted permanent resident.[26]

These three components are priced by multiplying the AN-ACC base price (or 'national efficient price') by their specified 'price weight' of national weighted activity units (NWAUs). In doing so, the Government can make a wholesale change to direct care funding by adjusting the AN-ACC base price (e.g. to accommodate an increase in the national award rate) and more targeted changes to specific categories or classes by adjusting their relevant NWAU price weights or the structure and number of the classes.

The Government announced several changes to the AN-ACC model for 2024-25, commencing from 1 October 2024:

1. An increase in the AN-ACC base price
2. More granular Base Care Tariff categories
3. A change in the NWAUs for the variable AN-ACC classes

The Government expects these changes to increase average direct care funding per resident per day by 13% to an estimated $305 from 1 October 2024.[27] The rationale and effects of each of these adjustments are explained below.

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21. For more information, see: Residential aged care funding reform update – Webinar | Australian Government Department of Health and Aged Care.
22. Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector 2022-23*, p.69
23. Respite residents are also funded under AN-ACC, with a fixed component (identical to permanent residents), a variable component (based on respite AN-ACC classes) and a respite supplement equivalent to the maximum accommodation supplement for permanent residents.
24. Modified Monash Model | Australian Government Department of Health and Aged Care.
25. AN-ACC assessment process and classification | Australian Government Department of Health and Aged Care.
26. Department of Health and Aged Care (2024), *The Australian National Aged Care Classification (AN-ACC) funding guide.*
27. Residential aged care funding reform update – Webinar | Australian Government Department of Health and Aged Care.

Increase in the AN-ACC base price

The first change to AN-ACC was a wholesale increase in the base price to $280.01 from the previous level of $253.82.[28]

The increase in funding is based on the annual advice from Independent Hospital and Aged Care Pricing Authority (IHACPA), which estimates changes in providers' cost of care.[29] IHACPA's methodology takes the average cost per NWAU in 2021-22, then adjusts for known cost increases since 2021-22 (e.g. uplift in care minutes) before applying an annual indexation rate to estimate the likely cost of delivering direct care services from 1 October 2024 to 30 September 2025.

The latest increase in the base price reflects expected increases in providers' costs, including:

- The increase in labour costs to meet the new minimum care minute requirements. From 1 October 2024, on average, providers must deliver at least 215 minutes of direct care staffing time per resident per day, with 44 minutes provided by registered nurses.[30]
- Implementation of Stage 3 of the Fair Work Commission aged care work value case, comprising award rate increases for personal care workers, assistants in nursing and recreational activities officers from 1 January 2025.[31]
- The annual 0.5% increase in the Superannuation Guarantee from 1 July 2024.
- A 3.75% increase in award rates following the FWC Annual Wage Review 2023-24.
- Estimated increases in inflation and other non-labour costs.
- Backpay adjustment for the change in AN-ACC start date from 1 July to 1 October 2024.

The policy expectation is that the increase in AN-ACC funding is necessary to cover the cost of direct care services in the coming year, mainly to fund the uplift in direct care staffing and the rise in award rates of aged care workers. However, as discussed in the Direct Care Staffing section of this report, a substantial portion of the sector (40.5%) has yet to meet its mandatory care minute targets, resulting in a significant underspend on direct care staffing.

28. During 2023-24, the AN-ACC base price was $243.10 from 1 July 2023 and then $253.82 from 1 December 2023. Across the entire year, the average AN-ACC base price was $249.34.
29. Residential Aged Care Pricing Advice 2024–25 | IHACPA.
30. Funding for the uplift in care minutes had already been committed by the Government in the 2022-23 Budget. The increase in the AN-ACC price provides the mechanism for providers to access this funding.
31. In total, the Government will spend an additional $3.8 billion over 4 years to fund Stage 3 of the FWC aged care work value case, comprising $3.3 billion for award wage increases for residential care workers (personal care workers, assistants in nursing, recreational activities officers, administration staff, laundry hands, cleaners, food service assistants) and $0.4 billion for award wage increases for home care workers. For more information, see: Investing another $3.8 billion in quality aged care | Australian Government Department of Health and Aged Care.

More granular Base Care Tariff categories

In our full-year 2022-23 report, UARC outlined the disparities in financial outcomes of homes in different locations (denoted by different Modified Monash model remoteness classifications or 'MM categories'). In particular, we highlighted the acute rates of financial distress experienced by homes in medium rural towns (MM4), noting that 82.4% of homes in these areas were operating at a loss, losing an average of $43.86 per day.[32]

Our analysis identified several likely factors contributing to the plight of homes in medium rural towns (MM4), including declines in occupancy, lower transitional benefit of AN-ACC and high agency reliance and prices. We also attributed homes' poor financial outcomes to differences in AN-ACC funding outcomes, noting that homes in these areas tended to have lower variable AN-ACC funding flows than metropolitan homes but also received the lowest BCT rate. At the time, we concluded that:

> *"Taken together, while homes in medium and large rural towns face similar operational challenges as their more remote counterparts (i.e. low occupancy, diverse resident profiles, and higher input costs), they remain ineligible for higher BCT funding under AN-ACC. As a consequence, UARC proposes that the Department, informed by advice from IHACPA, consider adopting more granular BCT subsidy rates that differentiate funding for homes in MMM1-4 areas."*[33]

The poor results of homes in these areas have continued in the last year. Our updated results for 2023-24 (see Part 2) show that medium rural homes (MM4) had the largest operating deficit at $24.26 per resident per day compared to a $8.90 deficit for homes in rural and remote (MM5-7) areas and a $3.45 surplus for homes in a metropolitan (MM1) areas.

In the updated AN-ACC model, the Government has recognised the need to change the BCT to reflect better the geographic cost differences in delivering care:

> *"Analysis found that costs for services in MM 1-4 vary, with this update adapting the BCT structure to make it more granular, to ensure funding matches costs in these locations."*[34]

In alignment with UARC's proposal, the new BCT categories for homes in areas MM1 to MM5 have become more granular. As shown in Table 1, homes are now grouped into more categories, allowing the Government to attach different NWAU price weights to homes in major cities (MM1), in regional centres and large rural towns (MM2-3), and medium and small rural towns (MM4-5). Furthermore, the relative funding for each category (i.e. the NWAUs) has been increased, with the largest increases for homes in MM2, 3 and 4 areas.

There have been no changes to the price weights relating to non-specialised MM6 and MM7 services, specialised homeless and specialised Aboriginal and Torres Strait Islander services. However, the Government is reviewing the policy settings for homes in these BCT categories based on an analysis from IHACPA that showed that homes in these areas had low care expenditure relative to their AN-ACC funding.[35]

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32. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Woods, M., Tsihlis, E., Lin, J., Parker, D. (2023), *Australia's Aged Care Sector: Full-Year Report (2022-23)*, UTS Ageing Research Collaborative.
33. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Woods, M., Tsihlis, E., Lin, J., Parker, D. (2023), *Australia's Aged Care Sector: Full-Year Report (2022-23)*, UTS Ageing Research Collaborative, p.35.
34. Department of Health and Aged Care (2024), *The Australian National Aged Care Classification (AN-ACC) funding guide.*
35. Residential aged care funding reform update – Webinar | Australian Government Department of Health and Aged Care.

Table 1: Summary of changes to Base Care Tariff

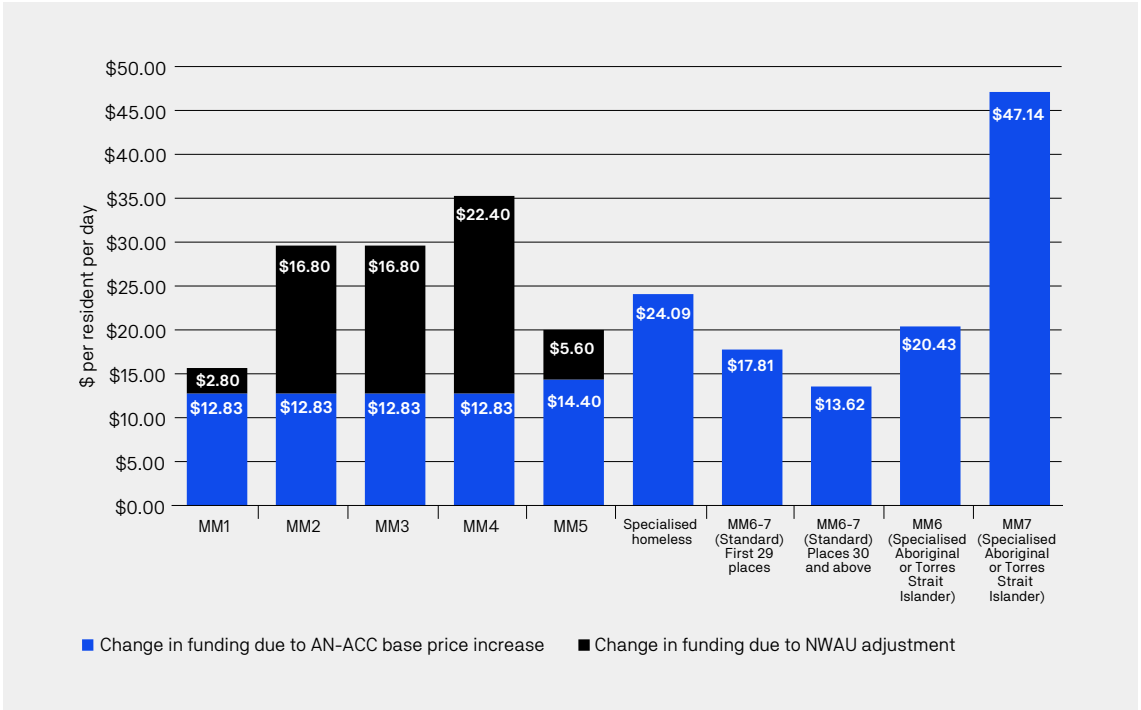
Description	Previous BCT structure	New BCT structure	NWAU (1 December 2023)	NWAU (from 1 October 2024)
Metropolitan areas (MM1)	MM1 - 4	MM1	0.49	0.5
Regional centres (MM2)		MM2 -3	0.49	0.55
Large rural towns (MM3)			0.49	0.55
Medium rural towns (MM4)		MM 4-5	0.49	0.57
Small rural towns (MM5)	MM5		0.55	0.57

Source: Adapted from Department of Health and Aged Care webinar materials[36]

Figure 10 shows the incremental impact of changes to BCT, measured in terms of per resident per day. It shows that from 1 October 2024, all homes will receive an increase in their BCT funding due to the increase in AN-ACC base price.

However, homes in MM1-5 will also receive an additional increase in their BCT due to the changes in BCT categories and relative NWAUs. UARC estimates, for example, that homes in medium rural towns (MM4) will receive an additional $22.40 per resident per day due to their re-categorisation. In the context of the latest financial results for 2023-24, this additional funding will materially improve the financial viability of the 187 aged care homes in these areas, thus enhancing the continuity of access to the 13,000 residents they serve.

Figure 10: Forecast increase in Base Care Tariff funding for 2024–25



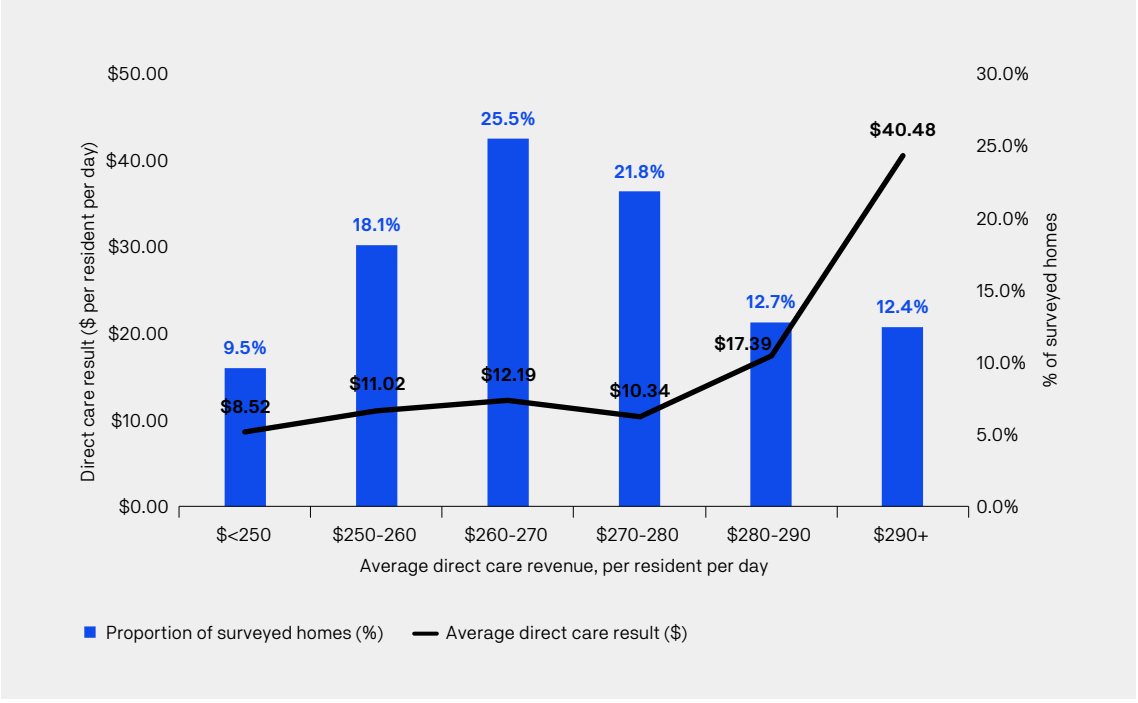
36. Residential aged care funding reform update – Webinar | Australian Government Department of Health and Aged Care.

Changes in the relative NWAUs of the variable AN-ACC classes

In our full-year 2022-23 report, UARC presented evidence indicating that the financial outcomes of homes' direct care services varied by their resident casemix. Specifically, we found that, on average, homes with higher AN-ACC funding per resident per day earned substantial direct care surpluses. In contrast, those with lower average AN-ACC (i.e. with more residents with lower care needs) tended to make a loss on direct care services. At the time, UARC recommended that AN-ACC funding be calibrated to achieve greater parity across AN-ACC classes so that homes' direct care outcomes were similar, regardless of their resident casemix. [37]

Figure 11 shows an update of this analysis for the 2023-24 financial year, illustrating the average direct care result for homes, by their average direct care revenue per resident per day.[38] This shows that there appears to be reasonable parity in the direct care financial outcomes of homes that receive up to $280 per resident per day in direct care revenue (i.e. their average direct care result ranges from $8.52 and $10.34 per resident per day). However, homes that receive more than $280 per resident per day in direct care revenue still have much higher direct care margins. Noting that other supplements may distort these results, we repeated the analysis using only homes in major city areas (MM1), resulting in much the same pattern.

Figure 11: Direct care result, by average direct care revenue, per resident per day



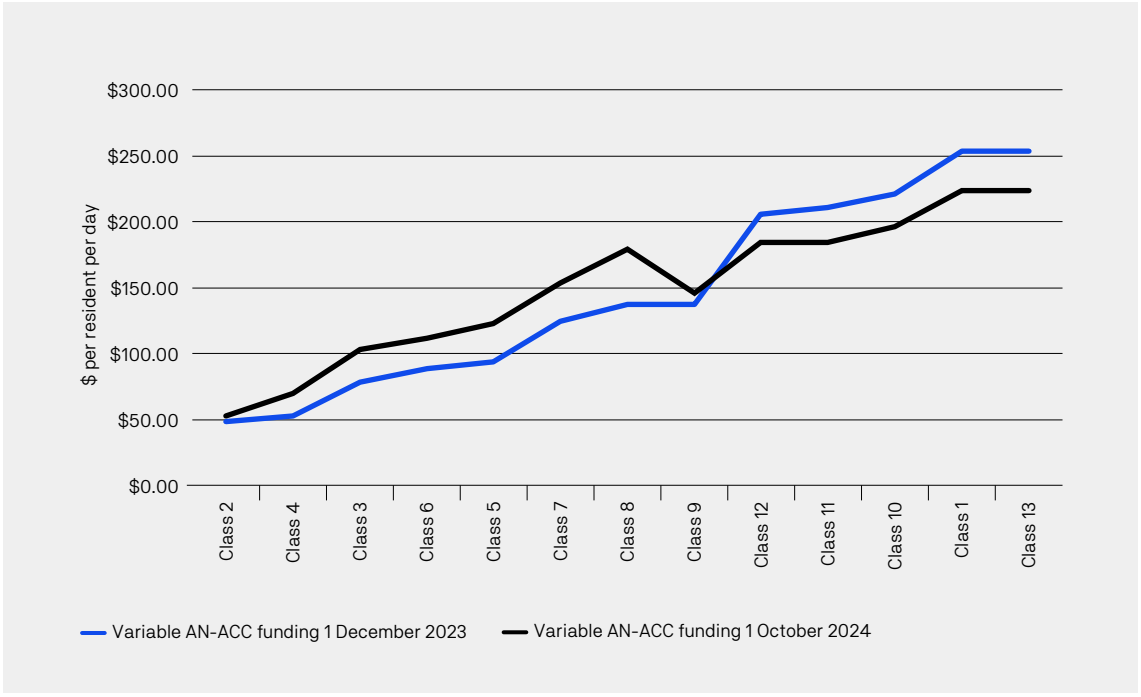
37. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Woods, M., Tsihlis, E., Lin, J., Parker, D. (2023), *Australia's Aged Care Sector: Full-Year Report (2022-23)*, UTS Ageing Research Collaborative.
38. This analysis was conducted using 1,194 homes in the StewartBrown 2023-24 ACFPS residential dataset.

In the latest update to AN-ACC, the price weights (NWAU) for each variable AN-ACC class have been revised, resulting in an uplift in the variable funding for residents with lower care needs and relatively lower funding for residents with higher care needs.[39]

IHACPA recommended adjustments in price weights[40] based on its analysis of data captured in the 2023 Residential Aged Care Costing Study.[41] These changes align with the different mobility classifications, one of the primary criteria underpinning the AN-ACC assessment structure.

The most significant change has been the increases for Class 3 (independent, with compounding factors) and all assisted mobility classes (Classes 4–8). Together, these six classes represent approximately 107,390 residents (55.7% of all residents nationally). In contrast, there has been a decrease in the price weights of all classes relating to residents who are not mobile (Classes 9–13), which comprises 70,925 residents (36.8% of all residents nationally).[42]

Figure 12: Variable AN-ACC funding per resident per day, by AN-ACC class



Due to these pricing adjustments, from 1 October 2024, there will be smaller differences in the variable funding for permanent residents with different assessed care needs (see Figure 12). By implication, this should result in higher direct care funding for homes that have more residents in more 'low care' AN-ACC classes, such as those in non-metropolitan areas.

39. Department of Health and Aged Care (2024), *The Australian National Aged Care Classification (AN-ACC) funding guide.*
40. Residential Aged Care Pricing Advice 2024–25 | IHACPA.
41. Scyne Advisory (2023), *2023 Residential Aged Care Costing Study Final Report.*
42. There have also been changes to the price weights for the respite classes (approximately 8,000 residents), which align with the changes in the respective mobility classes of permanent residents.

However, until we better understand the direct care cost requirements associated with each AN-ACC class, it is difficult to predict whether these pricing adjustments will translate into greater parity in the financial outcomes of homes with different resident profiles. Although price weights are tied to care minute requirements, as the 2023 Residential Aged Care Costing Study showed, the actual labour required to meet the care needs of residents of each class may differ from the assigned care minute targets.[43] Likewise, different AN-ACC classes may vary in their consumption of other resources (e.g. consumables, administration, other labour) in a way that differs from the NWAU price weights. Finally, as discussed in UARC's submission to IHACPA, the within-class variation in the staffing of some classes (i.e. Class 3 and 8) may indicate the need to revise the AN-ACC class structures to better distinguish between residents with heterogeneous resource requirements to support their care delivery.[44]

Increase in the hotelling supplement

The Government also announced a modest increase in the hotelling supplement, from $11.24 to $12.55 per resident per day. The increase comprises $0.22 per resident per day to reflect bi-annual indexation and $1.09 to fund Stage 3 of the FWC aged care work value case, as it applies to laundry hands, cleaners, food assistants and other indirect care workers.

However, there are concerns that the pricing of the new hotelling supplement will not be sufficient to cover the average total costs of providing everyday living services. Before the announced changes, IHACPA estimated that if the supplement were set at $11.42, there would be a shortfall of $4.30 between the estimated revenue and costs of delivering hotelling services in 2024-25.[45] Updating this analysis with the announced supplement rate (i.e. at $12.55 per resident per day) would imply that there will still be an estimated funding gap of $3.17 per resident per day.

There is also a concern about IHACPA's inclusion of revenue received for additional and extra services within its calculation of total everyday revenue, noting that many non-metropolitan homes do not charge these fees, potentially reflecting differences in residents' capacity to pay. For these homes, the funding shortfall between revenues and costs for everyday living may be higher.

The Government has accepted the recommendation from the Aged Care Taskforce that:

> *"Funding for daily living needs to cover the full cost of providing these services. It is recommended this be composed of the Basic Daily Fee and a supplement."*[46]

However, the proposed changes to consumer contributions as part of the Aged Care Taskforce response will not alleviate the funding concerns for everyday living services, as the hotelling supplement will most likely inform the maximum price that providers can charge residents who have the means to pay the entirety of their everyday living costs. If the total revenues for everyday living services are insufficient to cover the actual cost of providing these services, particularly those in regional areas, then this will contribute to financial viability problems for providers and potentially compromise the quality of services for residents.

43. Scyne Advisory (2023), *2023 Residential Aged Care Costing Study Final Report.*
44. Woods, M., Sutton, N. (2024), *IHACPA Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025–26: UARC response*, The University of Technology Sydney.
45. IHACPA estimated the average cost of providing everyday living services would be $86.37 per resident per day and forecast revenue (including the basic daily fee, hotelling supplement, extra services fees, additional services fees and other hotel revenue) at $82.07 per resident per day. For more information, see: Residential Aged Care Pricing Advice 2024–25 | IHACPA.
46. Department of Health and Aged Care (2024), *Australian Government Response to the Aged Care Taskforce.*

Sector sustainability

Aged Care Taskforce response

Key messages

- Following a September 2024 cross-party agreement to support the recommendations of the Aged Care Taskforce Report, many of its funding proposals are now reflected in the new Aged Care Act.

- The Government will fully fund clinical care services and provide safety-net funding for individuals with low means.

- Changes to residential care and the Support at Home program will see wealthier individuals make greater personal contributions towards the cost of independence, everyday living and accommodation services.

- The reforms are likely to improve the equity and sustainability of the aged care system by reducing existing structural disparities, improving the viability of residential providers and reducing the rate of growth in government spending.

On 12 September 2024, the Government announced a "once-in-a-generation" cross-party agreement to support the recommendations of the Aged Care Taskforce Report.[47] Much of this agreement is reflected in the new *Aged Care Act 2024*, which paves the way for a more equitable and sustainable approach to funding subsidised aged care services.

In terms of some overarching principles, the Government has committed to continuing to be the majority funder of aged care services. Having ruled out an aged-care-specific tax or levy, it has proposed changes to recalibrate the balance between taxpayer-funded subsidies and the personal contributions made by wealthier care recipients.[48]

The Government will also fully fund the clinical care needs of all older people assessed as eligible and in need of that care. It will also continue to provide various forms of safety-net funding to cover most aged care costs for individuals with low financial means. However, there is now an expectation that wealthier individuals will make greater personal contributions towards services they have typically paid for or undertaken themselves throughout their lives.

Regardless of their means, all individuals already in the aged care system will be protected by a 'no worse off' principle.[49] Grandfathering and transition arrangements will ensure that all current residents, home care package recipients and people on the waitlist for home care will not be required to make higher contributions to the cost of their care.

In the sections below, we outline the specific changes to funding arrangements for residential care and the new Support at Home program before reflecting on the impact of these changes on the equity and sustainability of Australia's aged care system. Other proposals not directly related to funding are summarised as a textbox at the end of the section.

Key changes to residential aged care funding

The Government's response outlines significant changes to the funding framework for residential aged care, focusing on the three key service areas: direct care, everyday living, and accommodation.

First, for direct care services, the means-tested care fees will be abolished.[50] In 2023-24, residential aged care homes earned on average $7.16 per resident per day in means-tested care fees (equivalent to 2.6% of total direct care revenue),[51] with the remainder funded via Government subsidies and grants.

47. Once in a generation aged care reforms | Health Portfolio Ministers | Australian Government Department of Health and Aged Care.
48. Department of Health and Aged Care (2024), *Australian Government Response to the Aged Care Taskforce.*
49. The 'no worse off principle' will apply to everyone in residential care from 30 June 2025, who will have their current contribution arrangements maintained until they leave care. They will also be exempt from changes to accommodation payments. It will also apply to people who, on 12 September 2024, were either receiving a Home Care Package, on the National Priority System or assessed as eligible for a package. These individuals will make the same contributions, or lower, than they would have had under Home Care arrangements. When these participants move to residential care, they will stay on the existing contribution arrangements unless they opt to move to the new program. However, they will be subject to the new accommodation payment arrangements in residential care, noting accommodation payments are an agreement negotiated between the resident and their provider.
50. Response to the Aged Care Taskforce – Residential care contributions | Australian Government Department of Health and Aged Care.
51. Based on an analysis of 1,194 homes in the FY24 StewartBrown residential care dataset.

From 1 July 2025, the Government will fully fund all clinical care services, regardless of a resident's financial means. Non-clinical direct care services, such as bathing, mobility assistance, and lifestyle activities, will be funded through Government support and a new means-tested non-clinical care contribution. This contribution will be capped at $101.16 per day (or $708 per week) and will cease once a resident reaches a lifetime limit of $130,000 or after four years, whichever comes first. Previous contributions towards Support at Home services will also count towards the lifetime cap. Unlike the means-tested care fee, the non-clinical care contribution will not be linked to the resident's care level but will be determined as a percentage of their income and assets.[52]

Second, for everyday living services, the hotelling supplement will be means-tested. Currently, everyday living services are funded uniformly for all residents, regardless of their financial means, through a combination of the basic daily fee (set at 85% of the Age Pension) and a government-funded hotelling supplement (currently $12.55 per resident per day). Under the changes, the Government will only cover the hotelling supplement for fully and partially supported residents. As a result, individuals with significant financial means will be required to pay an additional amount to cover the cost of their services.[53]

Also, the current complex and ambiguous arrangements for additional service fees and extra service fees will be replaced with a new Higher Everyday Living Fee. This new fee structure will allow residents to purchase additional daily living services while providing stronger consumer protections to ensure fees are applied exclusively to additional services that residents genuinely want and can use.

Finally, for accommodation, the main reform is the introduction of a deferred rental payment for people who pay for their accommodation using a refundable lump sum deposit.[54] That payment, equivalent to 2% per annum of the value of their deposit, will be taken from their refund at the end of their stay. For those paying via daily accommodation payments, their daily rate will be indexed twice a year.

Also, starting on 1 January 2025, the maximum room price providers can charge (without prior regulatory approval) for new residents will increase from $550,000 to $750,000.

While these changes may appear substantial, many residents will remain unaffected. Due to the grandfathering provisions, only incoming (new) residents will be subject to the revised arrangements. Among these, individuals with low financial means—typically full pensioners without significant assets—will experience minimal impact, as the Government will continue to cover most of their costs. The primary group affected will be new residents with significant financial means, such as self-funded retirees, who will be required to contribute more to the cost of their non-clinical services.

52. Residents will be asked to contribute 7.8% of their assets over $502,981 or 50% of their income over $131,279 (or a combination of both), up to a daily limit of $101.16. For some residents, particularly those with high care needs, the non-clinical care contribution will be substantially less than if they were asked to pay a means-tested care fee under the existing arrangements.
53. The exact price setting of the gap payment will be determined in reference to the value of the hotelling supplement, as advised by IHACPA.
54. Response to the Aged Care Taskforce – Accommodation reform | Australian Government Department of Health and Aged Care.

Key changes to home care funding

Changes to the funding of home care services will align with the launch of the new Support at Home program on 1 July 2025.[55]

Under this program, services will be clearly defined and organised into three broad categories: clinical care, independence, and everyday living services. This detailed specification of inclusions and exclusions will regulate the appropriate use of taxpayer subsidies.

The program will introduce service price caps—maximum prices for each service—set by the Government based on advice from IHACPA.

The program will also feature a new means-tested contributions framework, under which care recipients will contribute a specified percentage of the total cost of the services they use. This differs from the current home care package arrangements, where client fees (income-tested care fees and basic daily fees) are not linked to individuals' service usage.

The remainder of the funding—the difference between the total price and the recipient's contribution—will be covered by the Government and drawn from the individual's quarterly budget subsidy entitlement.

Contribution rates, summarised in Table 2, will be determined based on the type of service received and an assessment of the individual's means (including their Age Pension status or Commonwealth Seniors Health Card status).

Table 2: Support at Home contribution rates

	Services		
	Clinical care	**Independence**	**Everyday living**
	Nursing, Allied Health, prescribed nutrition, care management, restorative care management	Personal care, social support and community engagement, therapeutic services for independent living, respite, transport, Assistive Technology and Home Modifications	Domestic assistance, home maintenance and repairs, meals
Full pensioner	0%	5%	17.5%
Part pensioner and people eligible for a Commonwealth Seniors Health Card	0%	Between 5% and 50% depending on income and assets	Between 17.5% and 80% depending on income and assets
Self-funded retiree	0%	50%	80%

Source: Department of Health and Aged Care (2024), *Support at Home program handbook*[56]

55. Support at Home – Fact sheet | Australian Government Department of Health and Aged Care.
56. Department of Health and Aged Care (2024), *Support at Home program handbook Program details for 1 July 2025.*

As with residential care, the Government will fully fund the assessed clinical care services for all Support at Home clients, regardless of their financial means.

For services in the independence category (e.g., personal care), contribution rates will range from 5% to 50%, depending on an individual's means. In comparison, individuals will be required to contribute between 17.5% and 80% of the cost of everyday living services (e.g., gardening, cleaning, meals). This differentiation in Government support reflects the distinct roles of these service categories: independence services are crucial for preventing hospitalisation and delaying entry into residential aged care, whereas the Government does not typically fund everyday living services at other stages of life.

The means-tested percentage contributions will be determined based on the Age Pension means test. This approach reduces the inefficiencies and confusion caused by the duplication between aged care and pension means-testing processes, as Services Australia already assesses pensioners and part-pensioners. More importantly, it aligns aged care means-testing more closely with residential care by considering both income and assets.

Finally, to protect individuals with limited financial means, a hardship provision process will be incorporated into the Support at Home program, mirroring the safety nets already in place for residential care.

Improving the equity of aged care funding

A key objective of the Aged Care Taskforce was to enhance the equity and fairness of funding for Australia's aged care system.[57] As highlighted in several of UARC's previous publications, the existing system has been characterised by significant structural inequities. These have included disparities in contributions between individuals receiving care in different settings or with varying asset profiles, a lack of differentiation in government support based on financial means, and an unsustainable reliance on taxpayer funding, raising concerns about intergenerational equity.[58] The incoming changes will attenuate several of these inequities, at least partly, thus creating a fairer funding framework.

The increase in participant co-contributions from those with significant means will go some way to recalibrating the balance of funding between taxpayers and care recipients, particularly for home care. As a result of these reforms, the Government expects its share of funding to fall from 76% to 73% for residential care and from 95% of home care funding to 89% for Support at Home.[59] This will improve intergenerational equity by taking some of the pressure off income taxpayers who are meeting the rising cost of providing subsidised aged care.

The changes will also ensure taxpayer funding is more effectively targeted to support low-means individuals. In residential care, safety-net taxpayer supplements for everyday living services will now be means-tested. Similarly, in the Support at Home program, Government contribution rates for independence and everyday living services will be substantially higher for full- and part-pensioners than self-funded retirees.

57. Australian Government (2024), *Final report of the Aged Care Taskforce.*
58. Woods, M., Sutton, N., McAllister G., Brown, D. & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper*. The University of Technology Sydney; Sutton, N., Ma, N., Yang, J.S., Lewis, R., Woods, M., Tsihlis, E., Lin, J., Parker, D. (2023) *Australia's Aged Care Sector: Full-Year Report (2022–23)*. UTS Ageing Research Collaborative.
59. Once in a generation aged care reforms | Health Portfolio Ministers | Australian Government Department of Health and Aged Care.

At the same time, broader safeguards remain in place to protect all care recipients from the risk of catastrophic out-of-pocket costs as they age. By fully funding all clinical care costs, the Government will serve as a national insurer, shielding individuals from the financial burden of expensive clinical care, particularly at the end of life. Additional protections, such as the lifetime cap on co-contributions to Support at Home and non-clinical care costs and the five-year limit on deferred rental payments, will further limit long-term costs for individuals with ongoing care needs.

The proposals will also align the means-testing frameworks for residential and home care programs, as per the recommendation of the Tune Review.[60] The low contribution rate from home care package recipients—accounting for less than 5% of total funding— is partly due to the existing means-testing system that assesses only income. As a result, individuals who are 'income-poor but asset-rich,' such as pensioners with significant housing assets, have not been required to contribute to the cost of their home care services. In contrast, the same individuals have been subject to mandatory fees in residential aged care, where means-testing includes both income and assets. Under the proposed changes, individuals in both settings will now be assessed considering both their income and assets.[61]

Introducing the deferred rental payment in residential care also starts to address a longstanding disparity between people who can afford an upfront lump sum deposit and those who cannot. Under existing arrangements, a room priced at $550,000 costs someone using the daily accommodation payment method about $884 per week ($46,090 per year). Yet, if they can pay the full value upfront, they don't pay rent and would have the full nominal value of their lump sum returned at the end of their stay, thus only incurring the opportunity cost of lost after-tax interest earnings. Under the new arrangements, paying via lump sum will attract a deferred rental charge of $212 per week ($11,000 per year, for up to 5 years), which would be deducted from the $550,000 deposit when it is returned to the resident or their estate at the end of their stay.

Nonetheless, the introduction of deferred rental payments does not completely address the disparities in the payments and funding of accommodation services for different individuals. Amongst other issues, this should be addressed as part of the independent review of accommodation pricing.

60. Department of Health (2017), *Legislated Review of Aged Care.*

61. Some differentiation in contributions between aged care settings is appropriate, noting that people living in their own homes must continue to self-fund the costs of their everyday living activities (i.e. food, cleaning) and accommodation.

Improving the sustainability of aged care

The proposed changes will likely improve fiscal sustainability by attenuating the rate of growth in public expenditure on aged care services over the long-term. The Government projects that the reforms will result in a $12.6 billion saving over the next 11 years.[62] This is forecast to moderate the growth of annual aged care spending (from 5.7 per cent to 5.2 per cent) and aged care spending as a share of GDP (from 1.5 per cent of GDP to 1.4 per cent). Most of these savings will stem from the contribution framework in Support at Home, which will facilitate greater cost-sharing between taxpayers and new participants in the program.

In the medium-term, the changes are likely to impact the financial viability of residential care service providers positively. Despite improvements in direct care funding, more than half of all residential aged care homes are operating at a loss. This is not sustainable, and every home that closes means less chance older people have of getting the residential care and support they need. Furthermore, as discussed earlier in this report, poor operational returns undermine the necessary investment that should be occurring now to ensure a sufficient pipeline of capital infrastructure, in terms of new and refurbished stock, to meet the forecast growth in demand for residential care in the coming decade.

The proposed changes, particularly around accommodation, will help ensure providers have sufficient revenue to cover the costs of the services they deliver. However, it remains up to providers to set appropriate (market-based) prices for their accommodation rather than rely on cutting costs in their delivery of taxpayer-funded direct care to cross-subsidies their losses elsewhere.

One area of concern is the short-term impact of these changes on the viability of home care service providers under the new Support at Home program. As detailed in the following section, there is a risk that a price-capped system may adversely affect the viability of a substantial portion of home care providers, particularly those that rely on care management fees to cross-subsidise losses in other parts of their business model.

In addition, it is unclear how introducing differential participant co-contributions will affect the demand for different types of services. On the one hand, having a co-contribution model based on actual services used will likely introduce an additional spending discipline by program participants who previously did not make any contribution under the Home Care Package program.[63] However, on the other hand, the higher contribution rates may reduce the demand for subsidised everyday living services (particularly for those who will be asked to contribute 80% of the price), which could affect the viability of providers oriented towards delivering these more entry-level services.[64]

There are also concerns that introducing participant contributions for independence activities may discourage individuals from accessing services that may provide preventative health and well-being benefits for themselves (e.g. personal care, social engagement, home modifications) and their carers (e.g. respite). This could put upward pressure on overall spending on aged care by increasing the risk that individuals require more resource-intensive support, such as residential care, earlier in life and for more extended periods. An important caveat is the contribution rate for these services ranges from 5% to 50%, depending on an individual's means. Nonetheless, this may be something that the Government monitors in the rollout of Support at Home.

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62. Once in a generation aged care reforms | Health Portfolio Ministers | Australian Government Department of Health and Aged Care.
63. In contrast, a larger proportion of individuals who have been receiving services as part of CHSP have been making
64. There may also be instances where the required contribution for a subsidised service (i.e. 80% of the price offered by a Support at Home provider) may be higher than what might be available privately, such as through a less formal labour market in a local area.

Other recommendations of the Aged Care Taskforce

While most of the headline announcements in the Taskforce response concerned changes to funding arrangements, the Government also committed to a range of other reforms:

- **IHACPA advice:** IHACPA will provide advice on the Hotelling Supplement to ensure funding for daily living needs will cover the full cost of providing these services, as well as advice on pricing for rural and remote areas.
- **Independent Accommodation Pricing Review:** The review will assess the current rate of the Accommodation Supplement, explore incentives for providers to offer and maintain high-quality accommodation, and consider measures to encourage acceptance of low-means participants. It will also examine the potential for the Daily Accommodation Payment (DAP) to become the default pricing method and the relationship between Refundable Accommodation Deposits (RADs) and DAPs.
- **Review of RADs:** An independent review will evaluate the financial state of the sector and access to capital, with a view to reducing reliance on RADs. Progressive steps may include the phased elimination of RADs by 2035.
- **Review of remoteness classification:** The Government will review the appropriateness of the current Modified Monash model system used to classify remoteness for funding and policy purposes.
- **Support for providers in thin markets:** Grants will be offered under the new Support at Home program, alongside adjustments to the AN-ACC funding model for residential care to better support providers in thin markets.
- **Supporting innovation:** Continued funding will be provided for Aged Care Research and Industry Innovation Australia (ARIIA). Additionally, a Data and Digital Support Panel will be established to assist providers in adopting new technologies. The Aged Care Quality and Safety Commission (ACQSC) will be supported in recognising providers that demonstrate innovative approaches to care delivery.
- **Improving use of retirement wealth:** The Government will explore options to enable people to more effectively utilise their wealth in retirement.
- **Review of financial reporting:** A review will be undertaken to ensure that financial reporting requirements genuinely enhance transparency and accountability.

Fiscal sustainability provisions in the new Aged Care Act

Finally, it is worth drawing attention to some of the features of the new Aged Care Act, which set the foundation for a more sustainable aged care system.

The Act recognises the importance of the Commonwealth's aged care system being sustainable. One of the stated Principles (section 25(12)) is that:

> *The Commonwealth aged care system is managed to ensure:*
>
> *(a) it is sustainable and resilient; and*
>
> *(b) the Commonwealth's investment in the system represents value for money, including by ensuring that public resources are used in the most efficient, effective, ethical and economic manner.*

A consequence of this principle is that the design of the funding arrangements must balance the rights of older people to have equitable access to the funded aged care services that they have been approved to access (Statement of Rights section 23(2)) with the rights of taxpayers to expect the system to be fiscally sustainable as per the above, and with the expectation that people accessing funded services will meet some of the costs of those services if those individuals have the financial means to do so (Principles, section 25(10).

The mechanisms by which this balancing is brought into effect include the establishment of priority categories to which an individual is assigned (sections 84 – 90) and the process and method used to calculate the number of places to be available to individuals for each service group. (sections 91 – 102). Places will be allocated according to an individual's priority category and placement in the queue (section 93(3). Separately, the levels of individual fees and contributions payable are set out in Chapter 4 of the Act.

In its submission to the Senate Committee, the Office of the Inspector-General of Aged Care drew attention to the Royal Commission's recommendation that access to care should be a universal entitlement based on assessed need. It contrasted this with the rationing approach adopted by the Bill. UARC supports the need for government policy and program design to balance access to needed services and a funding regime that apportions the system's costs equitably between system beneficiaries and taxpayers while maintaining strong safety nets for those in need.

Pricing Support at Home

Key messages

- Key details of the new Support at Home program have been released. One of the most significant features is the introduction of a defined service list with capped pricing.
- The Government will set a maximum price that providers can charge for each service type based on advice from IHACPA. This advice will be informed by the cost of delivering services, including labour, transport, consumables, and administration.
- It is unclear how a capped price system will account for the diversity of providers' cost structures and differentiate between legitimate cost variations and spending inefficiencies.
- There is a risk that a 10% cap on fees for care management fees will be insufficient to cover service costs, which in 2023-24 averaged 10.5% of revenue. If care management revenue is capped, the pricing for other service types must be sufficient to cover their cost without cross-subsidisation.
- Providers will no longer be able to charge separate fees to cover administrative costs, which will be priced within service revenue. These costs constitute 26.6% of total package revenue and will likely increase under the new program.
- There are concerns about the condensed timeframe between publishing detailed prices and the scheme's commencement on 1 July 2025.

When fully implemented, the Support at Home program will provide aged care services to more than 1.5 million older Australians living in their own homes and communities. It will fulfil a long-term policy objective of bringing all subsidised home and community-based aged care services under a single unified program.

The Government has recently outlined details of the program's first phase, set to commence on 1 July 2025.[65] Support at Home will replace the Home Care Package program, in which 909 providers currently serve 275,486 participants, and the Short-Term Restorative Care Program, involving 64 providers who support approximately 10,000 individuals annually.[66] At a later stage, no earlier than 2027, over 800,000 clients of the Commonwealth Home Support Programme (CHSP) will transition into the Support at Home.

Key features of the program's first phase are summarised in the textbox below.

Among the most significant changes is the introduction of a defined service list with capped maximum pricing for each service type, alongside a new participant contribution framework (discussed in the previous section).

This section explores the potential implications of the new pricing model, focusing on the viability risks it may pose to the provider market for Support at Home aged care services.

The Support at Home program will provide aged care services to more than 1.5 million older Australians living in their own homes and communities. Among the most significant changes is the introduction of a defined service list with capped maximum pricing for each service type.

65. Department of Health and Aged Care (2024), *Support at Home program handbook.*
66. Department of Health and Aged Care (2024), *Report on the Operation of the Aged Care Act 1997 2023-2024*.

Key features of the new Support at Home program (from 1 July 2025):

- **Single assessment system:** Assessors will work with older people to develop an individual support plan, including an ongoing quarterly budget based on assessed classification and/or approval for short-term supports.
- **New package structure:** Level 1-4 packages will be replaced with eight ongoing service classifications, with the highest level reaching the equivalent to $78,000 per year. In addition, there will be two short-term care pathways (restorative care and end-of-life care) and a separate Assistive Technology and Home Modifications (AT-HM) scheme.
- **Defined service list:** Subsidised Support at Home services are categorised into three categories (clinical, independence, everyday living) subject to inclusions and exclusions. Most exclusions relate to services covered by other funding, general or personal expenses and administrative activities.
- **Price caps for services:** The Government will set maximum service prices based on the advice of IHACPA. The maximum price for each type of service is expected to include the cost of labour, transport, consumables and administration.
- **Care management fee cap**: Providers can set aside a maximum of 10% of each client's total package in a separate pool to fund care management services across its portfolio of clients.
- **Participant co-contributions:** A new contribution framework will define the contribution rates participants will pay for the services they use. The rates are based on the service category and the individuals' assessed means: clinical care (fully taxpayer-funded), independence (client contributions 5%–50%), and everyday living (client contributions: 17.5%–80%).
- **Quarterly client budgets:** Clients will only be allowed to carry over $1000 or 10% of their budget (whichever is higher). AT-HM funding tiers will also be subject to caps.
- **Provider payment in arrears**: After service delivery, providers will invoice Service Australia for payment, calculated as the service price minus any participant contribution.
- **Additional grants for thin markets:** Providers operating in thin markets will be able to apply for a 2-year supplementary grant to support their financial viability.
- **Provider registration regulatory model**: Providers will need to be registered in relevant registration categories to deliver their participants' services, with six different registration categories aligned to a new risk-proportionate regulatory model.
- **Transition arrangements:** Existing home care package recipients (and those on the waitlist) will be transitioned into the new program. Grandfathering arrangements will ensure they are 'no worse off' regarding contributions to their care.

Service list with capped prices

The Government has sought to clarify subsidised services under the new Support at Home program by developing a defined service list. This list is organised into three broad categories—clinical, independence, and everyday living—each containing specific service types and participant contribution arrangements.[67]

The service list specifies which services are considered in-scope and out-of-scope. Most exclusions relate to services funded through other programs, general or personal expenses, and administrative activities. The Government initially proposed service cap limits for gardening and cleaning, but these have since been removed.[68]

The Government will also set maximum prices for each service type based on advice from IHACPA. These caps will specify the maximum rates providers can charge, presented as hourly or unit prices.

In its recent Consultation Paper on pricing, IHACPA indicated that its advice would be informed by the "actual cost of delivering in-home aged care services."[69] According to the Government, this will include all relevant expenses, such as labour, transport, consumables, and administration.[70]

Introducing a capped price system represents a significant departure from the current market-based pricing of services delivered for home care packages. In its recent submission to IHACPA's consultation, UARC cautioned that it is unclear how a capped price system will deliver a superior pricing outcome relative to that achieved through market dynamics with appropriate regulatory oversight.[71] Further, as noted in the Financial Viability section in Part 1, there are indications that providers' pricing behaviour within the Home Care Packages Program has not led to excessive revenues. Indeed, growth in revenue earned has tracked lower than growth in home care package funding, and unspent funds have continued to grow.

Developing effective pricing advice for in-home services will require substantial resources. Furthermore, there is a risk that the progressive specification of inputs and in-home prices may curtail the scope for provider innovation and competition.

67. The service list is organised as follows: Clinical Services (Allied Health and other Therapeutic Services, Nursing Care, Nutrition, Care Management, Restorative Care Management); Independence Services (Personal Care, Social Support and Community Engagement, Therapeutic Services for Independent Living, Respite, Transport, Assistive technology and home modifications); Everyday Living Services (Meals; Domestic Assistance; Home Maintenance and Repairs).
68. Australian Government backs choice in aged care | Health Portfolio Ministers | Australian Government Department of Health and Aged Care.
69. Consultation Paper on the Pricing Approach for the Support at Home service list 2025—26 | Resources | IHACPA.
70. Department of Health and Aged Care (2024), *Support at Home program handbook.*
71. Woods, M., Sutton, N. (2024), *IHACPA Consultation Paper on the Pricing approach for the Support at Home service list 2025—26: UARC response.* UARC, The University of Technology Sydney

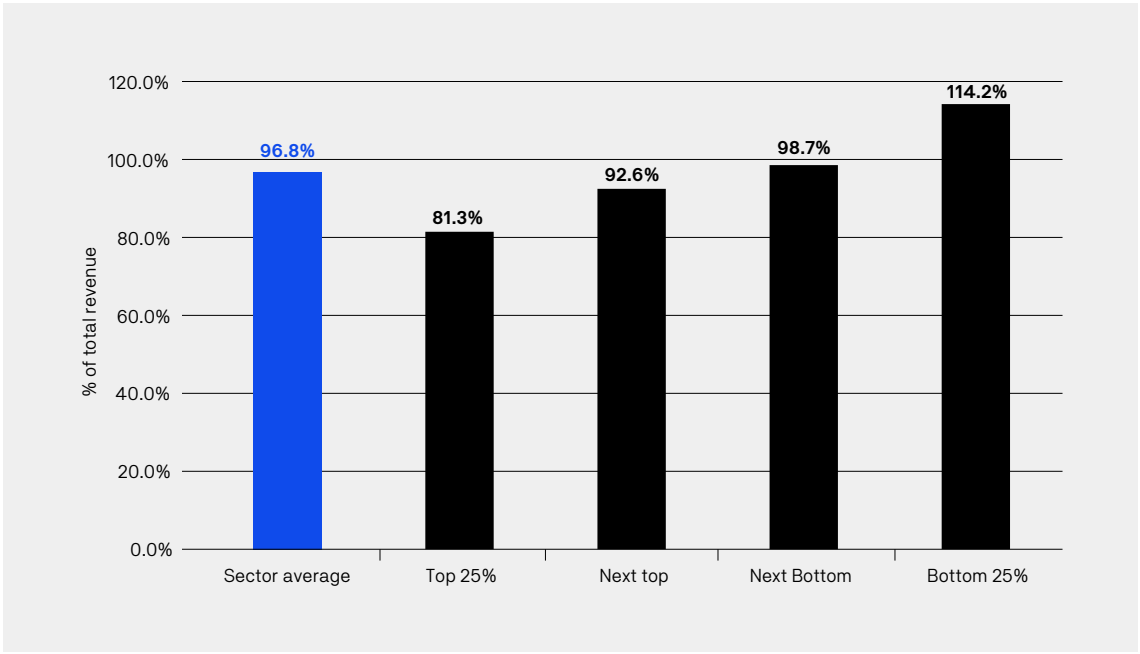
Variations in providers' cost structures

In its Consultation Paper, IHACPA proposed a 'pricing equity' principle, under which prices should "account for legitimate cost variations faced by some providers in delivering care and services."[72] It acknowledged that some providers operating in rural and remote areas, or those serving specific populations, could face higher costs. Without pricing adjustments, such services – and potentially those in other contexts not yet recognised – may not be viable, thus compromising the equity of access to older people in those areas or communities.

Separate from pricing adjustments, the Government will provide $600 million for thin market grants.[73] From 1 July 2025, Support at Home providers operating in thin markets will be eligible to apply for a two-year supplementary grant via a competitive process to support their financial viability.

However, despite these initial measures, it is not yet clear how a capped price regime will accommodate the heterogeneity of providers' cost structures across the sector. To illustrate, Figure 13 depicts the average ratio of home care providers' total expenditure to revenue, split by profitability quartile in 2022-23.[74] This shows a substantial gap in the relative expenditure rates between providers across the sector. For example, the least profitable quartile of providers ('bottom 25%) on average incurred expenditures far above their total revenue (averaging 114.2%). In contrast, the most profitable providers ('top 25%') incurred expenditures far below their average revenue (81.3%).

Figure 13: Home care expenses as proportion of total revenue, by quartile



72. Consultation Paper on the Pricing Approach for the Support at Home service list 2025—26 | Resources | IHACPA.
73. $900 million for rural, remote and specialist aged care | Health Portfolio Ministers | Australian Government Department of Health and Aged Care.
74. These figures have been collated from sector statistics published in: Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector 2022-23*.

Going forward, the challenge will be to ascertain what constitutes "legitimate cost variations" and differentiate these from expenditure variations arising from process inefficiencies or poor productivity. Prices must be set at levels that enable efficient providers to recover the costs of delivering quality care in their specific operating contexts.

If prices are set too low, this may jeopardise the financial viability of some providers, potentially disrupting eligible older persons' access to funded services. Conversely, excessively high prices may result in some providers generating significant surpluses without delivering additional value. Such outcomes would not represent an efficient use of taxpayer funding or participant contributions.

Moreover, UARC identifies a critical omission in the current pricing discussion. Neither the IHACPA Consultation Paper nor the Support at Home documentation explicitly acknowledges the necessity for pricing to include an allowance for a fair return on providers' business activities. Without this, providers may lack the confidence to continue investing in the sector, potentially compromising its sustainability and capacity for improvement.

Caps on care management services

Another issue attracting attention is reducing the cap on care management fees, which is being lowered from 20% to 10%.

Under the new program, 10% of each provider's clients' budgets will be allocated to a separate pool to fund care management services.[75] Providers will access this funding by invoicing Services Australia in arrears for services delivered to their clients. Care management activities include care planning, service coordination, monitoring, and client support and education, and they are expected to be delivered using a team-based approach involving both clinical and non-clinical staff. This funding model aims to provide providers with greater flexibility in delivering services, allowing them to adapt to the changing needs of their client base over time.

The central concern is that the 10% cap is substantially lower than the current care management fee level, accounting for approximately 17.0% of home care package revenue.[76] Furthermore, there is a risk that at this level, there may not be sufficient revenue to cover the associated costs of care management services, which in 2023-24 averaged an equivalent of 10.5% of revenue (see Part 2).

In the recent Senate inquiry, the Department has defended the cap, arguing that the price settings are reasonable in funding the expected amount of care management individuals with different care needs would require each month:

> *"The 10 per cent care management equates to somewhere in the order of an hour a month for someone on the lowest level of supported home, up to somewhere in the order of six hours a month for a person on the highest level of supported home."*[77]

75. The Government will provide an additional care management supplement for participants with diverse needs, including people referred by the care finder program, older Aboriginal and Torres Strait Islander people, people who are homeless or at risk of homelessness, care leavers, and eligible veterans.
76. Median quarterly figure for Q4 FY24 reported in Department of Health and Aged Care (2024), *Quarterly Financial Snapshot for the Aged Care Sector – Quarter 4 2023–24*, p.30. This accords with the average annual estimate for 2023-24 based on the StewartBrown dataset of 18.1% (see Part 2).
77. Senate Community Affairs Legislation Committee (2024), *Aged Care Bill 2024 [Provisions] Report*, p.76

Given the poor financial performance of many providers (see Part 2), it is plausible that under current arrangements, providers may be generating a surplus from care management fees, which is then used to cross-subsidise or offset losses in other areas of their operations, such as specific service delivery.

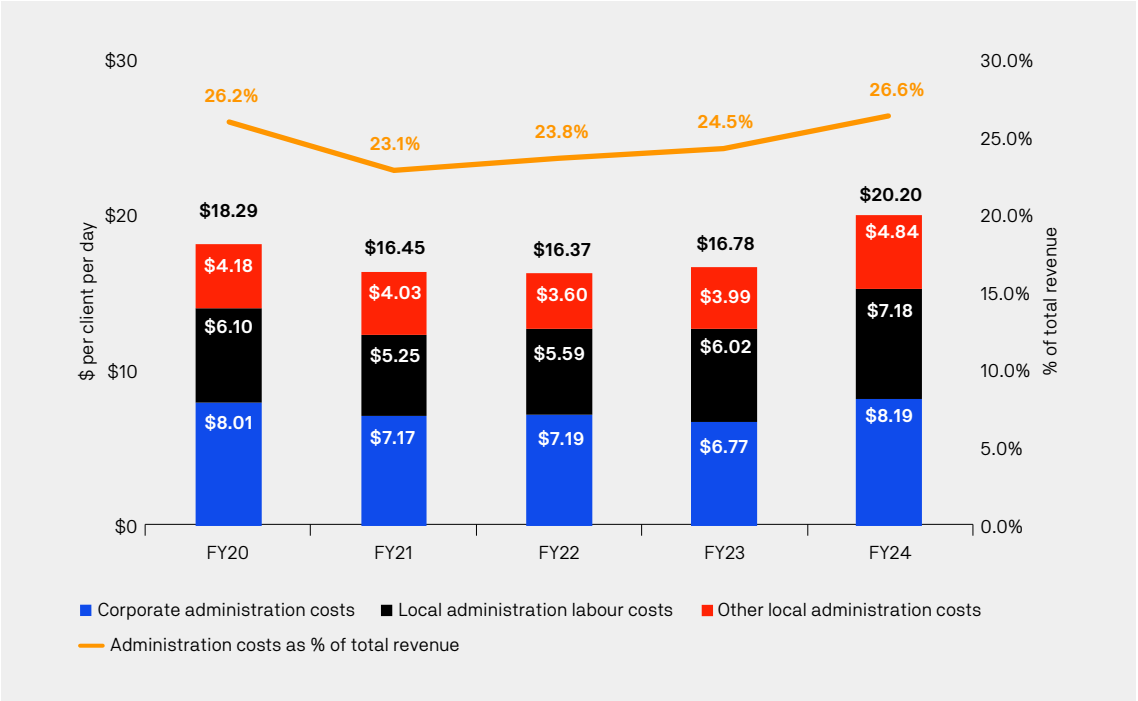
If this is the case, reducing the cap on care management fees to align with the actual cost of providing care management could be appropriate, with two caveats. First, the cap needs to be sufficient to cover the full cost of care management services, noting the importance of these services in helping older people navigate and manage their care. Second, the pricing for other service types under the Support at Home program must be sufficient to cover the cost of those services without the need for cross-subsidisation.

Accounting for administration costs

Under the new pricing model, providers will no longer be permitted to charge separate fees to cover administrative costs. Instead, the Government will set service price caps with advice from IHACPA to account for the full 'in-scope' cost of service delivery, including administration.

The cost of administration is significant. As illustrated in Figure 14, administration costs in 2023–24 accounted for an average of 26.6% of total package revenue, equivalent to $20.20 per client per day. This figure includes corporate administration recharges (allocated overhead costs of the approved provider) and service-level administration expenses, both labour-related and otherwise.

Figure 14: Home care administration costs, per client per day



There is a risk that if IHACPA bases its pricing recommendations solely on historical expenditure patterns, it may substantially underestimate the actual administrative costs that providers will incur under the new Support at Home program. For instance, the transition to the new program will likely involve considerable one-off costs, including upgrades to IT infrastructure, client management systems, and documentation processes; revisions to pricing and fee structures; changes to finance and accounting systems; and staff education and training.

Moreover, several aspects of the new program will likely increase the ongoing complexity and cost of administration. Providers must now collect client participation contributions, issue invoices more frequently for services delivered, and closely monitor client entitlements. This includes managing existing unspent funds, quarterly budgets, and funding provisions for assistive technology, home modifications (AT-HM), and short-term care pathways.[78] These factors collectively suggest that historical data may fail to capture the full scope of administrative demands and associated costs under the new system.

Transition issues

Finally, concerns have been raised about the condensed timeframe between publishing detailed prices in February 2025 and the scheme's commencement on 1 July 2025, noting that a Federal election will also occur in the interim. Many participants in the recent Senate Standing Committee for Community Affairs Inquiry into the new Aged Care Bill noted the need for providers to have adequate time from the release of the detailed prices to scheme commencement to enable them to review their business operations, make suitable adjustments and implement any requisite strategic, operational and system changes.[79] Coalition Senators have recommended a revision to the program's commencement date, subject to the timing of the transition Bill and subordinate legislation.[80]

78. Department of Health and Aged Care (2024), *Support at Home program handbook*
79. Senate Community Affairs Legislation Committee (2024), *Aged Care Bill 2024 [Provisions] Report*.
80. Senate Community Affairs Legislation Committee (2024), *Aged Care Bill 2024 [Provisions] Report*, p.107

Workforce

Direct care staffing

Key messages

- As of June 2024, less than half of homes (40.5%) had met both their care minute targets, meaning the majority of homes (59.5%) were still below their legally required staffing levels.
- Homes still below their care minute targets report substantially better financial outcomes than homes that meet or exceed their targets, driven by lower expenditure on staff.
- While the proportion of government-operated and not-for-profit homes meeting their care minute targets has steadily increased, the compliance rate of for-profit homes has plateaued and then contracted.
- The gap between the staffing rates of metropolitan and non-metropolitan homes has not closed. On average, only areas classified as small rural towns, remote communities and very remote communities (MM5-7) have direct care compliance rates above 50%.
- UARC estimates that only one in five (20.8%) homes have sufficient staffing to meet the increased service-level targets from 1 October 2024.

During 2023-24, the minimum direct care staffing requirements became mandatory for residential care providers. According to these minimum standards, providers were required to ensure that:

1. a registered nurse is onsite and on duty 24 hours a day, seven days a week
2. residents receive, on average across the sector, at least 200 minutes of total direct care per day (from 1 October 2023); and
3. a registered nurse provides at least 40 minutes of that care (also from 1 October 2023).

Furthermore, as of 1 October 2024, the two care minute requirements were increased. Across the sector, providers now need to ensure that residents receive at least 215 minutes of direct care per day, with at least 44 minutes from a registered nurse.[81,82]

As of June 2024, less than half of homes (40.5%) had met both their care minute targets, meaning the majority of homes (59.5%) were still below their legally required staffing levels.

81. The update to the requirements also allows for 10% of the registered nurse minutes to be satisfied with enrolled nurse minutes.
82. Care minutes and 24/7 registered nurse responsibility guide | Australian Government Department of Health and Aged Care.

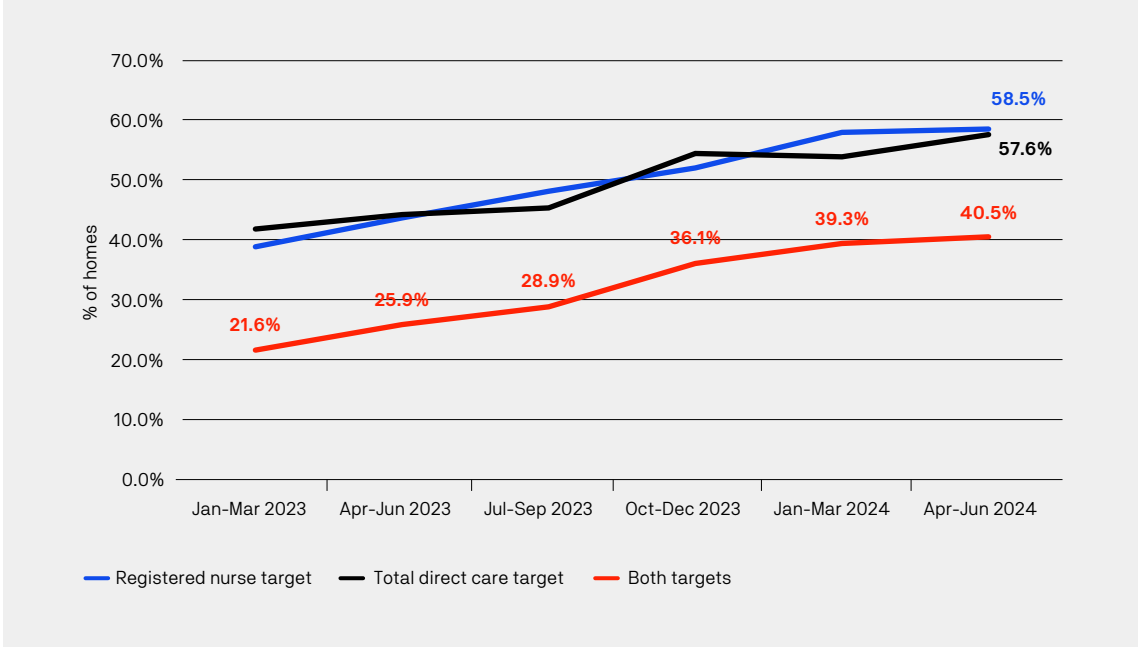
Majority of homes still below care minute targets

Each home's service-level care minute targets are adjusted each quarter to account for differences in the relative needs of their residents (based on their AN-ACC classification). This means that homes with residents with more complex needs will have higher care minute targets, whereas homes with residents with less complex needs have lower care minute targets.

Based on sector-level data published by the Department, UARC has modelled the trend in the proportion of all homes across the sector that have staffing at or above their care minute targets.[83]

This analysis, depicted in Figure 15, shows that while there had been a steady increase in the proportion of homes meeting their care minute targets in 2023, it has plateaued in the last two quarters. As of June 2024, less than half of homes (40.5%) had met both their targets, meaning the majority of homes (59.5%) were still below their legally required staffing levels.[84]

Figure 15: Proportion of homes meeting their service-level care minute targets



As detailed earlier in Part 1, all homes across the sector have received substantial additional funding through higher AN-ACC subsidies to pay for additional direct care staff since 1 October 2022, with a further uplift on 1 July 2023 and another on 1 October 2024. Homes have received this additional funding regardless of whether they have met their care minutes or not.

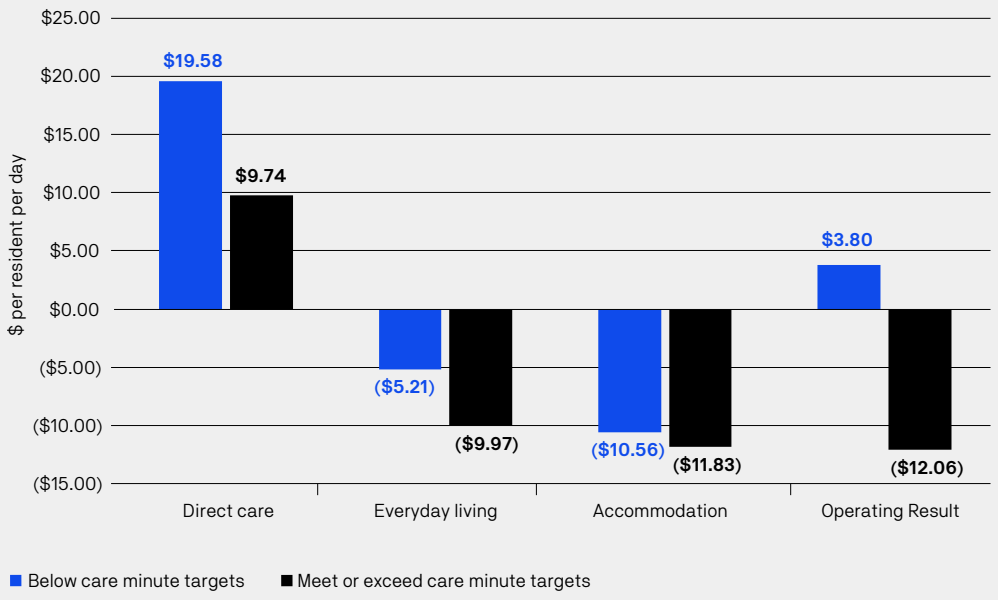
83. Data was sourced from previous quarters of Star Ratings Quarterly extracts and the most recent service-level care minutes performance data (both published by the Department of Health and Aged Care). Each quarter included aged care services that received a Star Rating for staffing. There may be very minor differences in the unit of analysis, where a single home (or facility) may be separated into two co-located services for the purpose of reporting the care minutes for the Star Ratings.

84. In the eighteen months since January 2023 there has been a very gradual increase in homes' service-level targets as a result of homes' changing resident profiles and slight adjustments in the care minute weighting formula over 2023. In January-March 2023, across all homes, the average total direct care minutes target was 195.6 minutes per resident per day. In April – June 2024, this had increased by 4.4% to an average total direct care minutes target of 204.2 minutes per resident per day. While a gradual increase in targets will require commensurate uplifts in homes' staffing, the small magnitude of this target growth does not explain the low rates of compliance with mandatory requirements

To investigate the financial implications of having a direct care staffing shortfall, UARC has separately analysed the average financial outcomes of homes meeting or exceeding their direct care minute targets compared to those falling short.[85] The leftmost column of Figure 16 illustrates that, in 2023–24, residential care homes operating below their care minute targets achieved significant direct care margins, averaging $19.58 per resident per day. This margin was sufficient to offset losses incurred in everyday living and accommodation services, resulting in an average operating surplus of $3.80 per resident per day.

In contrast, homes meeting or exceeding their care minute targets reported a much lower average direct care margin of $9.74 per resident per day. This was insufficient to cover deficits in other service areas, leading to an average operating deficit of $12.06 per resident per day. In sum, the results illustrate that homes still below their care minute targets have substantially better financial outcomes than homes that meet or exceed their targets, most likely driven by lower expenditure on staff.

Figure 16: Financial results of homes below and meeting care minute targets



The recent open letter from the Minister of Aged Care to providers suggests the Government's stance towards providers not meeting their care minute obligations is hardening.[86] Minister Wells states explicitly:

> *"The Australian Government expects that you are spending your increased care funding on meeting your mandatory care minutes."*

85. This modelling was conducted on 1,161 de-identified homes in the StewartBrown residential aged care dataset 2023–24. The analysis compared their actual and target direct care minutes for April – June 2024, published by the Department of Health and Aged Care. Homes were classified as 'meet' if their staffing was at or above both their care minute targets for registered nursing and total direct care (n=468, 40.3%) and were otherwise classified as 'below' (n=693, 59.7%).
86. Letter to aged care providers from the Minister for Aged Care about care minutes – 1 October 2024.

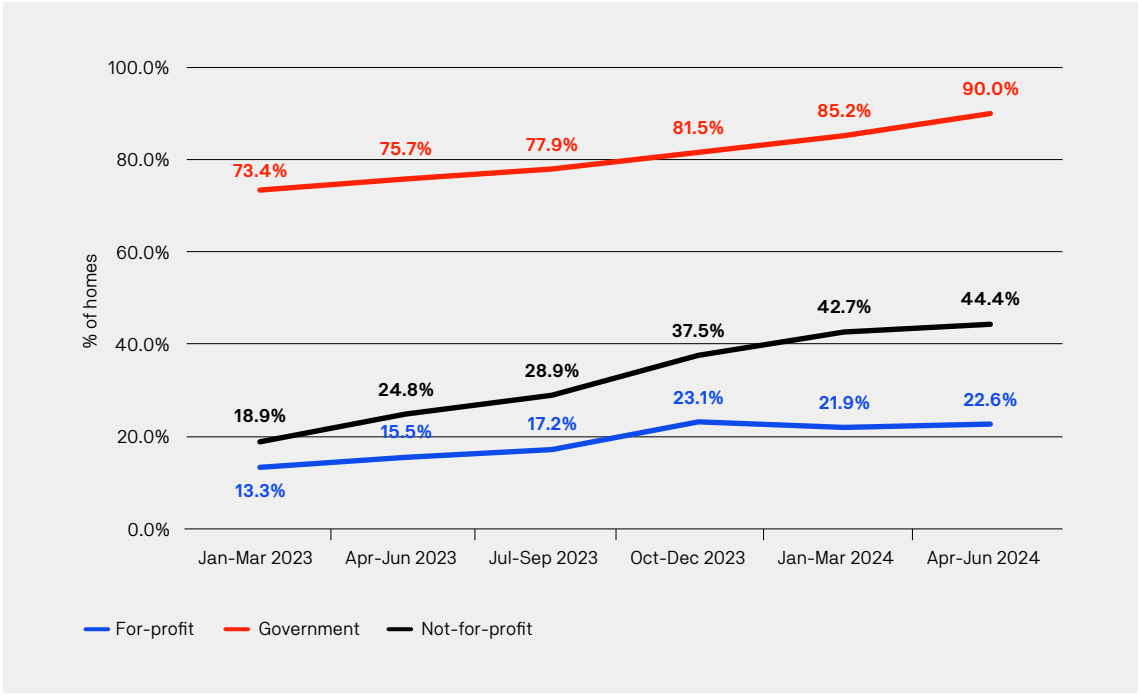
Variation in compliance rates across the sector

In the mid-year 2023-24 edition of the Aged Care Sector Report, UARC presented a detailed analysis of the characteristics of residential care homes compared to their compliance with mandatory care minutes requirements and direct care financial performance.[87] We found that homes with the lowest care minute compliance rates tended to be operated by for-profit providers and located in large cities and regional centres.

Four months later, the Minister's letter advised that the Department had undertaken a similar analysis of data submitted by the sector and, unsurprisingly, came to exactly the same conclusions. The Department's latest staffing data, current as of June 2024, show these differences have persisted, as per the Minister's letter.[88]

Furthermore, trend analysis reveals a widening gap between the compliance rates of homes owned by different types of providers (see Figure 17). Over the last 18 months, the proportion of government-operated and not-for-profit homes meeting both care minute targets has steadily increased. By contrast, while there was growth in compliance rates amongst for-profit homes during 2023, there was no growth in the first two quarters of 2024.

Figure 17: Proportion of homes that meet both care minute targets, by ownership type

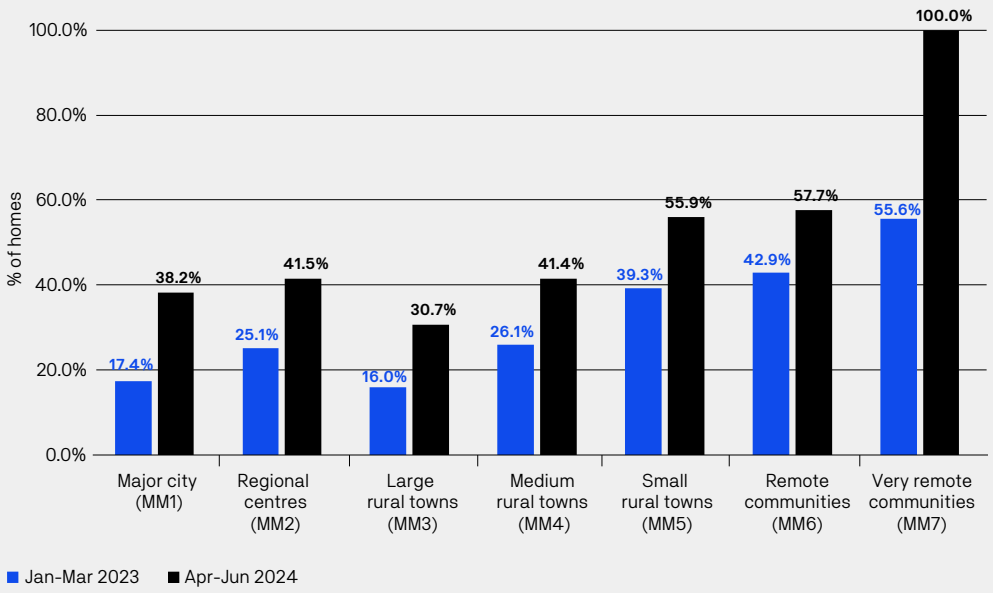


87. For example, as of December 2023, only 33.2% of homes in major cities (MM1) were meeting both their targets, compared to 85.7% of homes in very remote communities (MM7). The proportion of homes meeting both their targets also varied by ownership, with the highest rates amongst government homes (81.5%), followed by not-for-profit homes (37.5%) and the for-profit homes (23.1%). Sutton, N., Ma, N., Yang, J.S., Woods, M., Tsihlis, E., Brown, D., Debono, D., Ries, N. (2024), *Australia's Aged Care Sector: Mid-Year Report (2023–24)*. UTS Ageing Research Collaborative

88. Service-level care minutes performance in residential aged care (from October 2023) | Australian Government Department of Health and Aged Care.

Figure 18 shows how homes' compliance rates have changed over the last 18 months, this time split by location. This reveals that while there has been a modest improvement in compliance rates across the sector, the gap between homes in different locations has not closed. Furthermore, on average, only areas classified as small rural towns, remote communities and very remote communities (MM5-7) have compliance rates above 50%.

Figure 18: Proportion of homes that meet both care minute targets, by location



Further increases in minimum staffing levels

Despite these low compliance rates, they will likely fall further across the sector as the mandatory minimum requirements increase. From 1 October 2024, the care minutes targets increased to a sector-wide average of 215 care minutes per resident per day, including 44 minutes of registered nurse time.

UARC estimates that based on the April – June 2024 staffing levels, only one in five (20.8%) homes have sufficient staffing to meet both of their new service-level targets, even after accounting for the added flexibility of using enrolled nurses to cover part of the registered nurse target.[89]

The Minister has asked the Department to develop options to boost care minute compliance, including 'exploring funding options to improve care minute delivery'. The Minister also has reinforced the expectation that the Aged Care Quality and Safety Commission will work actively with providers to improve their compliance and to "use its full range of regulatory powers to enforce compliance with care minutes if aged care homes are not making genuine attempts to increase their staffing levels, which could lead to resident harm and safety".

As per our mid-year commentary, UARC supports imposing more explicit conditions that would require homes to meet their mandatory direct care staffing level obligations. Options include a change in regulatory stance and/or a reset of incentives on providers to recruit and retain staff by way of the level of direct care funding provided. However, UARC continues to caution against any policy response that adopts a blunt approach (e.g. whole-sector adjustment of the AN-ACC base price) that unfairly and unintentionally penalises homes that are meeting or exceeding their staffing obligations.

89. From 1 October 2024, providers will be allowed to meet up to 10% of their service-level registered nurse target with care time provided by an enrolled nurse.

Quality of care

Recent trends in Star Ratings

Key messages

- There has been a further improvement in the overall Star Ratings, mainly due to an shift of homes from 3 stars to 4 stars. The improvement has been driven by the resident experience, staffing and compliance sub-categories, with minimal changes in quality measure ratings.
- However, with most homes (96.1%) now receiving either 3 or 4 overall stars, questions remain about the effectiveness of ratings in providing meaningful guidance to individuals in differentiating the quality of care services.
- Most (98.1%) homes now rated 4 or 5 stars for compliance. However, the Department has proposed changes to this sub-category design in 2025.
- Only a quarter of homes (26.3%) are rated 4 or 5 stars for staffing.
- Homes with higher ratings for resident experience tend to be smaller, based in rural and remote areas, government-owned and operated by a single-site provider.
- Residents' experience surveys show residents are most satisfied with their safety and respect from staff and least satisfied with food and communication.

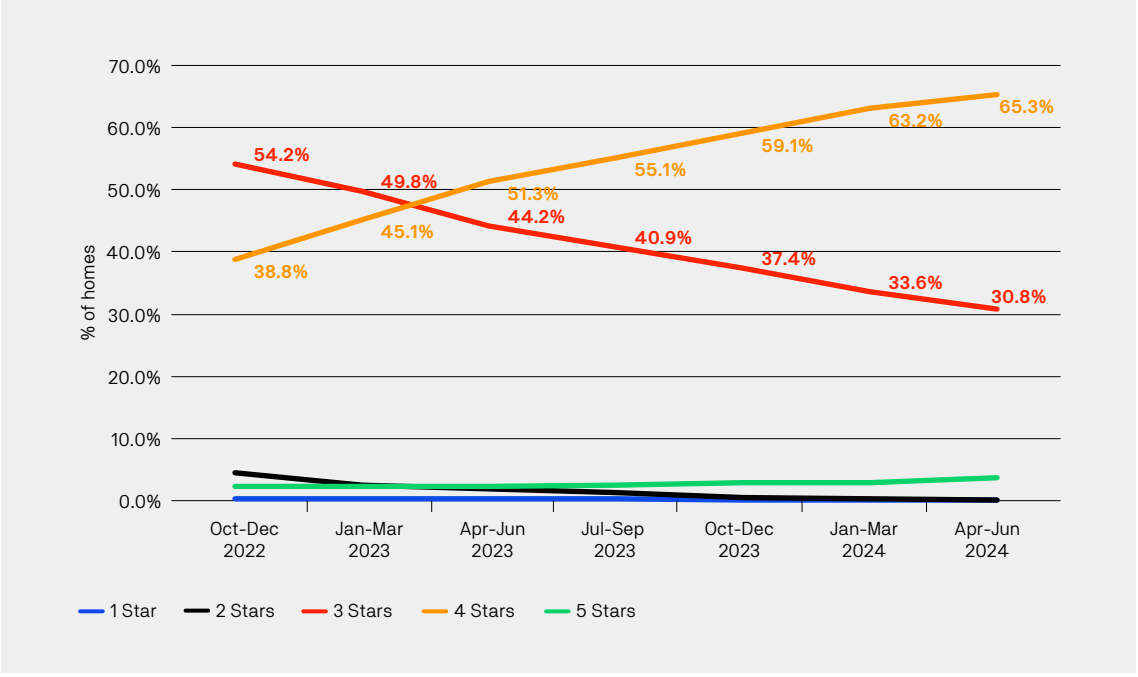
Recent trends in overall Star Ratings

This section explores recent trends in the residential aged care Star Ratings, drawing on seven quarters of data published by the Department of Health and Aged Care.[90]

In general terms, homes' ratings have continued to improve across the sector. When ratings were first published (for October – December 2022), the average overall Star Rating was 3.4 out of 5. As of the latest results (April – June 2024), it is now 3.7 out of 5.

As shown in 19, this improvement has primarily been driven by a shift in many homes from 3 to 4 stars. For example, 65.3% of residential homes are rated 4 stars overall, and 30.8% are rated 3 stars. Of the remaining homes, 3.8% are rated 5 stars and 0.1% are rated 2-star homes. No homes received have a 1 overall Star Rating in the last two quarters.

Figure 19: Proportion of homes by overall Star Rating



However, with most homes (96.1%) now receiving either 3 or 4 overall stars, questions remain about the effectiveness of these ratings in providing meaningful guidance to older Australians and their representatives in making informed decisions.

90. Star Ratings quarterly data extracts | Australian Government Department of Health and Aged Care. This data spans from Quarter 2, 2022-23 to Quarter 4, 2023-24, inclusive.

Improvement in sub-category ratings

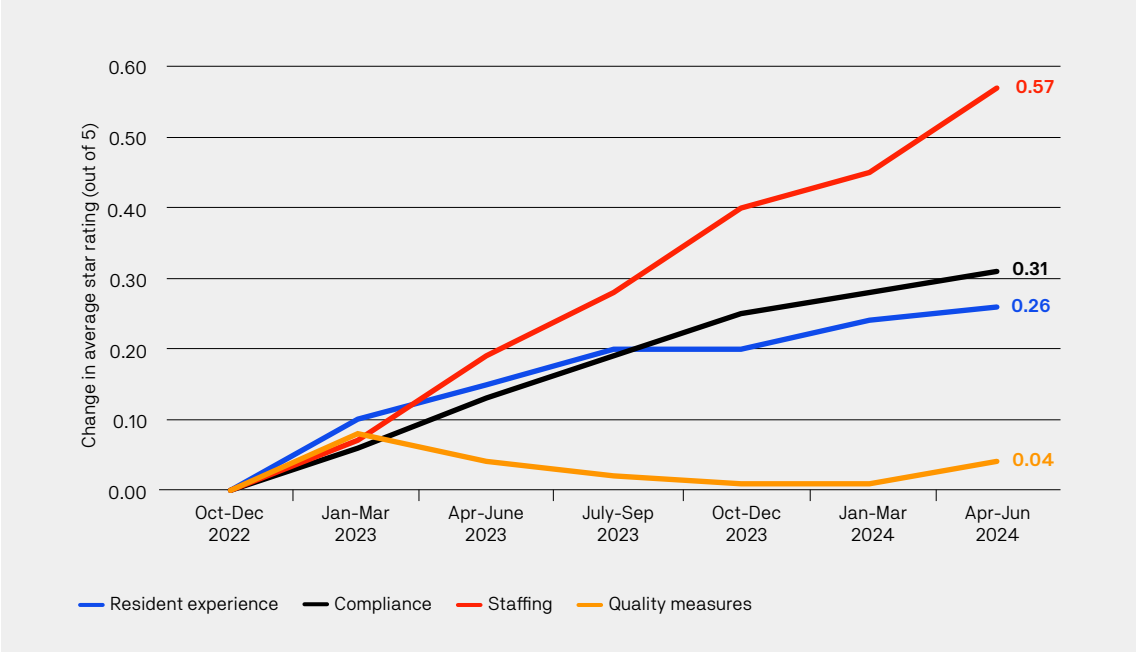
Delving further into the sub-category ratings, Figure 20 shows how the sector average ratings have changed since they were first published. This shows that the improvement in average scores has generally slowed across most sub-categories this calendar year.

The category that has experienced the largest cumulative change has been staffing, which has increased by an average of 0.57 stars (21.1%) since December 2022. Notably, this started with the lowest average score (2.5 out of 5 in October – December 2022) and still trails the other sub-categories (now averaging 3.0 out of 5). Nonetheless, the average rating has progressively increased in the lead-up to the mandatory care minute targets in October 2023 and the quarters since.

The growth in the average ratings for both resident experience and compliance has been more modest, which are now averaging 3.5 (resident experience) and 4.6 (compliance) out of 5. The compliance rating is more likely to encounter ceiling effects (i.e., homes already rated 5 stars cannot increase any further).

By comparison, there has been practically no change in the quality measure average rating across the sector, having improved by just 0.04 stars (1.2%) since December 2022. The stability of the quality measure rating is likely an artefact of how the rating is constructed. The algorithm uses a forced distribution, whereby each home's performance for each quality indicator is ranked into quintiles based on its performance relative to all other homes.

Figure 20: Cumulative change in the average Star Rating, by sub-category

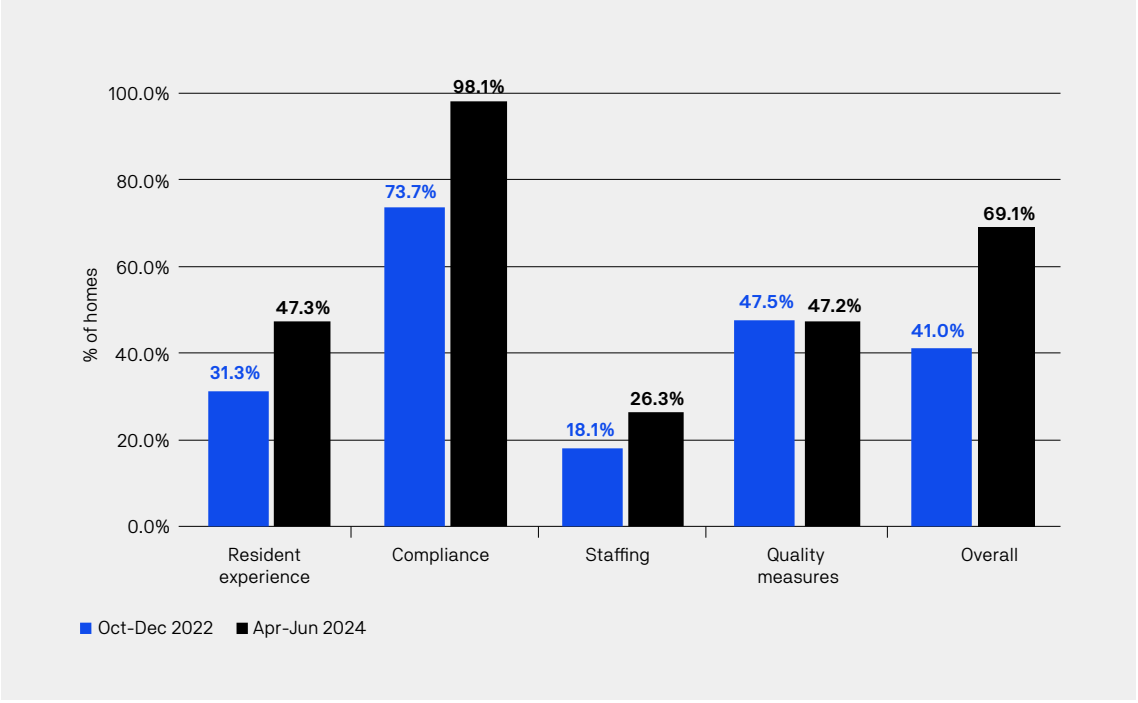


Changes in highly-rated homes

While these recent results generally portray a positive picture of residential care quality, there is a question about how prospective residents and their families may interpret Star Rating values. As reported previously by UARC, consumer research by Catalyst Research indicates that most older people and their families would only consider homes rated 4 stars and above.[91] This likely reflects how people generally interpret star ratings, noting their prevalence in other service industries (e.g. online shopping, hotel accommodation, restaurant reviews).

Using this benchmark, Figure 21 depicts the percentage of homes rated as 4 or 5 stars at the inception of Star Ratings (October – December 2022) and also according to the most recent statistics (April – June 2024). This shows that over two-thirds (69.1%) of homes are now rated 4 or 5 stars overall, up from 41.0% in December 2022.

Figure 21: Proportion of homes rated 4 or 5 stars, by sub-category

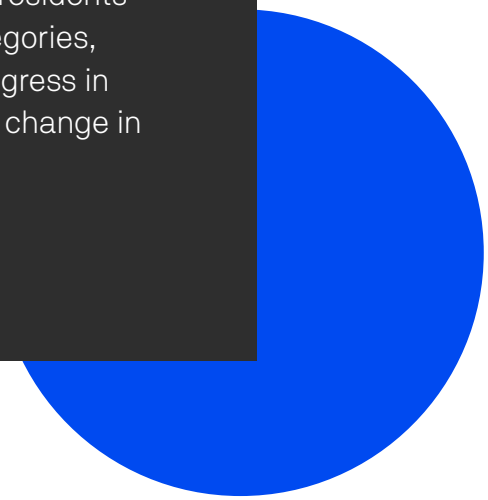


91. Catalyst Research (2023), *The Catalyst Report – Residential Aged Care Insights 2022*. This reported on the results of a large-scale consumer research survey, with responses from 4,904 respondents, (20 residents, 2,317 family members and 2,537 shoppers). The results showed that 84% of participants would only consider homes rated 4 stars and above.

This improvement in the overall stars appears to be primarily driven by enhancements in the compliance and residents' experience sub-categories, with only modest progress in staffing and minimal change in quality measures. The low proportion of highly rated homes for staffing (26.1%) aligns with the analysis reported in this report's Direct Care Staffing section regarding the low compliance rates with the minimum care minute requirements.

Notably, 98.1% of homes are currently 4 or 5 stars for compliance. Commentators have critiqued the design of this sub-category, highlighting discrepancies between Star Ratings and instances of non-compliance recorded by the Aged Care Quality and Safety Commission.[92] The Department has proposed changing the Star Ratings' design, focusing in particular on the compliance category. These revisions align with the new regulatory model set to commence in 2025 and will incorporate graded assessments against the strengthened Aged Care Quality Standards.[93]

Two-thirds (69.1%) of homes are now rated 4 or 5 stars overall, driven by enhancements in the compliance and residents' experience sub-categories, with only modest progress in staffing and minimal change in quality measures.



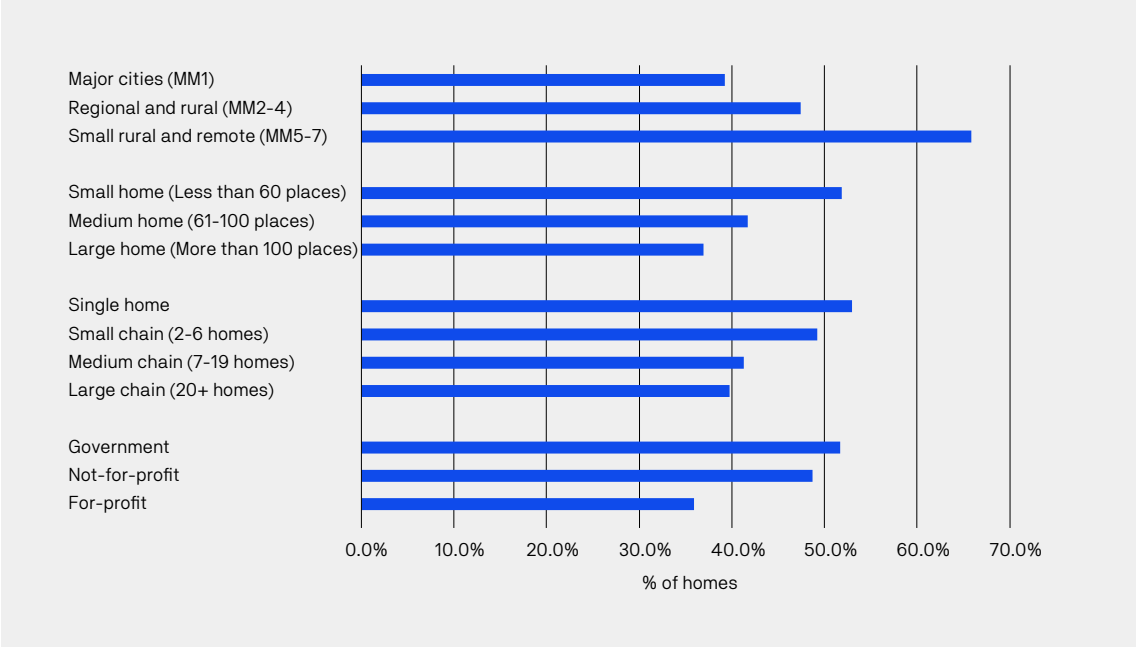
92. ABC (2024) Five-star ratings are being awarded to aged care facilities that are non-compliant with government standards.
93. Star Ratings for residential aged care – design changes | Australian Government Department of Health and Aged Care

Resident experience

The resident experience ratings comprise the largest component of the overall Star Rating (worth 33% of overall star weighting). It is based on an annual survey of a small sample of residents (or their representative), with the rating based on responses to 12 scale questions.[94]

As highlighted earlier in this section, 47.3% of homes are now rated 4 or 5 stars. However, a closer examination reveals cross-sectional differences in Star Ratings based on the characteristics of the homes (see Figure 22).[95]

Figure 22: Proportion of homes rated 4 or 5 stars for resident experience

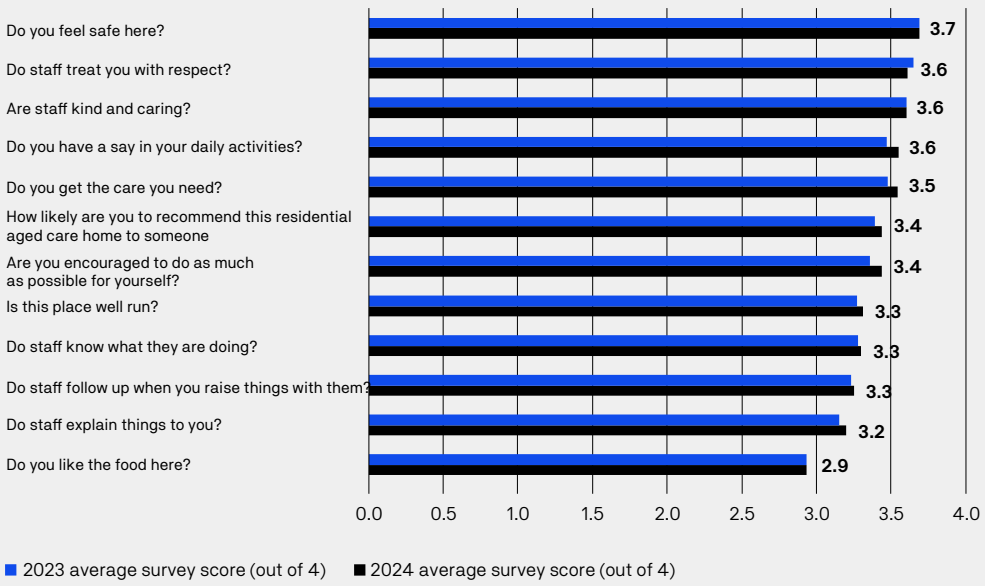


This analysis shows that non-metropolitan homes tend to have higher resident experience ratings than their city counterparts. For example, while almost two-thirds (65.8%) of homes in small rural towns and remote communities (MM5-7) homes are rated 4 or 5 stars, this falls to two-fifths (39.2%) in major cities. Regarding home size, more highly rated homes tend to be smaller (fewer places); for provider scale, the highest-rated homes tend to be operated by single-home providers. Finally, for ownership type, government and not-for-profit homes are more likely to receive 4 or 5 stars than for-profit homes. Finally, the highest-rated homes tend to be operated by single-home providers.

In sum, homes with higher ratings for resident experience are more likely to be non-metropolitan, government-operated, small, and run by a standalone, single-site provider.

94. At a minimum, the resident survey must sample at least 10% of all residents within a given residential home.
95. The figures reported here reflect homes' most recent resident experience rating as of June 2024. An important caveat in interpreting this analysis is that because the resident experience survey is conducted annually, some homes' ratings reflect scores from their 2023 annual survey.

Figure 23: Average resident experience survey score, by question



Using the detailed data reported in the Star Ratings extract, UARC has also analysed the average scores across the sector for the 12 questions used to calculate the resident experience rating (see Figure 23).[96] Each question is assigned a score out of 4 based on the residents' responses:

- Always – 4
- Most of the time – 3
- Some of the time – 2
- Never – 1

Encouragingly, residents rated their homes favourably on 11 out of 12 questions, with the majority responding "Most of the time" or "Always," resulting in average scores above 3 out of 4. Also, for most questions, there were modest improvements in the average scores between the surveys conducted in 2023 and 2024.

For 2024, the highest-rated aspects included feelings of safety, respect from staff, staff kindness, and having a say in daily activities. In contrast, the lowest-rated areas were staff communication (explaining things) and satisfaction with food.

96. As the surveys are conducted during the year, not all homes have reported 2024 resident experience survey results. Therefore, homes that have reported both survey results for 2023 and 2024 are included in this analysis in order to meaningfully compare the changes in the residents' experience rating. Using data from the April to June 2024 data extract, 1,743 homes were included in the analysis for 2024 and 2023.

Legislation update

The abolition of ACAR

Key messages

- The abolition of ACAR and the expanded definition of a residential care home under the new Aged Care Act provide a foundation for giving older people greater control and flexibility to receive 24/7 care in a much wider range of accommodation settings that respond to their personal needs and preferences.

- The extent to which this is realised will depend on how the Government interprets Section 10 of the new Aged Care Act and how it engages with innovative and forward-looking providers who want to be responsive to their consumer base.

The demise of Aged Care Approvals Rounds and the rise of newly defined 'residential care homes'

With the repeal of the Aged Care Act 1997, Aged Care Approvals Rounds (ACAR) will be no more. With it will go the regionally-based allocation of 'bed licences' that were issued by the Government to a limited number of approved providers who were virtually guaranteed a high occupancy rate without needing to offer a commensurate quality of care and accommodation. Also gone is the assessment of ACAR applications, a bureaucratic process that seemed biased towards ongoing providers and facilities that looked like traditional nursing homes. This is not to say, however, that its replacement under the new Aged Care Act is without its issues – as discussed below.

The demise of ACAR has been a long time coming. The Productivity Commission's 2011 report, *Caring for Older Australians,* recommended that:

> *"The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences."* [97]

While the community care reforms commenced in 2017, a form of fiscal rationing continues to place older people assessed as eligible for a home care package into a National Priority System queue.

Later in 2017, the *Legislated Review of Aged Care* set several criteria for fully uncapping supply (in part again to ensure fiscal sustainability) and also recommended (Recommendation 3):

> *"That, as soon as possible, the government discontinue the Aged Care Approvals Round for residential care places, instead assigning places directly to the consumers within the residential care cap…"* [98]

Subsequently, the Department commissioned Professor Mike Woods and Grant Corderoy to undertake and report on an '*Impact analysis: alternative models for allocating residential aged care places*'.[99] The Impact Analysis found that the ACAR model propped up occupancy rates for less-preferred homes, reduced incentives to provide quality care and reduced the flexibility for innovative providers to increase the scale, location and diversity of their aged care homes in response to consumer preferences. The Report supported the abolition of ACAR and the removal of the cap on supply. Under these reforms:

> *"Places would be assigned directly to eligible consumers, who would exercise choice and would benefit from greater provider competition and diversity of providers, services and accommodation settings. Specialist and rural/remote providers would have more flexibility to meet consumer preferences, but ongoing viability remains their greatest concern."* [100]

In 2021, the Government announced that ACAR would be discontinued in July 2024 and that older people would have more control and flexibility in selecting a residential aged care provider of their choice.[101] With only one year of further delay, the reform is now imminent.

97. Productivity Commission (2011), *Caring for Older Australians, Inquiry Report.*
98. Department of Health (2017), *Legislated Review of Aged Care.*
99. Woods, M., & Corderoy, G., (2020), *Impact analysis: alternative models for allocating residential aged care places.*
100. Woods, M., & Corderoy, G., (2020), *Impact analysis: alternative models for allocating residential aged care places,* p.viii
101. Department of Health (2021), *Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety.*

As noted in the Foreword to this edition, these changes have the potential to enable many older people to receive 24/7 care in a much wider range of accommodation settings that respond to their personal needs and preferences. Hence, those who are frail, have a diagnosis of dementia, are living with a disability or have particular cultural and social needs may find a provider which is responsive to their circumstances and offers care and accommodation in which the older person can live an engaged life

An important determinant of whether this vision comes to reality will be the attitude of the Department as System Governor to its interpretation of Section 10 of the new Aged Care Act.[102] The wording at first reading looks both medicalised and restrictive:

> *"(2) A residential care home means a place that:*
>
> *(a) is the place of residence of individuals who, by reason of sickness, have a continuing need for aged care services, including nursing services; and*
>
> *(b) is fitted, furnished and staffed for the purpose of providing those services.*
>
> *(3) To avoid doubt, a residential care home includes any of the following places:*
>
> *(a) a place within, or co-located with, a hospital or other health service that is covered by an agreement with the Commonwealth to deliver aged care services alongside health services as a part of an integrated service arrangement;*
>
> *(b) a place within a retirement village that is a place described by subsection (2);*
>
> *(c) a place which is a complex of buildings;*
>
> *(d) any other place prescribed by the rules."*

Further, under subsection (5), a place can be taken to be 2 or more separate places and vice versa.

UARC considers that the rules and other guidance to the sector must provide a strong interpretation of Section 10 that is consistent with the legislative Principles that the role of the Commonwealth's aged care system is to enable older people, including those requiring complex continuous care, to lead active and fulfilling lives and engage in the community. This is a far cry from Section 10's current focus on a Constitutional workaround whereby older people live in clinical environments "by reason of [their] sickness".

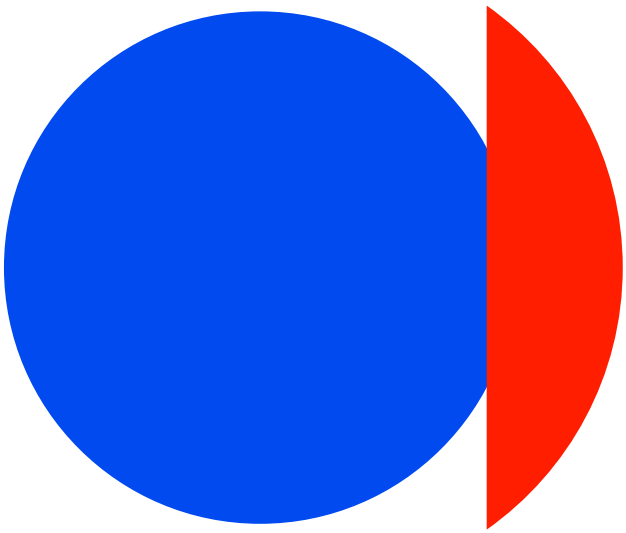
UARC also considers that, for the new Act to achieve some potential benefits, the Government should actively engage the States and Territories in creating a more consistent national framework for retirement village regulation, which may also relate to land lease communities and targeted social housing communities. Further, though as a medium-term goal, a referral of aged care powers by the States to the Commonwealth would enable the Act to be purged of some of the Bill's distracting complexities.

102. Commonwealth of Australia (2024), *Aged Care Bill 2024*.

UARC has long argued for a single, streamlined legislative framework that would enable innovative providers to respond to consumer needs and preferences and deliver the required care in a setting in which people want to live, and in a location where they want to live. This would be very different to the stereotypical 'nursing home' that has little favour in the minds of many older people.

It is pleasing to see that, even in this current transition period, many providers are developing such forward-looking models of care and accommodation. In this respect, ACCPA (Ageing Australia) released its State of the Sector Aged Care 2024 Report in October, in which it reported on a survey:

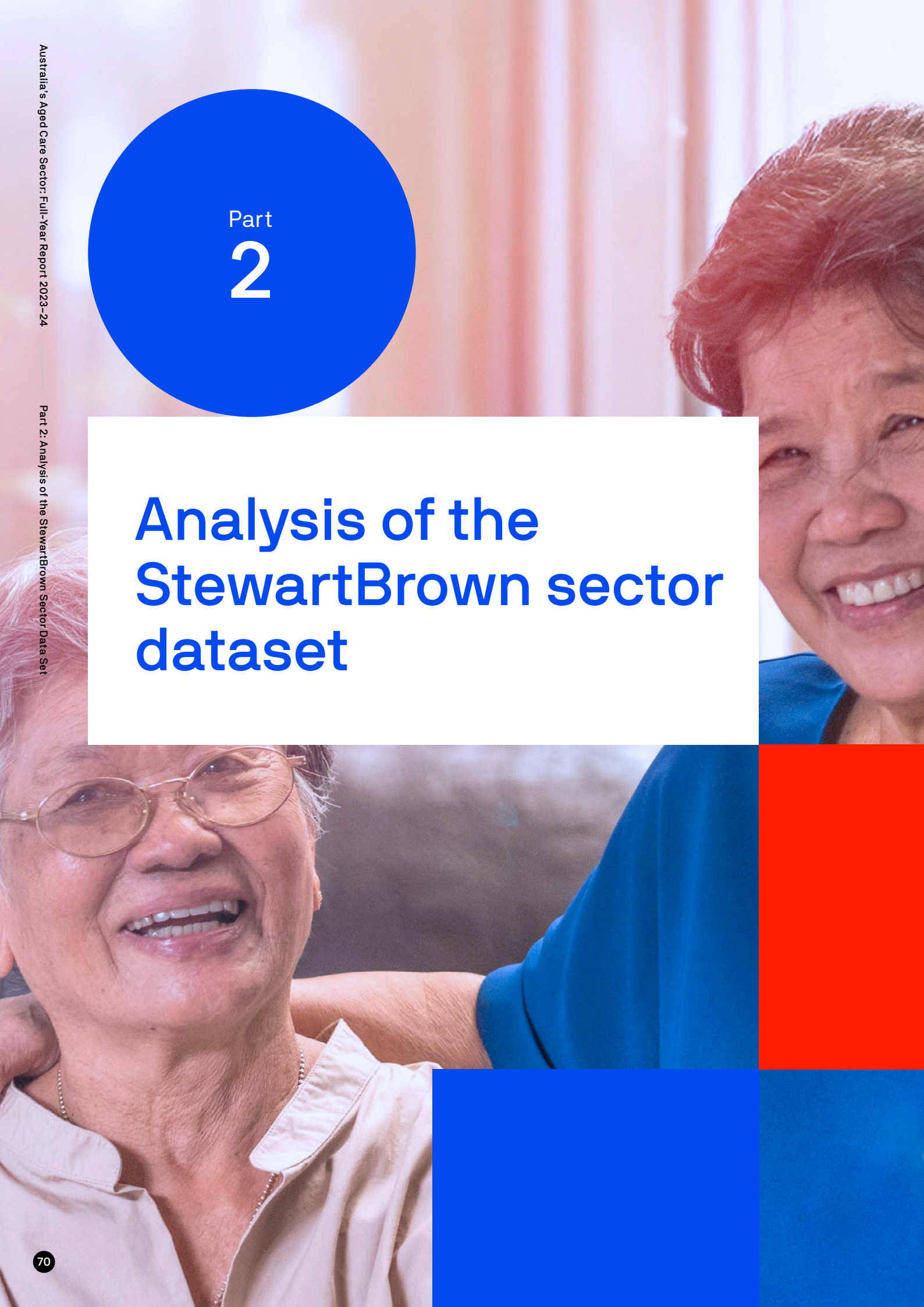
> *"Fifty per cent of providers feel confident or very confident in their ability to innovate to improve the quality of care provided with only 41 per cent confident or very confident they can invest in new business and ICT [information and communications technology] systems. Fewer than half (48 per cent) felt confident in their ability to innovate to improve the way they deliver their services."* [103]



103. ACCPA (2024), *State of the Sector Aged Care Report 2024*, p.18

Part
2

Analysis of the StewartBrown sector dataset



Part 2 of this report draws primarily on the 2023-24 StewartBrown *Aged Care Financial Performance Survey* (ACFPS), a de-identified large-scale dataset contributed to by aged care providers within Australia.[104]

StewartBrown conducts a subscription-based quarterly data collection and analysis service, enabling aged care providers to track their performance over time and benchmark their operations against other providers. Where relevant, this data has been supplemented with references to available sector-wide statistics, such as those published by the Department of Health and Aged Care and the Australian Institute for Health and Welfare (AIHW).

The data covers the 2023-24 financial year (2023-24). To enable meaningful trend comparisons, previous years' figures relate to the same reporting period of each year.

The analyses have been conducted at three levels:

- **Approved providers**
- **Residential aged care homes**
- **Home care package providers[105]**

The dataset does not cover the care and support provided by state government-owned agencies, CHSP, or other subsidised programs such as STRC.

Due to variations in method, the results reported in this report differ in some minor respects from those reported by StewartBrown. An explanation of the method appears in an Appendix at the end of this report.

104. StewartBrown (2024), *Aged Care Financial Performance Survey Report: June 2024*.

105. Many participant contributors to the dataset operate a combination of residential and home care services, which means that their data is represented in all three levels of analysis of the report. By comparison, those providers that only operate residential aged care homes are only represented in the Approved Provider and Residential Care analysis.

Approved provider analysis

Overview

- The financial results of participating providers for 2023-24 show some improvement compared to the prior year—nonetheless, two out of five (42.3%) providers operated at a loss.

- Operating revenue increased materially more than employee and other expenses despite a significant increase in employee expenses. The median wage expense per full-time employee has grown 14.6% compared to the prior year, reflecting increases in sector award rates.

- Providers' median Operating EBITDA margin was 3.3%, equivalent to generating $3.30 for every $100 of revenue earned before interest, tax, depreciation and amortisation expenses.

- Providers' total assets and liabilities expanded compared to the prior year, with a higher median liquidity (38.5%) and a stable capital adequacy ratio (33.6%).

Approved provider profiles

This approved provider analysis examines the financial outcomes of organisations that deliver residential and/or home care services within Australia. These organisations may also operate a range of other business streams, such as home support and community care programs, disability care, childcare and retirement living. As such, the analysis provides a sense of the overall financial performance of the going concern entities that provide subsidised aged care services, noting that a more detailed analysis of their residential care operations and home care services follow later in this Part 2.

Care should be taken when interpreting average (mean) results from a dataset containing providers that vary considerably in scope, scale and outcomes. For example, a provider with 20 or more homes is weighted equally with a provider with only one home. To account for these differences, when making year-on-year comparisons, the same providers are included in the current and prior year datasets (i.e. the sample is consistent). Where appropriate, the analysis reports ratios as median (middle point) values to reduce the effect of large outliers. Also, the section ends with an analysis that shows the results for different provider types.

Approved providers

Table 3: Profile of surveyed approved providers

	FY23	FY24
Number of providers in dataset	195	195
Ownership:		
For-profit	9.7%	9.7%
Not-for-profit	90.3%	90.3%
Staffing:		
Average number of staff (headcount)	841	947
Average number of full-time equivalent staff (FTEs)	553	604
Providers with residential aged care homes (%)	93.8%	93.8%
Average number of residential aged care homes	5.5	5.6
Average number of operational places	455	469
Location:		
Metropolitan	47.3%	47.8%
Regional	40.7%	39.3%
Metropolitan and regional	12.0%	12.9%
Provider scale:		
Single-home	42.6%	42.6%
2-6 homes	31.3%	31.3%
7-19 homes	13.8%	12.8%
20+ homes	6.2%	7.2%
No residential homes	6.2%	6.2%
Providers with home care operations (%)	47.7%	49.2%
Average number of home care packages	786	725
Providers with seniors housing (%)	64.1%	64.1%
Average number of retirement villages	7.0	7.2
Average number of retirement village units	330	341

This section contains analyses of the outcomes of 195 approved provider organisations that contributed to the StewartBrown dataset for the 2023-24 financial year (FY24), representing 13.4% of Australia's 1,450 residential and home care package providers.[106] As shown in Table 3, most (90.3%) of these providers are not-for-profit, and the remainder (9.7%) are private, for-profit providers.

106. Department of Health and Aged Care (2024), *Stocktake data: Operational providers, 30 June 2024*, Australian Institute of Health and Welfare. The proportion of providers differs from the proportion of residential homes due to the larger providers in the dataset.

In 2023-24, providers employed an average of 947 people (604 full-time equivalent staff). This was 12.6% more than the staffing levels the year prior, indicating growth in their operational scale and minimum standards requiring additional direct care staff to increase direct care minutes.

Almost all surveyed providers (93.8%) offered residential aged care services, operating an average of 5.6 homes and 469 places. About half (47.8%) of surveyed providers operate predominantly in metropolitan areas.[107] The geographic spread of providers in the dataset is consistent with sector-level statistics for all residential care providers in Australia.[108]

As with the national population of residential care providers,[109] the most prevalent provider scale in the dataset is those operating a single aged care home (42.6%). However, the few providers that are larger in scale operate a substantial share of the total number of operational places. For example, providers that operate 20 or more homes comprise only 7.2% of the total number of providers in the dataset but operate 41.4% of all the operational places.[110]

About half (49.2%) of the surveyed providers offered home care packages. The dataset is weighted towards larger home care providers. For example, the average number of home care packages per provider (725) is more than double that of the home care sector overall (303 packages per provider).[111] In addition, 64.1% of providers offered seniors housing (regulated by the states and territories retirement village legislation).

107. Provider location describes the geographic location and spread of the providers' residential care operations. Following the definitions used by the Department of Health and Aged Care in its Annual and Quarterly reports on the aged care sector, a provider is classified as being "Metropolitan" if more than 70% of its homes are located in metropolitan areas; "Regional" if more than 70% of its homes are located in regional (non-metropolitan) areas; and "Metropolitan and regional" if between 30-70% of its homes are located in metropolitan areas.

108. According to the Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector (2022-23)*, as of 30 June 2022, 420 (55.0%) of all residential providers are located in metropolitan areas; 302 (39.5%) in regional areas; and 42 (5.5%) in metropolitan and regional areas.

109. The relative distribution of residential care providers in Australia, based on scale, is single home (61.9%), 2-6 homes (28.3%), 7-19 homes (6.9%) and 20+ homes (2.9%). These statistics are reported in the Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector (2022-23)*.

110. This is a similar proportion to the 30 June 2024 figures reported on the population of residential aged care providers in the Aged Care Service List published by the Australian Institute of Health and Welfare.

111. As of June 2024, there are 275,486 home care packages provided by 909 providers, which is equivalent to 303 home care packages per provider. Department of Health and Aged Care (2024), *Report on the Operation of the Aged Care Act 1997*

Approved providers

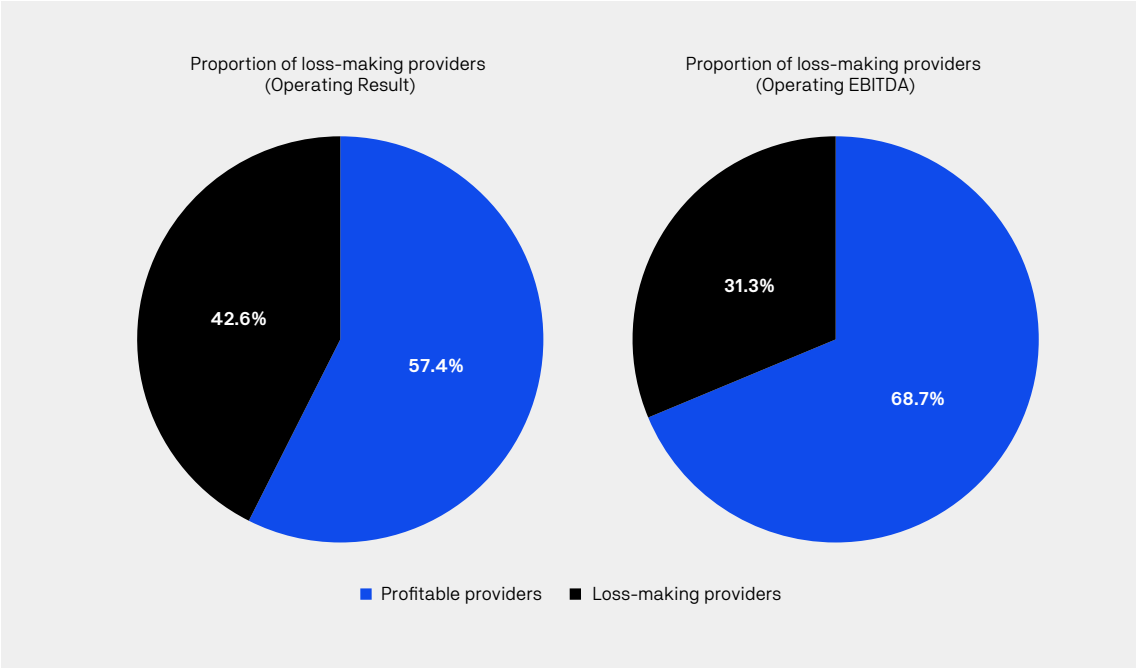
Financial performance

The level of profit or loss made by approved providers indicates the overall financial viability of organisations that provide subsidised aged care services to older people in Australia. Overall, the results for 2023-24 show some improvement in the financial performance of surveyed providers compared to the prior year.

Figure 24 shows the proportion of profitable providers, as measured by their annual Operating Result (left panel) and Operating EBITDA (right panel). The Operating Result shows the difference between providers' operating revenue and operating expenses for the year. Operating Result generally refers to the net profit before tax (NPBT) earned by an approved provider but excludes non-recurrent revenues and expenses. Non-recurrent revenues and expenses refer to items including flows relating to revaluations, impairments, donations, fundraising, bequests, gains or losses on asset sales and write-off of bed licences. Removing these items allows for better comparability in figures between years.[112]

In 2023-24, two out of five (42.3%) providers operated at a loss. Although this proportion is still significant, it represents some improvement compared to the prior year, when 61.0% of these providers reported a negative Operating Result. This outcome is a consequence of operating revenue (including AN-ACC payments) increasing materially more than employee and other expenses.

Figure 24: Proportion of loss-making providers, Operating Result and Operating EBITDA



112. By comparison, the Total Result shows the Operating Result net (i.e. inclusive) of non-recurrent revenues and expenses.

Figure 24 also shows that 31.3% of providers reported a negative Operating EBITDA[113] for 2023-24. The difference between profitability measures is expected, given that EBITDA excludes certain expenses from its calculation, including interest, tax, depreciation and amortisation. A potential advantage of Operating EBITDA compared to Operating Result is that it allows for greater comparability between providers with different corporate structures, financing arrangements, tax obligations and depreciation rates. However, an important caveat is that because it excludes these expenses, it does not account for longer-term costs relating to capital investment and may not be suitable for assessing the long-term viability of a provider's operations.

Table 4: Approved provider average profit and loss results

	FY23	FY24
Revenue		
Service revenue ($'000)	$72,633	$89,002
Investment revenue ($'000)	$1,484	$2,517
Total operating revenue ($'000)	$74,117	$91,519
Expenses		
Employee expenses ($'000)	$52,723	$63,955
Depreciation and amortisation ($'000)	$5,448	$4,932
Finance costs ($'000)	$1,343	$1,746
Other expenses ($'000)	$18,776	$21,854
Total operating expenses ($'000)	$78,290	$92,487
Operating Result ($'000)	($4,173)	($968)
Net non-recurrent income ($'000)	$1,895	$3,495
Total Result ($'000)	($2,278)	$2,527
Operating EBITDA ($'000)	$676	$2,484
Net non-recurrent income ($'000)	$1,895	$3,495
EBITDA ($'000)	$2,571	$5,979
Ratios (Medians)		
Profit margin (Operating Result)	(3.2%)	1.0%
Profit margin (Operating EBITDA)	1.3%	3.3%
Return on assets (Operating Result)	(1.1%)	0.3%
Return on assets (Operating EBITDA)	0.4%	1.1%
Wages-to-revenue	71.8%	71.0%
Median employee expense per FTE	$95,825	$109,859
Depreciation expense (as % of property assets)	3.4%	3.2%

113. Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) is a measure of profitability that excludes several key line items relating to the corporate structure, financing arrangements and tax status of an organisation. 'Operating EBITDA' also excludes all non-recurrent revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

The improvement in surveyed providers' financial results is detailed in Table 4. In 2023-24, the median rates for providers' profit margins improved by 4.2 percentage points (Operating Result) and two percentage points (Operating EBITDA) compared to 2022-23, and in both cases, returned to a positive result. For example, the median Operating EBITDA profit margin increased to 3.3%, meaning a $3.30 margin was generated for every $100 of revenue earned before accounting for further interest, tax, depreciation and amortisation costs.

Likewise, both measures of return on assets were higher than the year before. Nonetheless, the median Operating EBITDA return on assets remains low at just 1.1%. This very modest return on investment means concerns about the sector's financial sustainability and attractiveness as an investment option are likely to persist.

By breaking down the average value of providers' key revenues and expenses for the last two years, Table 4 gives insight into the underlying changes that have led to improved financial performance.

Across the 195 providers, the average reported Operating Result for 2023-24 was a deficit of $968,090 – much smaller than the average deficit of $4.17m in 2022-23. This improvement has occurred because of a substantial revenue growth rate (23.5% higher than 2022-23), which has outpaced the growth in expenditure (18.1%).

The largest expenditure continues to be on employee wages, salaries, and benefits. For example, the median rate of wages-to-revenue was 71.0% in 2023-24.[114] Employee costs increased substantially (21.3%), driven mainly by a 14.7% increase in median employee expense per FTE from $95,825 in 2022-23 to $109,859 in 2023-24. The growth in employee expenses reflects recent increases in the sector's award rates following the FWC's annual wage review, the implementation of Stage 2 of the FWC aged care work value case, and an increase in the overall number of FTE employed.[115] Nonetheless, the slight fall in the wages-to-revenue ratio indicates that this growth in employee expenditure is less than the expansion of providers' service revenue with revisions in the pricing of services, including direct care in residential aged care (see Part 1).

Most expense items have seen double-digit growth in the past year except for depreciation and amortisation, which contracted slightly. This decline, in part, likely reflects the contraction in intangible assets, as providers have written off the value of their bed licenses.[116] Nonetheless, the median depreciation and amortisation rate as a percentage of property assets has remained steady over two years at 3.2-3.4%. This rate implies that providers are expensing long-term assets (including buildings, equipment and furniture), assuming an average useful lifetime of approximately 29.4-31.3 years.[117]

114. The median wages to revenue ratio is calculated by dividing the total salaries and employee benefits, including management fees, by total revenue.
115. The increase in employee expenses also contains an adjustment made by some participating providers to their employee leave provisions as a result of the Fair Work Commission wage case.
116. A large portion of the depreciation and amortisation expense relates to the phasing out of bed licences with the discontinuation of ACAR on 1 July 2025. Accordingly, less amortisation expenses would be expected in subsequent financial years.
117. In practice, assumed useful life estimates may be even higher if providers record their property assets at their historical cost values.

Liquidity and capital adequacy

Approved providers' balance sheet figures provide an aggregate perspective on the value of their assets, liabilities and owners' equity, as well as their liquidity[118] and capital adequacy[119] risk profiles.

Approved providers must maintain access to sufficient liquid funds (i.e., cash, financial assets or lines of credit) to meet their debt obligations, including refunding RADs when residents leave the aged care homes. Furthermore, providers are expected to maintain sufficient capital adequacy, which means they have sufficient net assets to absorb unexpected losses. Although not a strict regulatory requirement, this is a risk factor that the Government may use to monitor viability. However, managing liquidity and capital adequacy risk must be balanced against sufficient investment in new and refurbished capital assets such as equipment, information systems, property and buildings that enable providers to provide quality aged care services into the future.

118. Liquidity is calculated as the total of cash, cash equivalents and financial assets, divided by total liabilities minus lease liabilities.
119. Capital adequacy is calculated as the net tangible assets divided by total tangible assets (i.e. intangible assets are excluded).

Approved providers

Table 5: Approved provider average balance sheet figures

	FY23	FY24
Assets		
Cash and financial assets ($'000)	$38,432	$47,866
Operating assets ($'000)	$12,725	$15,146
Property assets ($'000)	$171,257	$180,196
Right of use assets ($'000)	$3,217	$3,483
Intangibles - other ($'000)	$1,099	$1,055
Intangibles - bed licences ($'000)	$2,161	$471
Total assets ($'000)	$228,891	$248,216
Liabilities		
Refundable loans - residential ($'000)	$76,473	$86,314
Refundable loans - retirement living ($'000)	$55,726	$60,316
Home care packages unspent funds liability ($'000)	$1,387	$1,038
Borrowings ($'000)	$10,339	$8,228
Other liabilities ($'000)	$23,157	$25,055
Total liabilities ($'000)	$167,083	$180,951
Net assets ($'000)	$61,808	$67,265
Net tangible assets ($'000)	$58,549	$65,740
Ratios (Medians):		
Liquidity	32.6%	38.5%
Capital adequacy	33.8%	33.6%
Property assets as a proportion of total assets	66.4%	65.1%

Table 5 reports approved providers' average balance sheet figures and median ratios for 2023-24, showing a general strengthening of providers' financial position compared to the year prior.

Providers' total asset base grew by 8.4% over the last 12 months, driven by increased cash and financial assets, right of use assets and operating assets. Although property assets increased, the proportion of property assets making up total assets declined to 65.1%. However, the average value of intangible assets declined, particularly in terms of bed licenses, which will cease to exist with the discontinuation of ACAR from 1 July 2025.

The growth in assets was matched with a similar growth in liabilities. The most significant increases were in refundable residential and retirement living loans, which grew by 12.9% and 8.2%, respectively. This reflects the growing demand for aged care services, with residential care homes reporting increased average occupancy rates and RAD values. Overall, there was an increase in net assets of 8.8%.

The key balance sheet ratios (expressed as medians) show liquidity and capital adequacy remain above the generally expected 15-20% thresholds.

Analysis by provider type

Approved providers comprise a diverse range of organisational entities, from small providers that operate one aged care home or one type of home care service to large corporations that offer a diversified range of aged care services (residential, home care, CHSP) as well as retirement living, in multiple locations around the country.

This diversity of providers' scale and scope can make interpreting overall financial statistics at the provider-level somewhat challenging. UARC has developed the following typology (see Figure 25). This differentiates providers based on the scale of their operations (the number of aged care homes they operate) and the diversification of their service offering (i.e. whether they offer residential care only, home care only, or a more diversified range of services to older people).[120]

Figure 25: Typology of approved providers by provider scale and service diversification

Number of residential aged care homes	Provider types	
20+	Large chain providers	
7-19	Medium chain providers	
2-6	Small chain providers (residential care only)	Small chain providers (diversified)
1	Single-home providers (residential care only)	Single-home providers (diversified)
0	Home care only providers	

120. Diversification is measured by a providers' residential care revenue as a proportion of aged care service revenue. Providers that have more than 99% of their service revenue from residential care are classified as 'residential only'; the remainder are classified as 'diversified'. Given that the vast majority of medium and large chains are diversified, these categories are only defined through their scale.

Approved providers

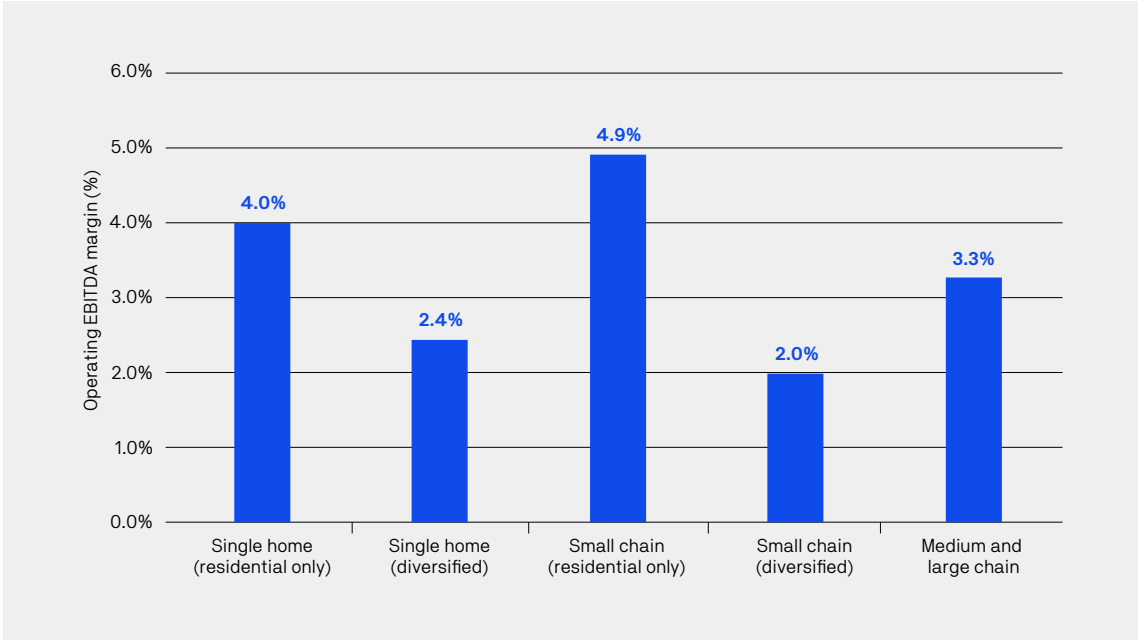
Table 6 shows the key financial indicators of providers within the 2023-24 dataset, as grouped by provider typology. Note that due to sample size restrictions, large and medium chain categories have been combined in this edition of the report, and 12 home care only providers have been excluded.

These results show substantial variation in the financial performance of providers, with different patterns depending on the measure of profit used. Most notably, Table 6 shows that diversified single and small chains report lower profitability across most measures than their residential only counterparts, as discussed later in this section. Beyond profitability, diversified providers have lower liquidity levels than residential only providers. These providers also recognised lower depreciation on property assets, resulting in longer (implied) useful life spans for property assets.

Table 6: Key performance indicators of approved providers, by provider type

	Single-home (residential only)	Single-home (diversified)	Small chain (residential only)	Small chain (diversified)	Medium and large chain
Number of providers in dataset	58	25	27	34	39
Financial performance:					
Proportion of loss-making providers (Operating Result)	34.5%	60.0%	25.9%	55.9%	48.7%
Proportion of loss-making providers (Operating EBITDA)	29.3%	36.0%	14.8%	41.2%	33.3%
Profit margin (Operating Result)	4.2%	(0.1%)	2.1%	(0.7%)	0.3%
Profit margin (Operating EBITDA)	4.0%	2.4%	4.9%	2.0%	3.3%
Return on assets (Operating Result)	1.3%	(0.0%)	0.7%	(0.1%)	0.2%
Return on assets (Operating EBITDA)	2.0%	1.9%	2.3%	1.4%	2.7%
Liquidity	62.3%	36.7%	32.6%	23.2%	20.6%
Capital adequacy	38.7%	39.6%	20.5%	32.6%	27.5%
Depreciation:					
Depreciation expense as % of property assets	4.0%	2.9%	3.8%	2.7%	2.9%
Implied useful life of property assets	25.2	34.7	26.5	37.2	35.1
Staffing:					
Average number of staff (headcount)	135	155	448	537	3,186
Average number of full-time equivalent staff (FTEs)	84	100	242	317	2,051
Wages-to-revenue	72.6%	68.9%	70.3%	69.2%	73.6%
Median employee expense per FTE	$106,931	$104,403	$115,863	$114,159	$114,185

Figure 26: Operating EBITDA margin (%), by provider type



In terms of operational performance, the most comparable measure of profit across providers of different scales is Operating EBITDA, as this removes the effects of differences in financing arrangements, tax status and accounting assumptions. According to this measure (see Figure 26), in 2023-24, the provider groups that reported the lowest results were small chain (diversified) providers (2.0%) and single-home (diversified) (2.4%) providers. By comparison, the provider groups with the highest Operating EBITDA rates were residential care only providers, both single-home (4.0%) and small chain (4.9%). Differences in the Operating Result margins reflect a similar pattern across provider groups (see Table 6 above). This pattern likely reflects the financial challenges associated with operating in the home care market, as detailed later in Part 2.

Residential care analysis

Overview

- Residential aged care homes, on average, continue to report poor financial performance, although there has been some improvement compared to the prior year. Revenue growth, including funding for wage rises and increased staffing requirements, has exceeded expenditure.

- In 2023-24, 51.3% of homes operated at a loss, with an average deficit of $3.07 per resident per day.

- There is a widening gap in financial outcomes across the sector. On average, the Operating Result of the top 25% of homes is $102.39 per resident per day higher than the bottom 25% of homes.

- Homes' Operating Results, on average, comprised a positive margin of $15.39 per resident per day for direct care services, consumed by losses for everyday living (loss of $7.36) and accommodation (loss of $11.09).

- Administration costs have grown by 8.8% compared to 2022-23, now averaging $51.75 per resident per day.

- Occupancy of available places has improved, with the national average rate now reaching 92.6%.

- Direct care staffing minutes have increased and are, on average, just over the sector-level target of 200 minutes. However, most homes are not staffed to meet their mandated requirements.

Residential aged care home profiles

The residential care analysis reports the average financial and workforce outcomes of participating residential aged care homes. The 2023-24 StewartBrown full-year residential dataset comprises 1,194 homes and 99,018 places,[121] representing 45.6% of Australia's 2,617 residential aged care homes and 44.3% of the 223,691 operational places.[122]

Table 7: Profile of surveyed residential aged care homes

	FY23	FY24
Number of homes in dataset	1,197	1,194
Total number of places in dataset	98,709	99,018
Average home size (number of places)	82	83
Ownership:		
For-profit	6.5%	7.1%
Not-for-profit	93.5%	92.9%
Location:		
Metropolitan (MM1)	63.2%	62.8%
Regional (MM2)	8.6%	8.9%
Large rural (MM3)	10.9%	11.1%
Medium rural (MM4)	7.1%	6.4%
Small rural and remote (MM5-7)	10.2%	10.8%
Provider scale:		
Single-home	9.6%	7.1%
2-6 homes	19.3%	17.0%
7-19 homes	31.3%	30.2%
20+ homes	39.8%	45.7%
Home size:		
Less than 40 places	9.4%	8.5%
40-80 places	41.6%	43.1%
80-120 places	31.9%	31.7%
More than 120 places	17.0%	16.8%

121. In total, 1,217 residential aged care homes participated in the full-year 2023-24 StewartBrown survey, however as part of the data cleaning and analysis process, 23 homes were excluded from the final sample either because of data integrity issues or because they were subject to substantial disruption to their operations, such as the case for homes that were newly built, undergoing major refurbishment or subject to sanction by the regulator. In the StewartBrown Aged Care Financial Performance Survey terminology, 'all homes' relates to the entire sample and 'mature homes' relates to the final sample, as used in the analysis in this report.

122. Department of Health and Aged Care (2024), *Aged care data snapshot—2024, second release*, Australian Institute of Health and Welfare.

Residential aged care homes

As shown in Table 7, the average size of each home in the 2023-24 full-year dataset was 83 operational places, comparable to the national average of 85.[123] Almost all (92.9%) surveyed homes are operated by not-for-profit providers, whereas they comprise 57.4% of the national population of homes.[124] The remaining surveyed homes are for-profit (compared to 34.6% of the national total). There are no government-operated homes in this dataset (8.0% of the national total).

The dataset is consistent with sector-level statistics on the overall geographic spread of homes by remoteness category (i.e. the Modified Monash Model, MMM), [125] with almost two-thirds being located in major cities.

Regarding provider scale, the dataset is weighted towards homes operated by larger providers. For example, while single homes comprise 17.5% of all aged care homes nationally, they represent only 7.1% of homes in the dataset. Conversely, while homes operated by large providers (20+ homes) comprise 37.5% of all homes nationally, they account for 45.7% of the dataset.[126]

Likewise, in terms of home size, the dataset is underweighted for small homes (less than 40 places). These homes comprise 12.8% of all aged care homes nationally; however, they represent only 8.5% of homes in the dataset. Nonetheless, the proportion of homes larger than 80 places (52.2%) is similar to that in the national statistics (48.5%).[127]

123. Department of Health and Aged Care (2024), *Aged care data snapshot—2024, Second release*, Australian Institute of Health and Welfare.
124. Australian Institute of Health and Welfare (2024), *Aged care service listing 30 June 2024*.
125. Australian Institute of Health and Welfare (2024), *Aged care service listing 30 June 2024*.
126. Australian Institute of Health and Welfare (2024), *Aged care service listing 30 June 2024*.
127. Australian Institute of Health and Welfare (2024), *Aged care service listing 30 June 2024*.

Key performance indicator summary

Table 8: Key performance indicators of residential aged care homes

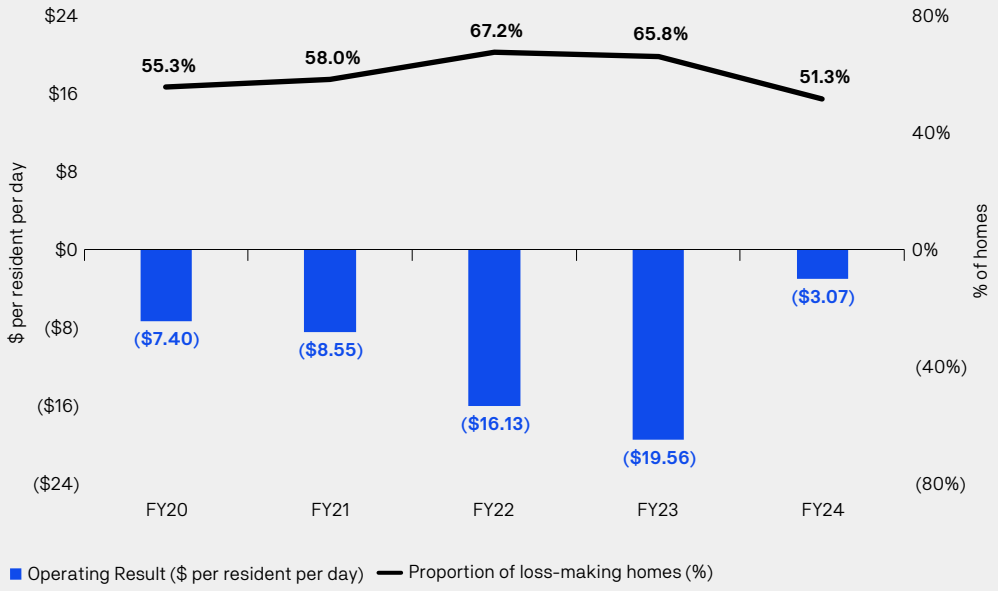
	FY23	FY24
Operating Result (per resident per day)	($19.56)	($3.07)
Operating Result (per bed per annum)*	($6,133)	($729)
Operating EBITDA (per bed per annum)*	$399	$6,546
Proportion of loss-making homes (Operating Result)	65.8%	51.3%
Proportion of loss-making homes (EBITDA)	45.2%	28.3%
Occupancy rate	91.1%	92.6%
Supported resident ratio	45.6%	46.0%
Average direct care revenue (per resident per day)	$214.74	$276.40
Average direct care expenditure (per resident per day)	$213.16	$261.01
Direct care expense ratio	99.3%	94.4%
Average direct care minutes (per resident day)	189.6	203.6
Average value of full RADs held at reporting date	$414,787	$432,357
Average value of new full RADs taken during period	$452,808	$468,365

* Per annum figures are the per resident per day result for 365 days adjusted for the occupancy rate.

Financial performance

The full-year results for 2023-24 show an improvement in the financial performance of residential aged care homes. As shown in Figure 27, the average Operating Result[128] was a deficit (loss) of $3.07 per resident per day, up from a deficit of $19.56 per resident per day a year prior.[129] This also means that the share of homes operating at a loss reduced to around half (51.3%) in 2023-24, down from the two-thirds (65.8%) of loss-making homes in 2022-23.[130]

Figure 27: Operating Result, per resident per day, and proportion of loss-making homes



In comparing the improved 2023-24 full-year results with the long-term trend, it should be recognised that homes now receive substantially more government funding through higher direct care subsidies (AN-ACC) and the hotelling supplement. Furthermore, as discussed in Part 1, the reported improvements in some homes may revert once they meet their mandatory care minute targets.

It is worth remembering that these results represent the average results of only the 'mature' homes that participated in the 2023-24 StewartBrown dataset.[131] If all participating homes were included, the average Operating Result for 2023-24 would fall to a deficit of $9.59 per resident per day.

Further, despite the improved results, the poor financial performance of many homes presents an ongoing challenge to the sector's sustainability. For example, nearly half of all aged care homes are still operating at a loss, and the average net result is still a deficit.

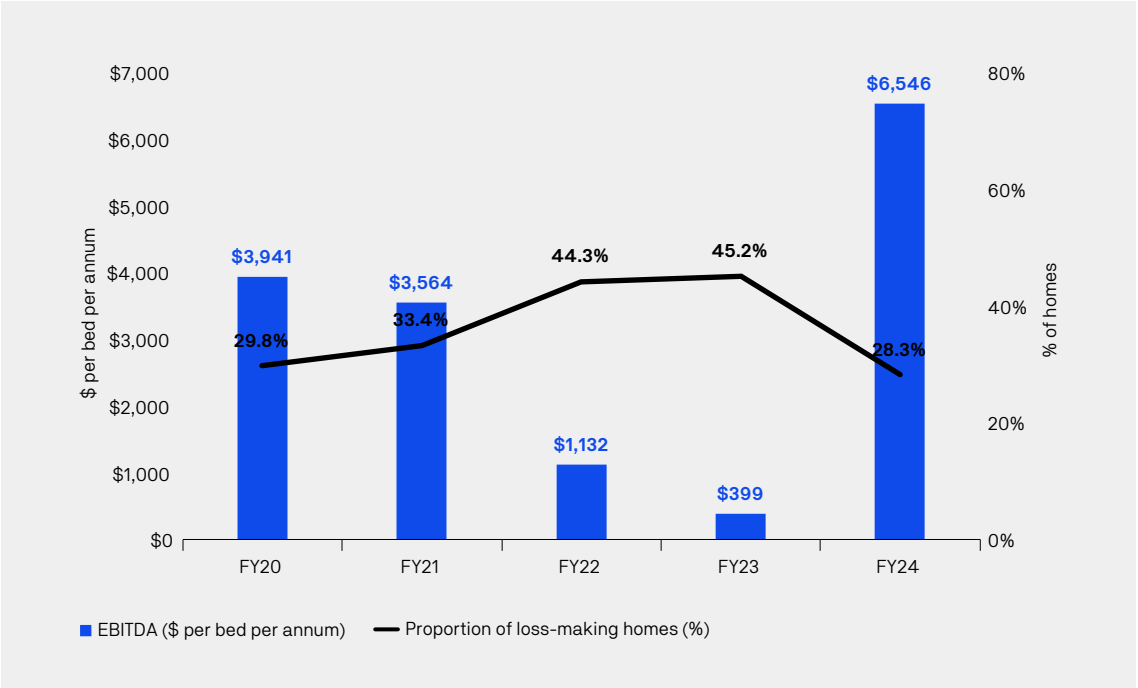
128. Operating Result refers to the Net Profit Before Tax (NPBT) earned by a residential aged care home.

129. The UARC estimate for average Operating Result (negative $3.07 per resident per day) is $1.49 lower than the StewartBrown estimate (negative $1.58 per resident per day): StewartBrown (2024) *Aged Care Financial Performance Survey Report June 2024*. This difference arises from method differences in the way averages are calculated, where the UARC estimate reflects home-level average and the StewartBrown estimate reflects a place-level average. For more information, please see the method guidance provided in the Appendix.

130. An Operating Loss occurs when an aged care home's Operating Result (i.e., NPBT) is below zero.

131. As part of the data cleaning and analysis process, 23 homes experiencing substantial disruptions to their operations have been excluded (e.g., newly built and still ramping up, undergoing major refurbishment or subject to sanction).

Figure 28: Operating EBITDA, per resident per day, and proportion of loss-making homes

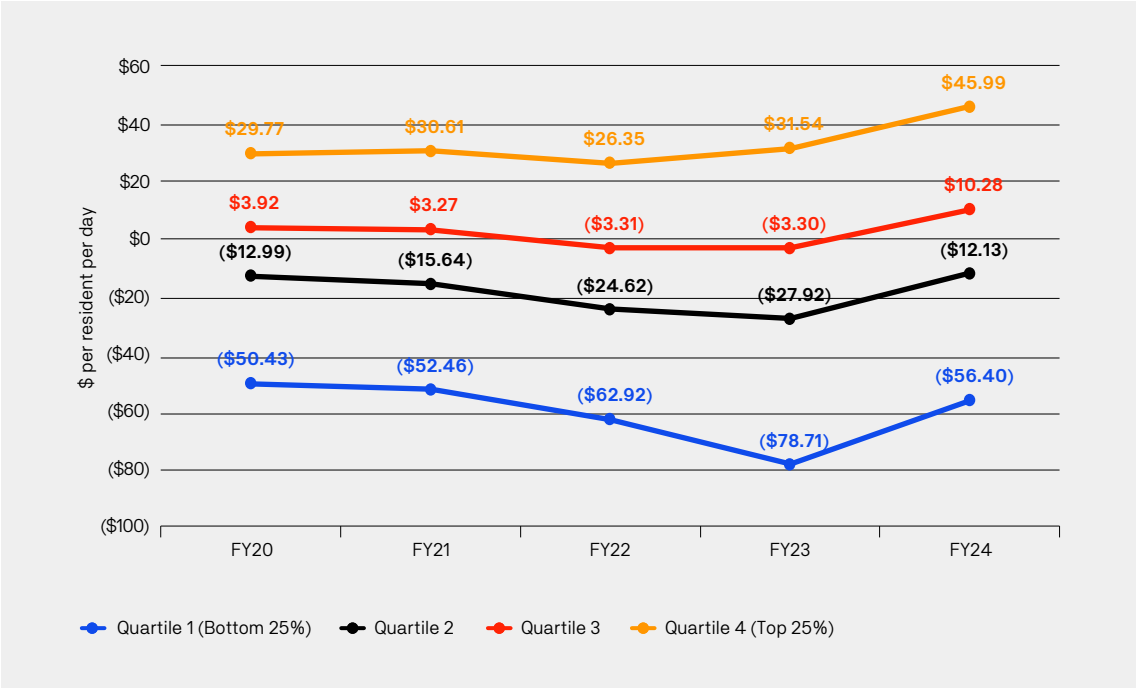


The Operating EBITDA of aged care homes[132] (Figure 28) has exhibited a similar trend to the Operating Result. Operating EBITDA improved relative to the prior year to an average of $6,546 per place per annum. In 2023-24, 28.3% of homes reported a negative Operating EBITDA result,[133] down from 45.2% in 2022-23. Homes that can generate an Operating EBITDA surplus over the longer term may be more viable, as they are less at risk of having to draw down on their asset base to cover their operating costs.

132. In general, Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) is a measure of profitability that excludes several key line items relating to the corporate structure, financing arrangements and tax status of an organisation. It thus allows for a comparison of the profitability of homes operated under different corporate arrangements and financing policies. 'Operating EBITDA' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

133. An Operating EBITDA loss occurs when an aged care home's Operating EBITDA is below zero.

Figure 29: Operating Result, per resident per day, by quartile



To some extent, the trend in the average financial results masks the dispersion in the financial outcomes of homes across the sector in recent years. Figure 29 shows the profitability trends of the top quartile ('top 25%') of homes each year (based on their Operating Result) compared to homes in the remaining three quartiles. Five years ago (2019-20), the top 25% of homes earned an additional $80.20 per resident per day compared to the bottom 25%. The most recent full-year results (2023-24) show this gap has grown to $102.39 per resident per day (in nominal terms).

Furthermore, while the average surplus earned by homes in the top 25% has grown by 54.5% in the last five years (from $29.77 per resident per day in 2019-20 to $45.99 in 2023-24), the performance of the lower two quartiles (i.e. the bottom 50% of homes), is ostensibly the same as it was five years ago (again, in nominal values).

One of the factors driving this is the variation in homes' direct care staffing vis-à-vis their care minute targets. For example, as of June 2024, only 29.1% of homes in the top 25% had met both of their service-level direct care minute targets. By comparison, for the remaining 75% of homes, this rate was 44.1%. Although all homes have received substantial increases in direct care funding from AN-ACC, homes that do not meet their care minute targets have lower expenditures on direct care staff. This enables them to retain a (larger) direct care surplus, contributing to their improved bottom line.

Other contributing factors differentiating the top and bottom 25% of homes include variation in occupancy rates (averaging 94.3% versus 88.8%) and supported resident ratios (52.0% versus 43.6%). The more profitable homes also tend to be located in metropolitan locations and slightly larger (i.e. number of places). The financial implications of these factors are detailed in the sub-sections below.

Operating Result breakdown

This section disaggregates the revenue and expenses that contribute to aged care homes' Operating Result into three service areas:

- direct care (nursing, other clinical and personal care services, including wound management, medication administration, allied health, care management and support with showering, dressing and toileting, as well as social care services such as recreational activities and emotional support)
- everyday living (food, cleaning, laundry, and other daily amenities)
- accommodation (provision and maintenance of buildings, equipment and other capital infrastructure)

This disaggregation enables better identification of the revenue streams and cost components that influence the financial performance of aged care homes and can indicate areas for policy and management focus.

Following the method used by StewartBrown, administration costs have been allocated across the three areas for a meaningful comparison between the respective revenues and costs.[134] Administration costs are allocated to three service areas according to the following proportions:

- Direct care - 37.0%
- Everyday living - 33.6%
- Accommodation – 29.4%[135]

This approach also accounts for the need for each revenue stream to contribute to the overhead costs of operating an aged care home, noting that no specific revenue stream is associated with administration costs.

134. StewartBrown periodically verifies the validity of the allocation percentages with reference to data collected from participating providers, including an additional Corporate Administration survey.

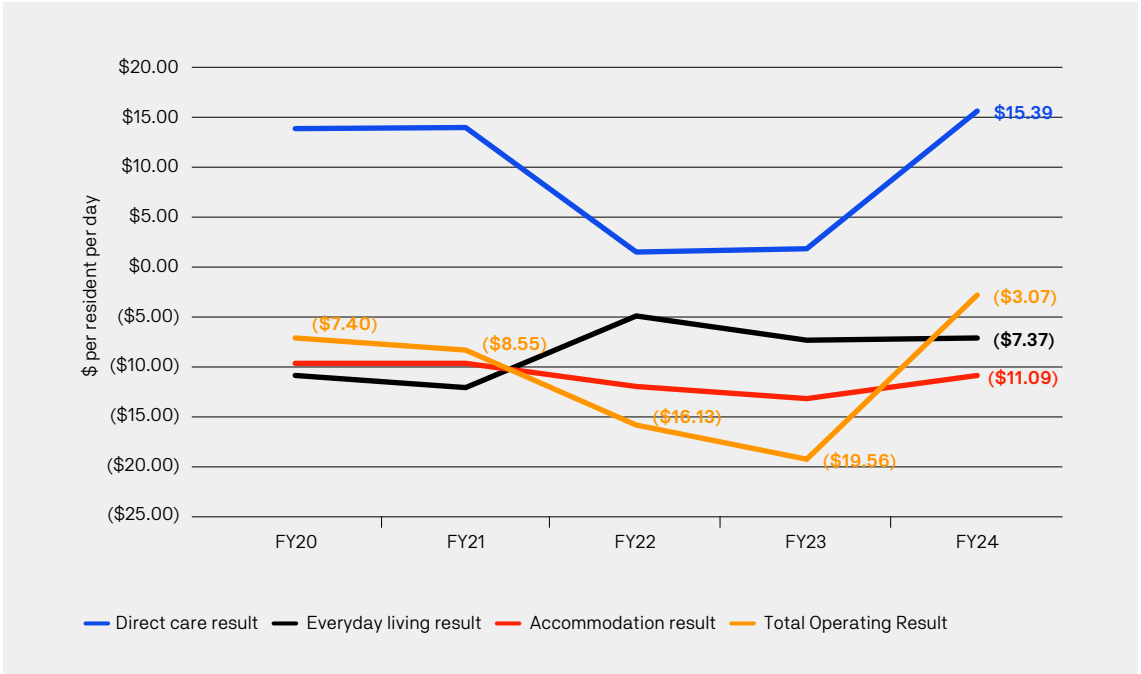
135. StewartBrown (2024) *Aged Care Financial Performance Survey Report June 2024.*

Overall, Figure 30 shows that in 2023-24, homes' average deficit of $3.07 per resident per day comprised a surplus ($15.39 per resident per day) from direct care services that were offset by ongoing losses for everyday living services (a deficit of $7.37 per resident per day) and accommodation (deficit of $11.09 per resident per day).

As discussed in UARC's 2023-24 mid-year report, this pattern is concerning in at least two respects. First, it suggests a reversion to a problematic pattern in the business model of residential care, where homes generate surpluses from direct care services (primarily taxpayer-funded) to cross-subsidise losses from everyday living and accommodation (two service areas generally considered to be areas of personal responsibility except for those in need of a safety-net).

Second, this business model is precarious because, as detailed in the Direct Care Staffing section in Part 1, the improved margins that many homes currently earn from direct care derive primarily from a misalignment between the revenue received for staffing levels (i.e. higher AN-ACC funding) and their direct care staffing levels. Thus, direct care margins are likely to reduce as more homes lift their direct care staffing to meet their care minute targets.

Figure 30: Service area revenue and expenditure, per resident per day



Direct care

The average direct care result in 2023-24 was much higher than in recent years.[136] On average, homes earned $15.39 per resident per day from direct care services (equivalent to 5.6% of direct care revenue), compared to a more modest margin of $1.58 (0.7% of direct care revenue) for the same period the year prior.

This improvement has been driven by a substantial increase in direct care revenues. As shown in Table 9, in 2023-24, homes, on average, earned $276.40 per resident per day in direct care revenue, 28.7% more than the same period the year prior ($214.74). This growth is attributable primarily to the increases in the AN-ACC base price during 2023-24 to fund the Stage 2 FWC 15% pay increase for direct care workers, increases in the Superannuation Guarantee, indexation for forecast inflation and the annual national award rate increase.[137] It also reflects funding for the mandatory care minute requirements and the 24/7 registered nurse supplement for eligible homes.

There has also been a modest increase in AN-ACC funding resulting from the gradual increase in the complexity of residents' assessed care needs over time. For example, as of June 2023, the average service-level target for total direct care time for homes in the StewartBrown dataset was 201.4 minutes per resident per day. Twelve months later, this had grown 1.8% to 205.0 minutes (June 2024).

136. The Direct Care Result represents the net difference between revenue and costs directly associated with care services. It includes direct care subsidies, supplements and grants from the Government and means-tested care fees) revenue less total direct care costs, and this includes an allocation of workers' compensation and quality and education costs, as well as an allocation of 37.0% of homes' administration costs.

137. The Independent Health and Aged Care Pricing Authority (2023), *Residential Aged Care Pricing Advice 2023–24*.

Residential aged care homes

Table 9: Detailed financial results, per resident per day

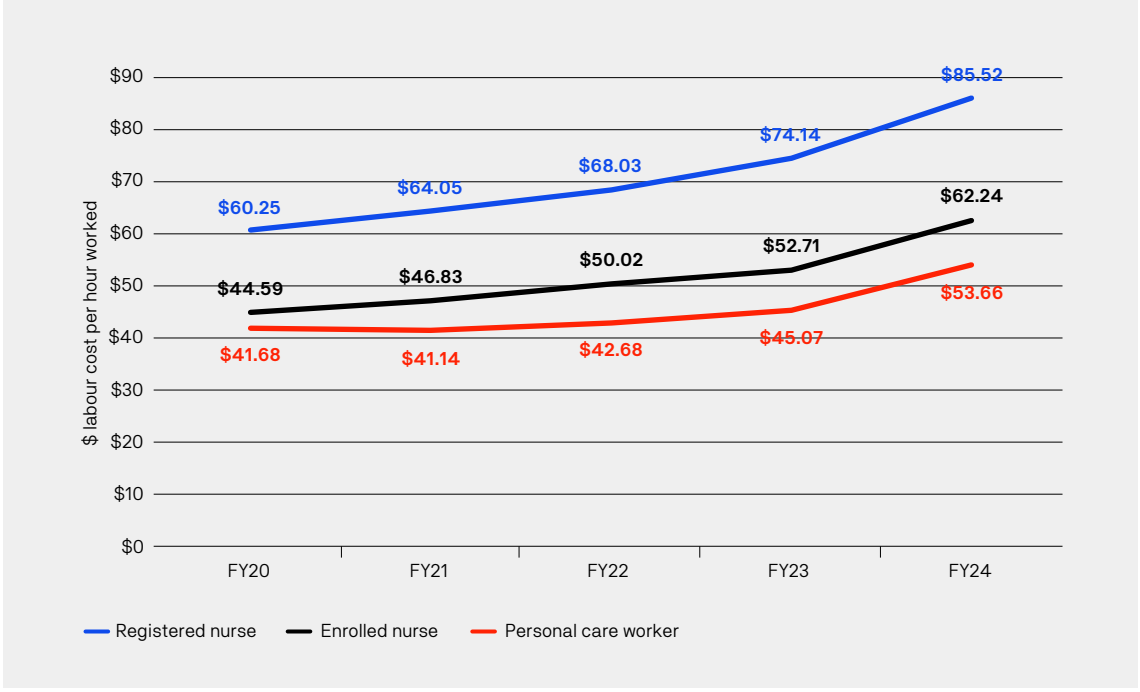
	FY23	FY24
Direct Care		
Direct care revenue:		
Residents	$6.55	$7.16
Government	$208.18	$269.24
Total direct care revenue	$214.74	$276.40
Direct care expenditure:		
Direct care labour costs	$161.32	$207.75
Other labour costs	$26.31	$25.00
Other direct care costs	$7.95	$9.11
Allocation of administration costs (37.0%)	$17.59	$19.15
Total direct care expenditure	$213.17	$261.01
Direct Care Result	**$1.58**	**$15.39**
Everyday Living		
Everyday living revenue:		
Residents	$59.99	$64.53
Government	$9.98	$11.08
Total everyday living revenue	$69.97	$75.62
Everyday living expenditure:		
Catering	$37.70	$40.59
Cleaning	$10.34	$10.65
Laundry	$4.58	$4.81
Utilities	$7.90	$8.43
Other	$1.09	$1.11
Allocation of administration costs (33.6%)	$15.98	$17.39
Total everyday living expenditure	$77.59	$82.98
Everyday Living Result	**($7.63)**	**($7.36)**
Accommodation		
Accommodation revenue:		
Residents	$14.54	$16.26
Government	$24.92	$25.72
Total accommodation revenue	$36.43	$41.98
Accommodation expenditure:		
Depreciation	$20.56	$21.50
Property maintenance and rental	$13.71	$14.61
Other	$1.68	$1.75
Allocation of administration costs (29.4%)	$13.97	$15.21
Total accommodation expenditure	$49.92	$53.07
Accommodation Result	**($13.49)**	**($11.09)**
Operating Result (per resident per day)	**($19.56)**	**($3.07)**
Total revenue (per resident per day)	**$321.14**	**$394.00**
Total expenditure (per resident per day)	**$340.68**	**$397.06**

*Accommodation revenue from residents only includes daily accommodation payments (DAPs) and does not include imputed interest relating to Refundable Accommodation Deposits (RADs)

Homes' direct care expenditure has also grown year-on-year, albeit not at the same pace as revenue. In 2023-24, homes incurred an average of $261.01 per resident per day, equivalent to 94.4% of direct care revenue.[138] Most of this expenditure (80.0%) relates to direct care staff's wage and salary costs, which have grown as the quantum of staffing has increased to meet the care minute and 24/7 registered nurse requirements, and the average hourly labour cost has risen.

At the same time, expenditure on other types of direct care labour has contracted per resident per day (from $26.31 in 2022-23 to $25.00 in 2023-24). As explored later in the Workforce section, this reflects an emergent trend in the staffing mix within aged care homes, potentially as an unintended consequence of the recent funding incentives and input controls regarding direct care staffing.

Figure 31: Median labour cost per worked hour, by direct care role



The rise in direct care wages is evident in Figure 31, which shows the long-term trends in the median labour cost per hour worked across the three main direct care roles.[139] This shows how direct care labour rates have continued to increase, particularly in the last year as the Stage 2 pay increases came into effect. For example, in 2023-24, the median hourly cost for registered nurses ($85.52) was 15.3% higher in nominal terms than in 2022-23 ($74.14).

138. The direct care expenses ratio is calculated by dividing total direct care costs by total direct care revenue.

139. These estimates include wages and salaries, on-costs, such as mandatory superannuation contributions, leave provisions and casual loadings, penalty rates paid for overtime, and contract costs of agency and externally contracted staff.

The rates in Figure 31 include both internal and agency staff. The continued reliance on agency staff in 2023-24 (detailed later in the Workforce section) places upward pressure on direct care staffing costs. As shown in Table 10, in 2023-24, the median hourly rates of agency staff were substantially higher than internal staff. For example, agency registered nurses' median hourly labour rate ($119.49) was 45.8% more than internal registered nurses ($81.97). Homes will incur particularly high rates for agency registered nurses if they rely on these staff to fill shifts outside regular working hours (e.g. evenings and night shifts, weekends and public hours) to comply with the 24/7 registered nurse requirement.

Table 10: Median hourly labour cost per worked hour, internal and agency staff

	Internal staff	Agency staff	Difference (%)
Registered nurse	$81.97	$119.49	45.8%
Enrolled nurse	$60.47	$83.38	37.9%
Personal care worker	$52.56	$70.75	34.6%

Homes will incur particularly high rates for agency registered nurses if they rely on these staff to fill shifts outside regular working hours (e.g. evenings and night shifts, weekends and public hours) to comply with the 24/7 registered nurse requirement.

Everyday living

As shown in Figure 30, the poor outcomes from everyday living services have persisted over the longer term. In 2023-24, the average Everyday Living Result was a deficit of $7.36 per resident per day, equivalent to negative 9.7% of everyday living revenue.[140] This result is similar to the deficit of $7.63 per day in 2022-23 (negative 10.9% of revenue). These losses are despite the introduction of a publicly funded supplement paid for all residents, which the Government introduced in July 2021 at an initial rate of $10 per resident per day.

On average, everyday living revenue has grown 8.1% compared to the prior year. This growth is attributable to the indexation of the basic daily fee (set at 85% of the Age Pension, which is indexed by the higher of either the consumer price index or living cost index) and the bi-annual revision of the hotelling supplement.[141] In addition, there has been a gradual increase in the average revenue earned by some providers from additional services. For example, in 2019-20, homes, on average, earned $1.95 per resident per day in additional services fees; by 2023-24, this has grown to $3.47.

Despite revenue growth, comparable increases in everyday living expenses have sustained the losses homes incur on these services. Food and catering comprise the bulk of this expenditure, averaging $40.59 per resident per day, followed by administration ($17.39), cleaning ($10.65) and utilities ($8.43). As discussed in the Financial Viability section in Part 1, the proposed increase in the hotelling supplement for 2024–25 is likely to still lead to a funding shortfall.

The newly passed Aged Care Act 2024 will see a restructuring of everyday living funding, including means-testing the hotelling supplement (see Aged Care Taskforce response in Part 1). The aim is to place the responsibility for these services, such as food, cleaning and utilities, on those who can afford to do so and have done so throughout their lives. At the same time, taxpayers will continue supporting those on low incomes by supplementing their payments from their pensions.

140. The Everyday Living Result includes revenue from the Basic Daily Fee, the hotelling supplement and extra or additional service fees. The main cost categories include hotel services (catering, cleaning, laundry), utilities, motor vehicles and regular property and maintenance (including allocation of workers' compensation premium and quality and education costs to hotel services staff). The Everyday Living Result also includes an allocation of 33.6% of homes' administration costs.

141. The Independent Health and Aged Care Pricing Authority (2023), *Residential Aged Care Pricing Advice 2023–24*.

Accommodation

Turning to the Accommodation Result,[142] homes lost an average of $11.09 per resident per day providing accommodation services in 2023-24 (equivalent to negative 26.4% of accommodation revenue). Although this represents a modest improvement compared to the same period for 2022-23 (where homes lost an average of $13.49 per resident per day or 37.0% of accommodation revenue), this service type continues to represent the most significant area of concern within the business model of providing residential care. In large part, it reflects provider behaviour in not setting accommodation values that would recover their costs and government behaviour in not setting a sufficient level of funding for the accommodation supplement it pays on behalf of those in need. There are also longstanding concerns about how accommodation financial performance is measured, including how RADs are taken into account when calculating their operating revenue earned from accommodation services.

The 2023-24 improvement is mostly attributable to increases in average revenue due to increases in the Maximum Permissible Interest Rate (MPIR), noting that there may also be an effect from a changing payment mix between lump sums (RADs), daily payments (DAPs) and combinations. The MPIR rate calculates the value of newly admitted private-paying residents' DAPs. In July 2022, the MPIR was 5.00%; by June 2024, it had grown to 8.34%.[143] The value of DAPs has also increased as providers have continued to increase the price of their accommodation.[144]

Table 9 shows accommodation services generate losses because current revenue settings are inadequate to cover the total accommodation cost (including administration expenses). Also, even though depreciation is one of the most significant cost categories (averaging $21.50 per resident per day), it likely understates the actual cost of replacing or refurbishing physical infrastructure.[145]

The Government has accepted the Aged Care Taskforce recommendations to enhance the financial viability of accommodation services. The Aged Care Act 2024 provides for a Refundable Accommodation Deposit (RAD) retention fee, which permits providers to retain 2% of the RAD value per annum for up to five years. For instance, with the current median RAD value of $468,365, a provider could retain approximately $9,368 annually, equating to about $26.66 per day. This retention fee applies exclusively to new non-supported residents who pay their accommodation costs via a lump sum.

For new non-supported residents opting for the Daily Accommodation Payment (DAP), the payment amount will no longer be fixed at the time of entry but will instead be indexed biannually. This change aims to ensure that payments remain aligned with economic conditions over time.

For residents whose accommodation is subsidised by the Government, the accommodation supplement will be reviewed as part of an Independent Accommodation Pricing Review, which is now scheduled to report by June 2026. A key outcome of this review will be to ensure the supplement is calibrated appropriately, minimising funding disparities between residents of differing financial means.

142. The Accommodation Result shows the net difference between accommodation revenue earned from daily accommodation payments made from non-supported or partially supported residents, and government supplements for supported residents, and expenses related to capital items such as depreciation, property rental and refurbishment costs. The Accommodation Result also includes an allocation of 29.4% of homes' administration costs.

143. Base interest rate (BIR) and maximum permissible interest rate (MPIR) for residential aged care.

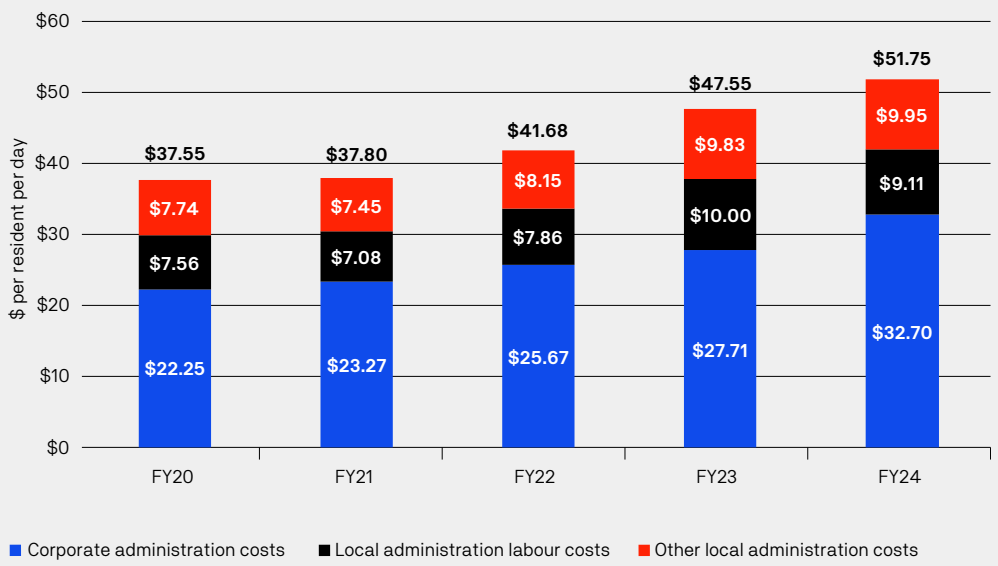
144. For example, in 2023-24, the median value of a new RAD was $468,365 compared to $452,807 in 2022-23.

145. The most significant accommodation-related cost is depreciation and amortisation, which is reflective of changes in homes' asset bases (i.e., through new or refurbished infrastructure) and accounting policies. While a minority of providers revalue their property assets, most depreciate based on cost. Of those, most providers depreciate based on 30-40 years of useful life, although a mid-life refurbishment is likely to occur after about 15-20 years.

Administration expenditure

The above analysis allocates administration expenditure to calculate the net results for direct care, everyday living and accommodation. Figure 32 shows the trend in the underlying expense items included in this allocation. In 2023-24, total administration costs were, on average, $51.75 per resident per day. In nominal terms, this is 8.8% higher than the average administration costs in 2022-23 and 37.8% higher than the same period in 2019-20. This growth appears to have been driven by growth in corporate more than local administration costs.[146]

Figure 32: Administration expenditure, per resident per day



146. 'Corporate administration costs' represent an apportion of the provider's corporate head office costs or organisation-wide administration costs; 'local administration labour costs' represent the wages and on-costs for administration and clerical staff employed directly by the residential care home; and 'other local administration costs' include all other administration costs, including quality, education & compliance costs, workers' compensation, other insurance, payroll tax, fringe benefits tax, advertising for staff, accounting fees, accreditation costs, audit fees, computer expenses, consulting fees, general expenses, legal fees, postage, printing, recruitment, subscriptions, telephone and travel costs.

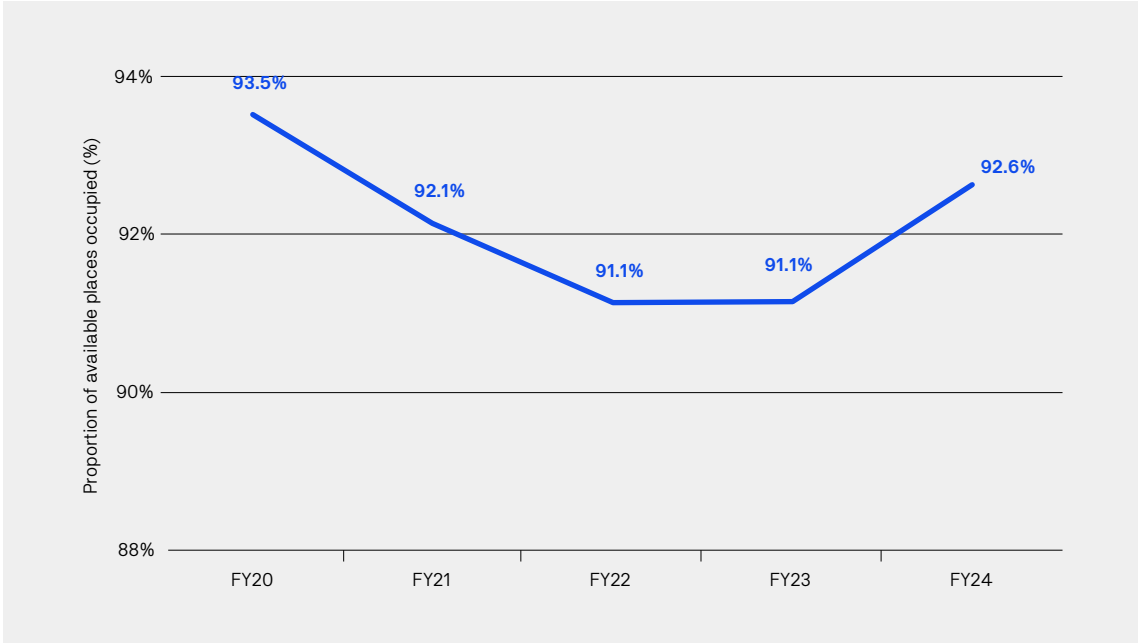
Occupancy

Occupancy is an important indicator within the residential aged care sector, reflecting the expressed demand for residential aged care relative to its supply.

As shown in Figure 33, the average occupancy rate across all mature homes in the StewartBrown dataset has increased to 92.6% in 2023-24.[147] Although this is still lower than rates reported five years ago, it represents an increase of 1.5 percentage points compared to the same period the previous year.

The improvement in occupancy likely reflects the return of demand for residential care, potentially as negative community perceptions ease, consumer information through Star Ratings improves, and direct care staffing increases. It may also be influenced by the increased wait times for home care packages, as described in UARC's 2023-24 mid-year report.[148]

Figure 33: Occupancy rate



Future occupancy rates will likely reflect the interaction between various supply and demand factors for residential care, including the increased availability of home care packages and the abolition of supply-side residential care restrictions with the formal end of ACAR on 1 July 2025. However, the current falling rates of refurbishment and new builds will need to be reversed if supply is to keep up with long term growth in demand.

147. Occupancy measures the rate at which an aged care home's places are used (i.e., occupied) by a resident. In the StewartBrown dataset, occupancy is calculated in terms of the available places, which excludes places that have been allocated but are not operational. This measure of occupancy differs from the estimates published by the Department, which measures occupancy as the proportion of total allocated places, including those that might not be operational.

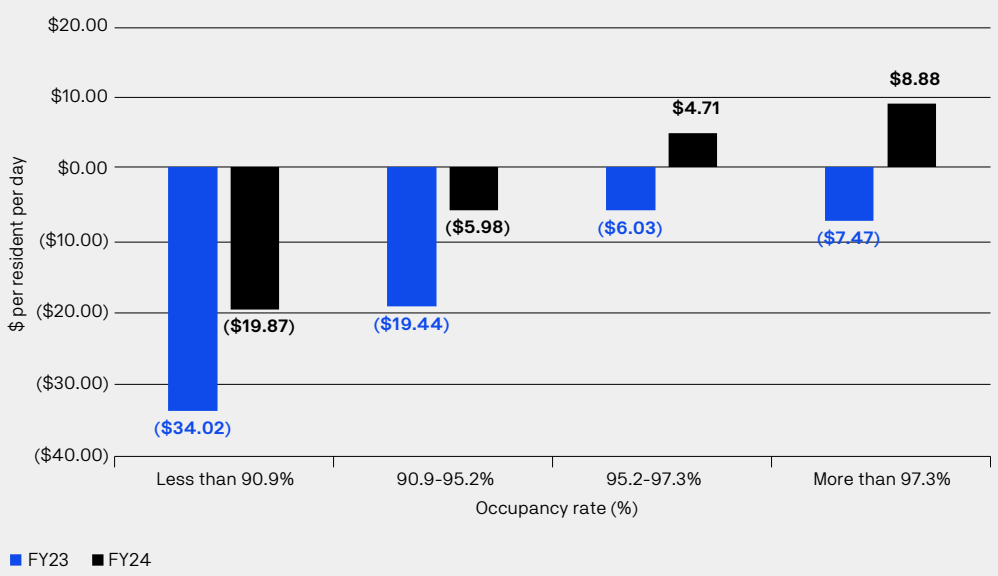
148. Sutton, N., Ma, N., Yang, J.S., Woods, M., Tsihlis, E., Brown, D., Debono, D., Ries, N. (2024) *Australia's Aged Care Sector: Mid-Year Report (2023-24).* UTS Ageing Research Collaborative.

Long-term demographic projections indicate that the demand for residential aged care will continue to grow as the number of older Australians with complex care needs, such as dementia, increases over time.[149] In that context, there are concerns that if occupancy rates continue to increase, prospective residents may encounter more difficulty finding available services that meet their needs in their local areas, which could put further pressure on informal carers or other health services.

There are also important financial implications of this trend. Occupancy is a critical driver of homes' financial performance. This is because while homes' revenue is highly sensitive to short-term changes in occupancy and resident mix, most of the costs involved in delivering residential aged care are fixed, at least over the short- to medium-term.[150]

In this context, the improvement in the financial results reported in the previous section is at least partially attributable to the improvement in average occupancy rates in 2023-24. However, while higher occupancy enables fixed costs to be spread over more residents, it also puts pressure on staffing by increasing the staff required to meet care minute requirements.

Figure 34: Operating Result, per resident per day, by occupancy rate



The relationship between occupancy and financial performance is evident in Figure 34. This figure shows the average Operating Result (per resident per day) of homes split by different occupancy rate ranges. In 2023-24, homes with the highest occupancy rates (more than 97.3%) had an average operating surplus of $8.88 per resident per day, while homes with the lowest occupancy rates (less than 90.9%) had an average operating loss of $19.87 per resident per day.

Furthermore, Figure 34 reinforces the improvement in the financial outcomes of the sector more generally. At all occupancy levels, homes achieved a higher average Operating Result than in 2022-23.

149. Commonwealth of Australia (2023), *Intergenerational Report 2023: Australia's future to 2063.*

150. These include costs of the physical infrastructure, administration and compliance, all of which must be incurred regardless of the number of places occupied. Furthermore, unless there is a significant and ongoing shift in residents' needs or occupancy, homes find it difficult to alter the configurations and costs of their staff.

Workforce

The aged care workforce is a crucial determinant of the quality and safety of residential care services. It also significantly impacts the financial performance of facilities, with staffing expenses representing the largest component of operational costs.

Table 11 shows the average staffing time by role, measured as minutes per resident per day. Overall, there has been a modest increase in the total staffing time compared to the year before. There has been a 7.4% increase in direct care staffing time[151] (i.e. registered nurses, enrolled nurses and personal care workers), which averaged 203.6 minutes per resident per day in 2023-24. This comprised uplifts in registered nurses and personal care workers but also a further slight decline in the staffing minutes of enrolled nurses. However, there also has been a 14.3% contraction in the average staffing time of other care roles per resident per day (care management, allied health, lifestyle) and a 4.4% reduction for everyday living, accommodation and administration.

Table 11: Average staffing time, minutes per resident per day

	FY23	FY24
Number of homes in dataset (workforce analysis)	1,137	1,154
Direct care		
Registered nurses	33.0	39.8
Enrolled and licensed nurses	12.6	11.5
Personal care workers/other unlicensed care staff	144.0	152.3
Total direct care staffing time	189.6	203.6
Other care		
Care management	6.2	4.6
Allied health	5.6	4.5
Lifestyle	7.0	7.0
Total other care time	18.9	16.2
Everyday living, accommodation and administration		
Hotelling	41.4	40.6
Maintenance and accommodation	3.8	4.4
Administration	10.6	8.4
Quality and education	1.2	1.1
Total everyday living, accommodation and administration time	57.0	54.5
Total staffing time	265.5	274.2

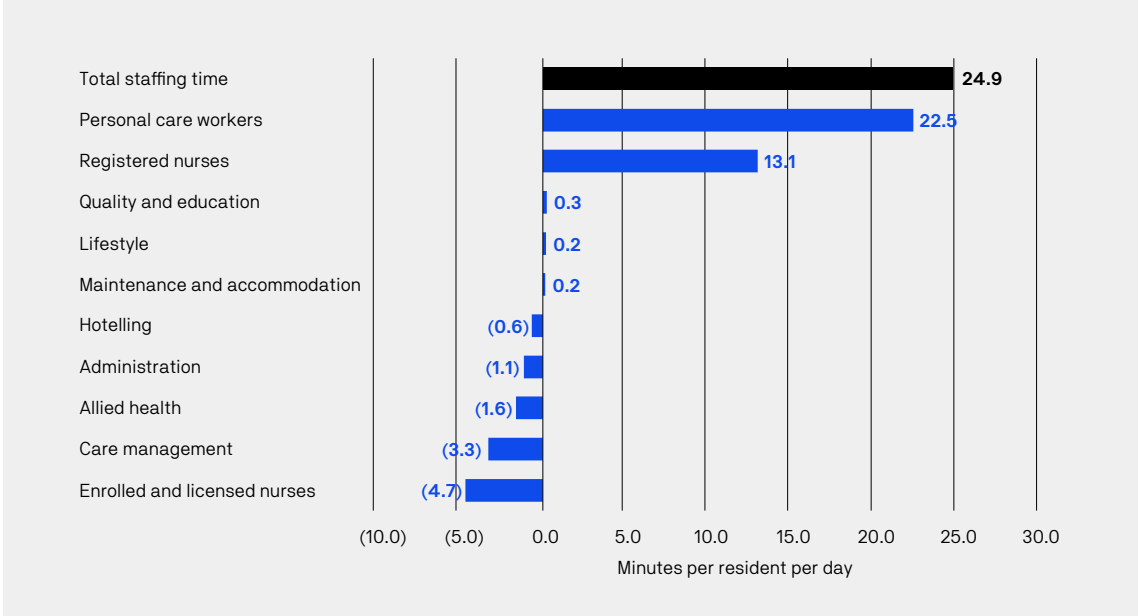
151. Direct care time measures the staffing hours (both normal and overtime) of registered nurses, enrolled nurses, and personal care workers. To allow comparisons between homes, it is measured as an average number of minutes per resident per day. It does not measure the actual time spent with each resident but provides an approximation based on the total normal and overtime hours worked by staff and the total number of residents.

The recent change in average staffing time of non-direct care roles may be partly attributable to the abovementioned occupancy changes. Several of these classifications are relatively fixed roles (i.e. a certain number of full-time equivalent staff), so the average rate per resident per day will decline as occupancy increases.

However, these recent changes also reflect a longer trend regarding the homes' staffing mix. Figure 35 shows the modelling of the change in the average staffing minutes per resident per day since 2020-21. In the three years since, there has been growth in the average time of personal care workers (22.5 minutes per resident per day) and registered nurses (13.1 minutes), likely driven by the Government's design of the input-based funding arrangements, which require specified categories of staffing to meet care minute mandates and the 24/7 registered nurse requirement.[152]

Equally, at the other end of the scale, there has been a decline in the average time of enrolled nurses (4.7 minutes), care managers (3.3 minutes) and allied health (1.6 minutes).

Figure 35: Change in average staffing time, per resident per day, since 2020-21



These changes may appear small when measured as minutes per resident per day, but when extrapolated to the size of the whole sector, they indicate substantive shifts in the aged care workforce. For example, based on the number of residents in aged care homes nationally, these changes represent 15,533 FTE additional personal care worker roles and 9,009 FTE additional registered nurses. More soberingly, they also suggest a contraction of 1,102 FTE allied health roles, 2,281 FTE care management roles and 3,228 FTE enrolled nurses.[153]

152. From 1 July 2023, all homes have been required to always have a registered nurse on duty. In terms of the care minute targets, on average, homes across the sector are expected to provide at least 200 minutes of direct care per resident per day, with at least 40 of those minutes provided by a registered nurse from 1 October 2023. Each individual home's service-level care minutes targets dependent on the relative care needs of its residents, as assessed under AN-ACC. Homes with a higher proportion of residents with more complex needs will have higher care minutes targets (for both total direct care and registered nurses), and vice versa for homes with residents with less complex needs.

153. These estimates were calculated assuming there are 198,362 residents in residential aged care (as of 30 June 2024), and that a full-time equivalent worker role was equivalent to 1,748 hours a year (i.e. comprised of 38 hours per week, with 20 days per annum annual leave and 10 days sick leave).

The change in care management may reflect the effect of changes in occupancy (see above) as well as some reclassification effects, where care managers (who also include clinical managers and care coordinators) may be recorded as having more involvement in direct care as registered nurses to meet care minute targets. However, these results reinforce concerns that resource-constrained homes have had less incentive to maintain staffing in other roles with the tightening policy for direct care roles.

The effects of those policy changes are also evident in Figure 36, which shows the increase in both personal care worker time and registered nurse time, particularly since the AN-ACC funding model was introduced and the minimum staffing requirements became mandatory.

The 2023-24 results show that the homes in the StewartBrown dataset reported average direct care staffing levels on par with the sector-level averages prescribed by the minimum staffing standards. Nonetheless, as discussed in Part 1, many aged care homes still lag behind their service-level targets.

Figure 36: Direct care staffing, per resident per day, by role

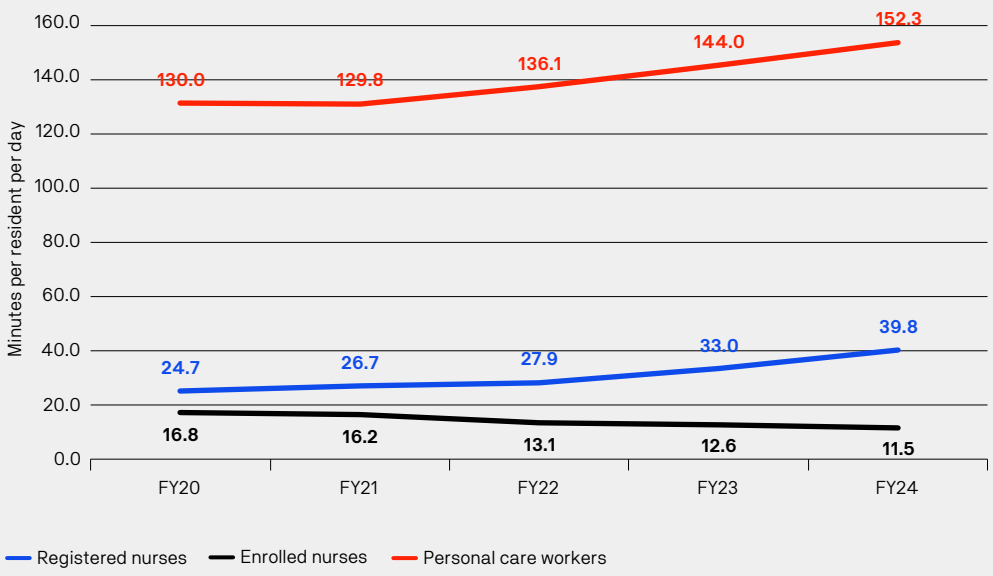
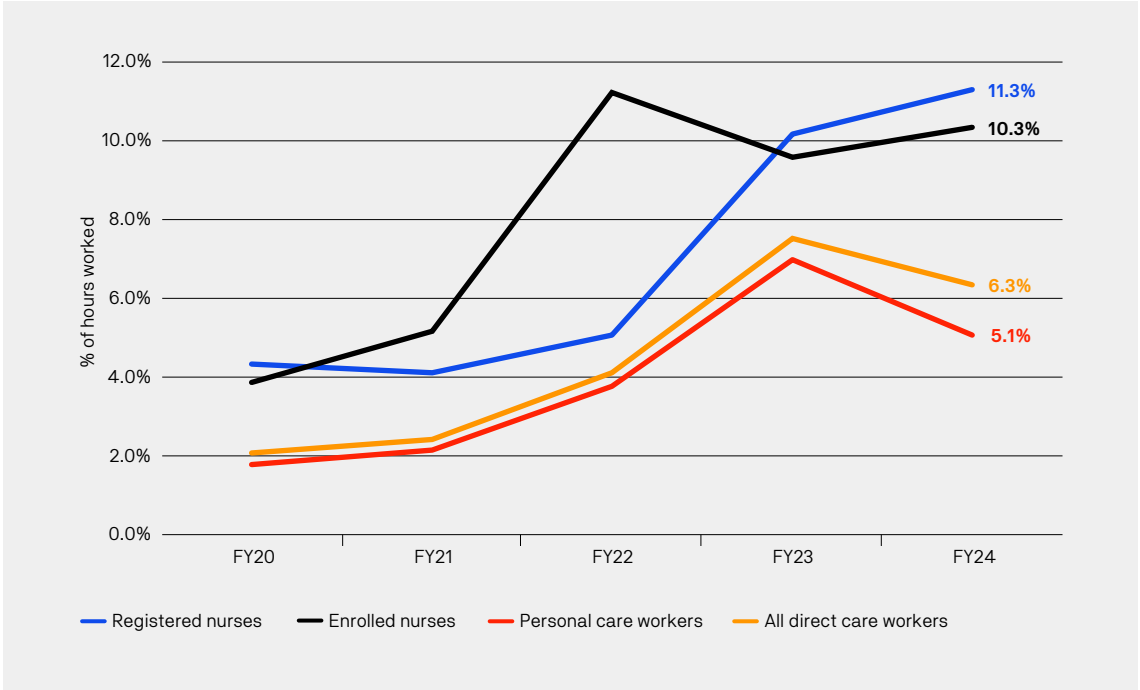


Figure 37: Agency staffing as a proportion of total direct care time



Another critical workforce trend over the past five years has been the increased reliance on agency staffing to fulfil direct care roles. As shown in Figure 37, agency staff comprised less than 2.1% of direct care staffing time in 2019-20, but it now averages 6.3%. The increased reliance on agency nurses is likely symptomatic of the challenges homes have faced in recruiting and retaining appropriately qualified registered nurses to meet the 24/7 and care minute requirements.

By comparison, over the last year, there has been a fall in the proportion of agency personal care workers, which indicates that the recent expansion of personal care worker time to meet the care minute targets has largely been filled by internal workers.

Results by location

Although most residential aged care homes are in major cities in Australia, close to 40% are in regional, rural or remote locations.[154] This geographic spread is essential in ensuring the accessibility of services to older Australians across the country. However, due to varying local conditions (e.g., demand for services, availability of workers, costs of supplies, socio-demographic factors and real estate values) and differences in government funding models and policies, homes in different locations tend to have different financial and workforce outcomes.

This report analyses these differences by examining the outcomes of homes classified using the MM remoteness classification, which the Department uses to determine various subsidies and supplements for residential care services.[155] Due to sample size restrictions, we have grouped homes in areas MM5, 6 and 7 together.

Table 12: Key performance indicators of residential aged care homes, by location

	Major city (MM1)	Regional (MM2)	Large rural (MM3)	Medium rural (MM4)	Small rural & remote (MM5-7)
Number of homes in sample	750	106	133	76	129
Average home size (number of places)	89	89	84	72	48
Operating Result (per resident per day)	$3.45	($15.12)	($12.45)	($24.26)	($8.90)
Operating Result (per bed per annum)*	$1,415	($4,637)	($3,659)	($7,435)	($3,010)
Operating EBITDA (per bed per annum)*	$8,904	$2,744	$3,054	$121	$3,353
Proportion of loss-making homes (Operating Result)	45.7%	62.3%	57.1%	69.7%	58.1%
Proportion of loss-making homes (EBITDA)	20.1%	42.5%	43.6%	38.2%	42.6%
Occupancy rate	93.5%	92.2%	91.6%	91.4%	89.8%
Supported resident ratio	45.4%	46.4%	46.0%	47.1%	48.7%
Average direct care revenue (per resident per day)	$272.54	$271.33	$271.25	$269.86	$312.15
Average direct care expenditure (per resident per day)	$255.00	$262.60	$262.97	$267.22	$288.91
Direct care expense ratio	93.6%	96.8%	96.9%	99.0%	92.6%
Average direct care minutes (per resident day)	203.0	202.7	203.0	200.5	210.1
Average of full RADs held at reporting date	$472,466	$385,936	$369,355	$374,542	$335,507
Average of new full RADs taken during period	$511,730	$411,474	$402,097	$399,364	$357,236

* Per annum figures are the per resident per day result for 365 days adjusted for the occupancy rate.

154. Department of Health and Aged Care (2024), *Aged care data snapshot—2024, Second release*, Australian Institute of Health and Welfare
155. Modified Monash Model | Australian Government Department of Health and Aged Care.

Table 12 shows that similar to previous years, in 2023-24, aged care homes in rural and regional areas encountered more financial challenges than their metropolitan counterparts, with higher rates of loss-making, lower operating margins and lower occupancy. While homes in major cities (MM1) averaged a positive Operating Result ($3.45 per resident per day), homes in all other areas (MM2-7) delivered deficits (losses ranging from $8.90 – $24.26 per resident per day).

In particular, homes in medium rural towns (MM4) appeared to experience the highest rates financial distress. 69.7% of homes in these areas operated at a loss, with an average deficit of $24.26 per resident per day and an annual Operating EBITDA of just $121 per bed per annum. The poor financial performance of MM4 homes continues a pattern detailed in UARC's 2022-23 full-year report, which detailed the various funding and operational challenges that contributed to their acute financial viability issues.[156]

Figure 38: Operating Result, per resident per day, by location

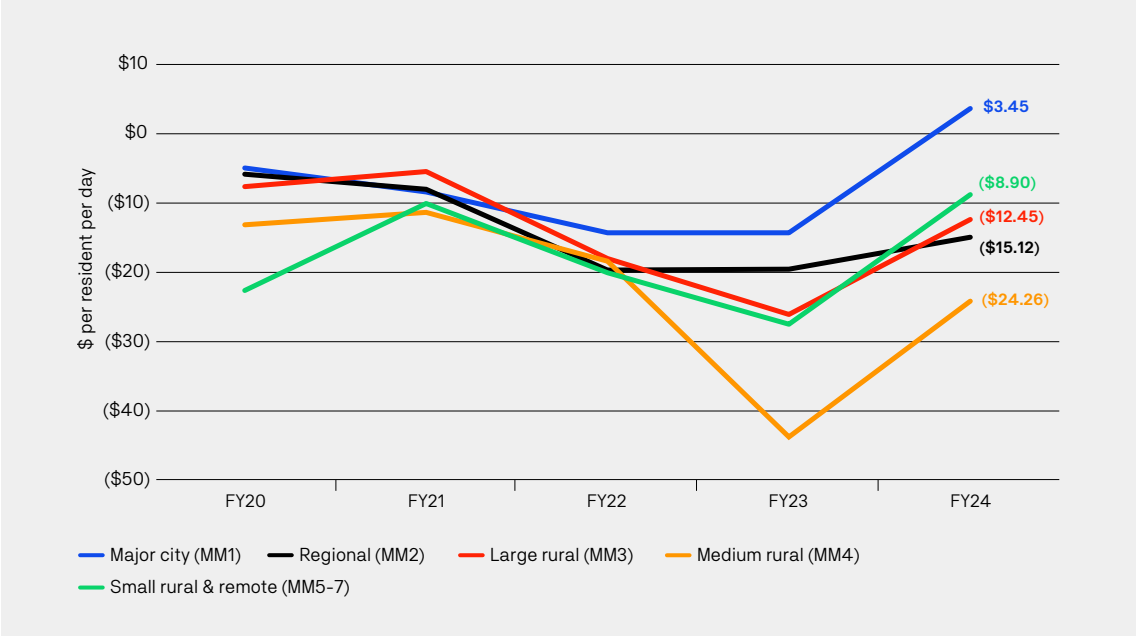


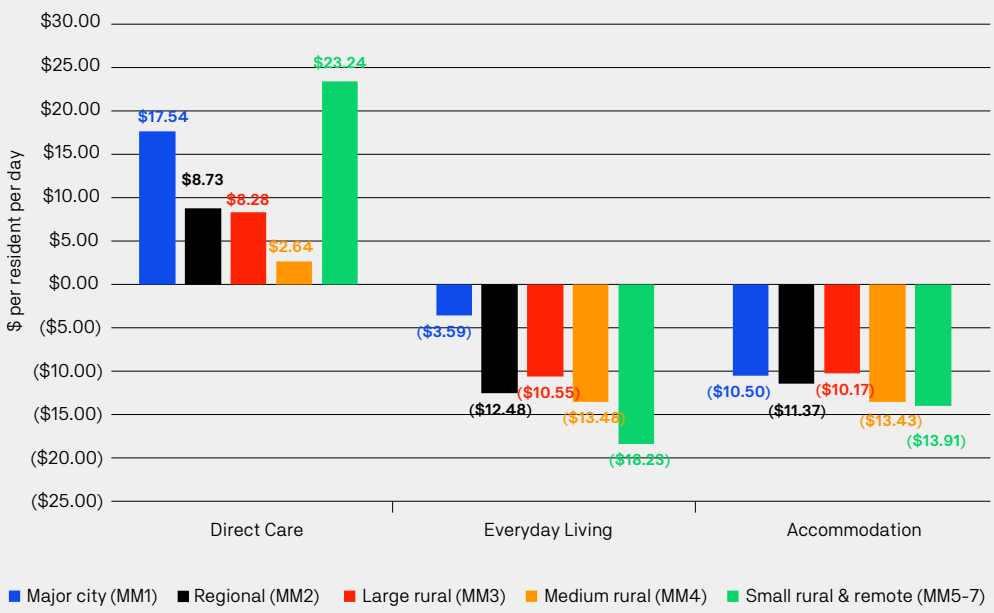
Figure 38 shows these results in the context of the longer-term trend, revealing the widening dispersion in the financial outcomes of metropolitan and non-metropolitan homes in recent years. Homes across all locations appear to have experienced a similar pattern since 2020-21 of declining financial performance, followed by a rebound in 2023-24, although with varying effects. For example, while homes in major cities (MM1) have now improved to their highest operating results in at least five years, the performance of homes in most other areas (MM2, 3, 4) is still below what it was in 2020-21.[157]

As a result, the gap between the average Operating Result of aged care homes in different locations is much wider than during the years directly affected by the COVID-19 pandemic. For example, in 2020-21, the average difference between MM1 and MM4 homes was only $3.00 per resident per day, whereas in 2023-24, it was $27.71 per resident per day.

156. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Woods, M., Tsihlis, E., Lin, J., Parker, D. (2023), *Australia's Aged Care Sector: Full-Year Report (2022-23)*, UTS Ageing Research Collaborative

157. The 2020-21 financial year also saw temporary improvement in most homes' financial performance due to the additional funding provided by the Government in response to the COVID-19 pandemic, particularly viability supports for non-metropolitan homes.

Figure 39: Financial results, per resident per day, by service area and location



The dispersion of financial results in 2023–24 can be further analysed by examining differences in homes' average outcomes across the three service areas (see Figure 39).[158] This analysis reveals that homes in major cities consistently achieve better financial outcomes than those in non-metropolitan areas. The only exception is in direct care, where homes in MM5–7 areas perform better, largely due to the impact of the BCT funding and the 24/7 registered nurse supplement.

With the exception of direct care results for MM5–7 homes, average financial outcomes deteriorate as remoteness increases across all service areas. For instance, homes in MM4 areas consistently report poorer average outcomes compared to those in MM2 or MM3 for direct care, everyday living, and accommodation services.

The regional differences are most pronounced in direct care and everyday living, whereas the variations in accommodation services are comparatively smaller.

Significantly, changes to the BCT funding in the AN-ACC model for 2024-25 will likely reduce the regional disparities in financial outcomes, particularly for direct care (see Part 1 of this report).

158. As in the Operating Result breakdown analysis earlier, these results show the net revenue and expenses for each area, including the allocation of overhead.

Table 13: Detailed financial results, per resident per day, by location

	Major city (MM1)	Regional (MM2)	Large rural (MM3)	Medium rural (MM4)	Small rural & remote (MM5-7)
Number of homes in dataset	757	103	130	85	122
Direct Care					
Direct care revenue:					
Residents	$7.86	$5.41	$5.89	$6.26	$6.38
Government	$264.68	$265.92	$265.36	$263.60	$305.76
Total direct care revenue	$272.54	$271.33	$271.25	$269.86	$312.15
Direct care expenditure:					
Direct care labour costs	$202.87	$210.90	$209.48	$213.67	$228.27
Other labour costs	$24.35	$24.53	$25.18	$26.00	$28.41
Other direct care costs	$8.93	$8.24	$9.90	$8.34	$10.48
Allocation of administration costs (37.0%)	$18.85	$18.94	$18.41	$19.21	$21.75
Total direct care expenditure	$255.00	$262.61	$262.97	$267.22	$288.91
Direct Care Result	**$17.54**	**$8.73**	**$8.28**	**$2.64**	**$23.24**
Everyday Living					
Everyday living revenue:					
Residents	$65.78	$62.21	$63.08	$62.67	$61.81
Government	$11.10	$11.01	$11.08	$11.07	$11.03
Total everyday living revenue	$76.88	$73.22	$74.16	$73.74	$72.84
Everyday living expenditure:					
Catering	$39.27	$41.17	$42.06	$43.33	$44.62
Cleaning	10.51	10.44	$11.00	$11.18	$11.00
Laundry	$4.77	$4.86	$5.01	$4.84	$4.73
Utilities	$7.70	$10.95	$8.80	$9.25	$9.71
Other	$1.09	$1.07	$1.11	$1.17	$1.25
Allocation of administration costs (33.6%)	$17.12	$17.20	$16.72	$17.44	$19.75
Total everyday living expenditure	$80.46	$85.69	$84.70	$87.21	$91.06
Everyday Living Result	**($3.59)**	**($12.48)**	**($10.55)**	**($13.48)**	**($18.23)**
Accommodation					
Accommodation revenue:					
Residents	$16.93	$15.72	$14.94	$15.33	$14.71
Government	$25.59	$25.75	$25.49	$25.86	$26.65
Total accommodation revenue	$42.52	$41.46	$40.43	$41.19	$41.36
Accommodation expenditure:					
Depreciation	$21.90	$21.89	$20.24	$22.61	$19.52
Property maintenance and rental	$14.33	$14.39	$14.16	$15.02	$16.67
Other	$1.80	$1.51	$1.58	$1.72	$1.80
Allocation of administration costs (29.4%)	$14.98	$15.04	$14.63	$15.26	$17.28
Total accommodation expenditure	$53.02	$52.83	$50.60	$54.62	$55.27
Accommodation Result	**($10.50)**	**($11.37)**	**($10.17)**	**($13.43)**	**($13.91)**
Operating Result (per resident per day)	**$3.45**	**($15.11)**	**($12.44)**	**($24.26)**	**($8.89)**
Total revenue (per resident per day)	**$391.94**	**$386.01**	**$385.84**	**$384.79**	**$426.35**
Total expenditure (per resident per day)	**$388.48**	**$401.13**	**$398.27**	**$409.05**	**$435.24**

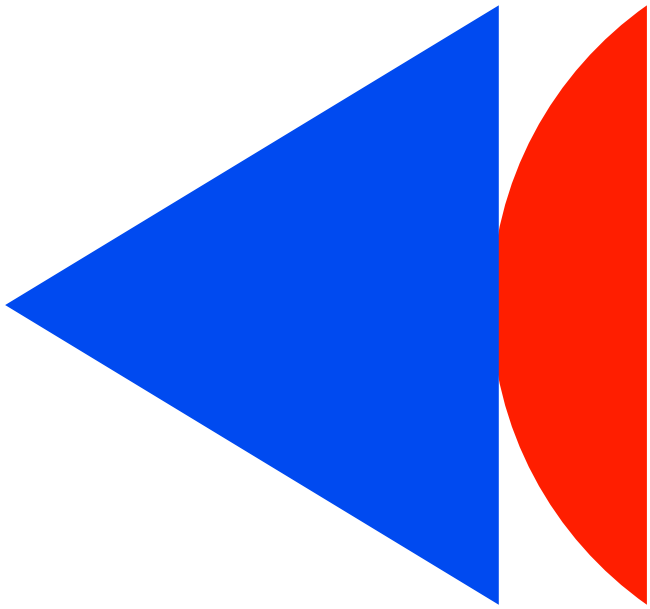
*Accommodation revenue from residents only includes daily accommodation payments (DAPs) and does not include imputed interest relating to Refundable Accommodation Deposits (RADs)

Residential aged care homes

In terms of everyday living, as Table 13 shows, all homes receive similar revenue from the basic daily fee and hotelling supplement. However, homes in major cities tend to earn more revenue from additional services, potentially reflecting differences in homes' capacity to offer these service offerings and in residents' financial capacity and willingness to pay. In addition, homes in major cities (MM1) tend to have lower average costs, particularly for catering, cleaning and utilities. While this will partly be driven by scale and occupancy effects (i.e. higher occupancy tends to deliver lower average costs), it could also reflect regional cost differences in providing everyday living services.

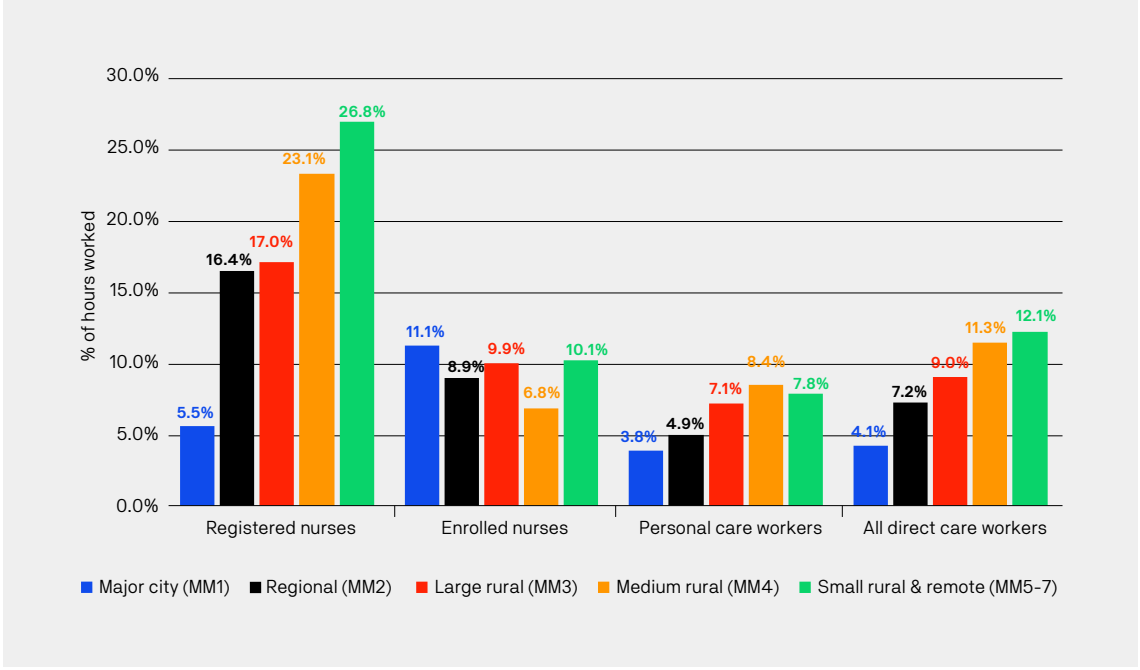
In terms of the direct care differences, as outlined in UARC's 2022–23 full-year report, some disparities can be attributed to revenue variations under the new AN-ACC funding model (see Part 1). For example, as Table 13 shows, homes in small rural and remote areas (MM5-7) earn much higher direct care revenue (averaging $312.15 per resident per day) compared to homes in other areas (ranging from $269.86 to $272.54).[159]

However, the regional differences in direct care outcomes extend beyond the funding model. There are also substantial disparities in the rates of direct care expenditure. For example, Table 13 shows that major city homes (MM1) have the lowest average spending on direct care ($255.00 per resident per day or 93.6% of direct care revenue). By comparison, the direct care expenditure of homes in medium rural towns (MM4) equals 99.0% of their direct care revenue, resulting in a much smaller direct care surplus.



159. Homes in these MM5-7 areas earn more fixed funding under AN-ACC through their higher BCT subsidy rates, particularly if they provide services to Aboriginal or Torres Strait Islander care recipients. In addition, the BCT paid to remote homes (MM6-7) is based on operational places rather than occupied bed days.

Figure 40: Agency Staffing as proportion of direct care hours, by role and location



These direct care outcomes partly reflect the differences in compliance rates with the care minute targets, as detailed in the Direct care staffing section in Part 1. However, it also reflects differences in the reliance on agency staff to fill direct care roles. Figure 40 shows that while agency staff work only 5.5% of the total registered nurse time in major city homes, they represent more than a quarter (26.8%) of all registered nurse time in small rural and remote communities (MM5-7). This pattern also exists for personal care workers but to a lesser degree.

Considering these results in conjunction with the regional differences in care minute compliance rates (see Figure 18 in Part 1), it would appear that homes outside major cities are meeting their care minute targets through greater reliance on agency staff.

Furthermore, this comes at a significant cost, as non-metropolitan homes also tend to pay a much higher hourly rate for agency staff than their city counterparts. For example, in 2023-24, the median hourly labour cost for agency registered nurses in major city areas (MM1) was $112.46 per hour, compared to a range of $131.42 - $134.13 in other areas. While homes in the MM5-7 regions have been able to cover these costs through higher BCT funding, up until now, homes in MM2-4 areas have been funded at rates similar to those in major cities despite their higher direct care labour costs.

To some extent, these regional disparities in direct funding vis-à-vis care costs are likely to be alleviated through the more granular BCT funding categories for 2024-25 (see Part 1). However, a more long-term structural issue remains regarding the sector's overall reliance on agency staffing to meet their legislative requirements, which is both costly and undermines the quality of care for residents.

Results by home size

In Australia, the size of residential aged care homes is measured by the number of operational places. Across the sector, the average home size is 85 places. However, this can range widely from as small as two places to as large as 333.[160]

Due to the many fixed costs of operations, homes' financial outcomes can vary widely by size, as explored below. However, as home size often correlates with their location (i.e. many smaller homes are located in non-metropolitan areas), these results should be read in tandem with those in the prior section.

Table 14: Key performance indicators of residential aged care homes, by home size

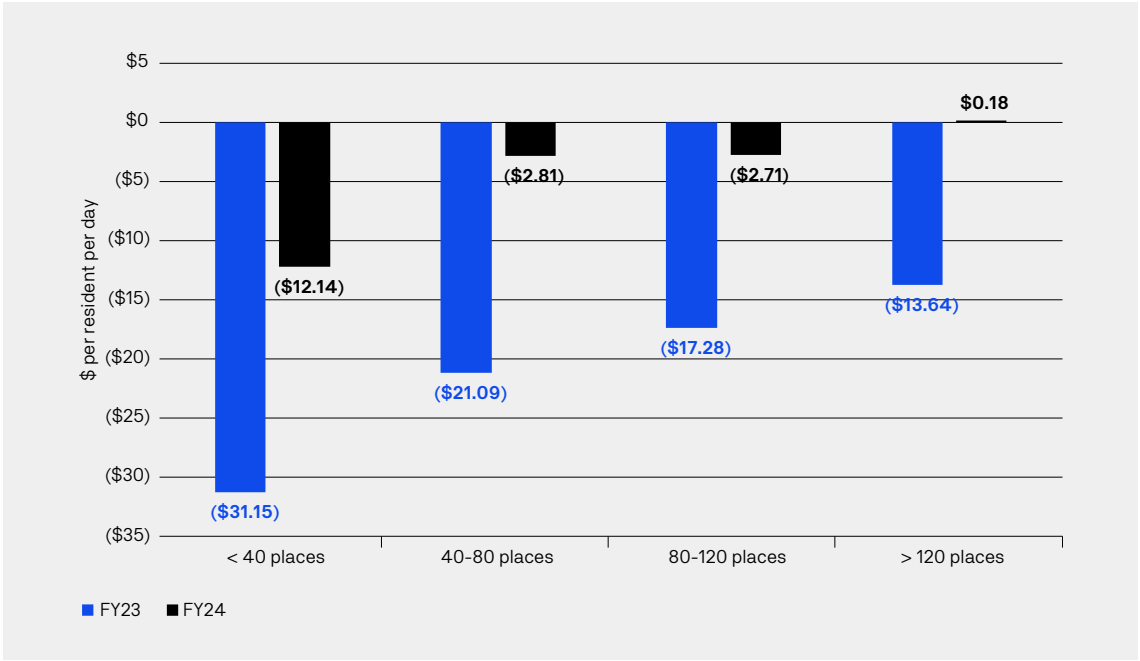
	<40 places	40-80 places	80-120 places	>120 places
Number of homes in dataset	101	515	378	200
Average home size (number of places)	29	59	97	146
Operating Result (per resident per day)	($12.14)	($2.81)	($2.71)	$0.18
Operating Result (per bed per annum) *	($4,035)	($654)	($537)	$386
Operating EBITDA (per bed per annum) *	$1,861	$6,216	$7,147	$8,627
Proportion of loss-making homes (Operating Result)	58.4%	50.9%	50.3%	51.0%
Proportion of loss-making homes (EBITDA)	43.6%	32.2%	24.1%	18.5%
Occupancy rate	90.9%	93.0%	92.8%	92.3%
Supported resident ratio	46.7%	48.4%	44.4%	42.8%
Average direct care revenue (per resident per day)	$314.35	$278.55	$268.53	$266.59
Average direct care expenditure (per resident per day)	$295.77	$262.03	$255.75	$250.76
Direct care expense ratio	94.1%	94.1%	95.2%	94.1%
Average direct care minutes (per resident day)	216.2	202.4	202.5	202.2
Average of full RADs held at reporting date	$355,309	$405,655	$453,028	$496,004
Average of new full RADs taken during period	$390,451	$443,400	$484,780	$529,407

*Per annum figures are the per resident per day result for 365 days adjusted for the occupancy rate.

Our analysis of homes of different sizes (summarised in Table 14) reveals that in 2023-24 the worst financial outcomes were concentrated within the homes in the smallest size bracket. On average, these homes (with fewer than 40 places) generated the most significant operating deficits and had the highest operating loss rates across surveyed homes.

160. Department of Health and Aged Care (2024), *Aged Care Service List—2024*, Australian Institute of Health and Welfare. Note that sector statistics are based on operational places, whereas the StewartBrown dataset reports the number of available places.

Figure 41: Operating Result, per resident per day, by home size



The plight of small homes is illustrated in Figure 41, which shows that in 2023-24, the smallest homes generated average losses of $12.14 per resident per day. By comparison, homes in the largest bracket (more than 120 places) achieved break-even results.

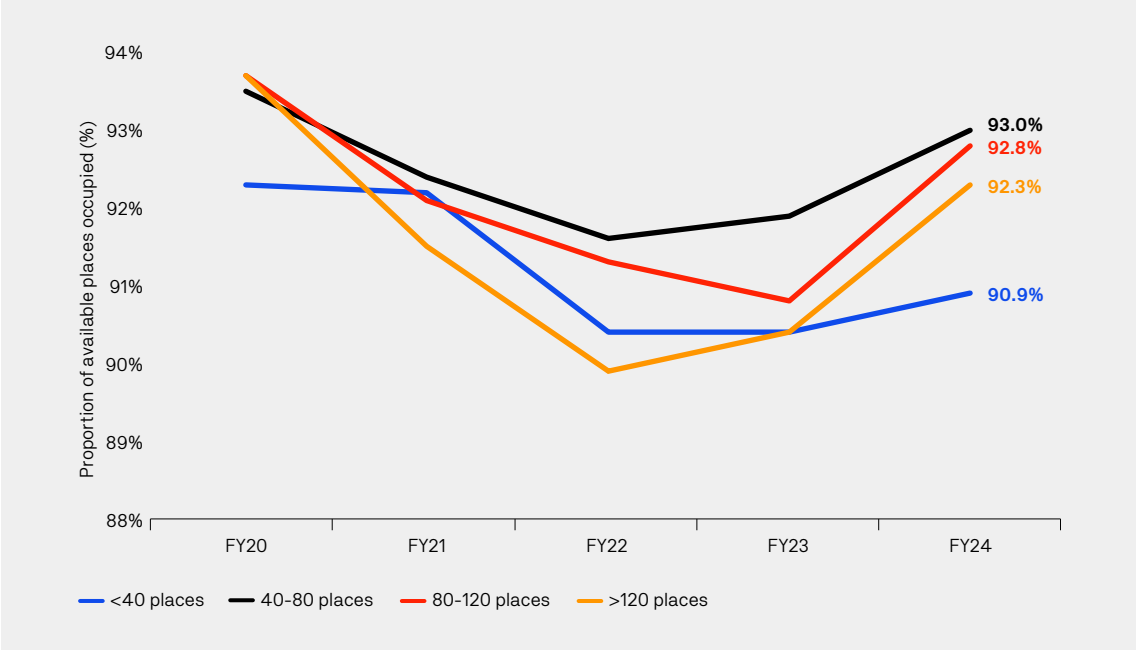
There appears to be a convergence in financial outcomes for the middle two size categories. While a clear gradient existed the previous year between financial results and home size, homes with 40 to 120 places now, on average, all report a similar modest deficit.

However, there appears to be some relative improvement for homes with 40 to 80 places when placed in the context of the 2022-23 results.

It should be noted that there is variation in the financial outcomes within some size categories, particularly for homes in 40 to 80 places. For example, in 2023-24, homes with 40 to 60 places had an average Operating Result of $2.98 per resident per day, whereas those with 61 to 80 places averaged a deficit of $7.46 per resident per day. Homes with up to 60 places have been eligible for the 24/7 registered nurse supplement that provides additional funding for smaller homes that comply with the 24/7 registered nurse requirement, with higher rates for those in MM5-7 areas.[161]

161. The 24/7 registered nurse supplement is applied to homes with up to 60 places, with higher funding provided for smaller homes. From 1 October 2024, the supplement will only apply to homes with up to an average of 50 residents.

Figure 42: Occupancy rate, by home size



One of the key drivers for the poor results of the smallest homes is their comparatively low occupancy rates (see Figure 42). While homes in the three larger size categories all experienced a sharp rebound in their occupancy rates in 2023-24 (up to 92.3-93.0%), the occupancy rates of small homes remained relatively stagnant at 90.9%.

These occupancy trends likely reflect differences in location. For example, 45.5% of homes with fewer than 40 places are located in MM5-7 areas, which tend to have lower occupancy (see previous subsection). By comparison, this percentage is much lower for bigger homes (i.e. 13.2% for 40 to 80 places, 3.7% for 80 to 120 places, and 0.5% for more than 120 places).

The low occupancy compounds the effects of small size on homes' average expenditure rates. Specifically, any fixed costs (such as having a registered nurse onsite 24/7) must be shared over fewer resident days. This pattern is evident in Table 15, which shows that the average total expenditure per resident per day is markedly higher for small homes ($441.02) compared to homes in the larger three size categories (ranging from $385.59 to $399.01). This pattern holds across all service areas, with the highest average expenditure for direct care, everyday living, accommodation and administration reported by the smallest homes.

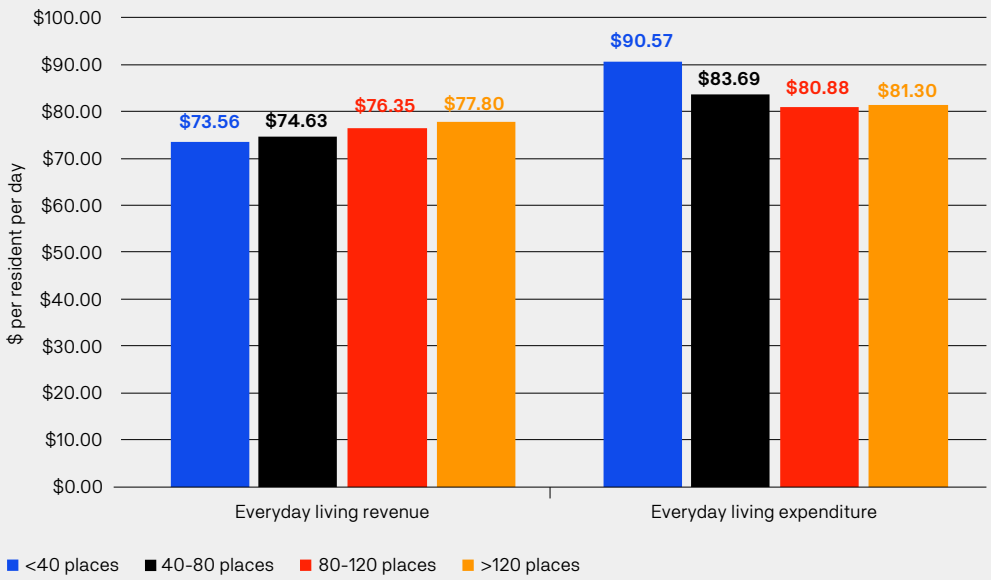
Table 15: Detailed financial results, by home size, per resident per day

	<40 places	40-80 places	80-120 places	>120 places
Number of homes in dataset	101	515	378	200
Direct Care				
Direct care revenue:				
Residents	$4.73	$6.10	$7.95	$9.61
Government	$309.62	$272.44	$260.57	$256.98
Total direct care revenue	$314.35	$278.55	$268.53	$266.59
Direct care expenditure:				
Direct care labour costs	$233.52	$206.39	$205.46	$202.57
Other labour costs	$30.39	$26.58	$23.32	$21.42
Other direct care costs	$9.89	$9.50	$8.55	$8.75
Allocation of administration costs (37.0%)	$21.99	$19.56	$18.42	$18.03
Total direct care expenditure	$295.79	$262.03	$255.75	$250.77
Direct Care Result	**$18.58**	**$16.52**	**$12.78**	**$15.83**
Everyday Living				
Everyday living revenue:				
Residents	$62.56	$63.54	$65.28	$66.71
Government	$11.00	$11.10	$11.08	$11.09
Total everyday living revenue	$73.56	$74.63	$76.35	$77.80
Everyday living expenditure:				
Catering	$44.61	$40.82	$39.31	$40.38
Cleaning	10.61	$10.51	$10.89	$10.60
Laundry	$4.49	$5.01	$4.61	$4.80
Utilities	$9.91	$8.43	$8.23	$8.04
Other	$0.96	$1.15	$1.11	$1.11
Allocation of administration costs (33.6%)	$19.97	$17.76	$16.73	$16.37
Total everyday living expenditure	$90.55	$83.68	$80.88	$81.30
Everyday Living Result	**($17.00)**	**($9.06)**	**($4.53)**	**($3.51)**
Accommodation				
Accommodation revenue:				
Residents	$14.52	$15.56	$17.03	$17.50
Government	$26.44	$27.46	$24.12	$23.89
Total accommodation revenue	$40.97	$43.02	$41.15	$41.39
Accommodation expenditure:				
Depreciation	$17.86	$20.26	$22.62	$24.44
Property maintenance and rental	$17.60	$15.62	$13.27	$13.05
Other	$1.77	$1.87	$1.59	$1.71
Allocation of administration costs (29.4%)	$17.46	$15.54	$14.63	$14.32
Total accommodation expenditure	$54.68	$53.30	$52.10	$53.52
Accommodation Result	**($13.71)**	**($10.27)**	**($10.96)**	**($12.14)**
Operating Result (per resident per day)	**($12.13)**	**($2.81)**	**($2.70)**	**$0.19**
Total revenue (per resident per day)	**$428.88**	**$396.20**	**$386.03**	**$385.78**
Total expenditure (per resident per day)	**$441.02**	**$399.01**	**$388.73**	**$385.59**

*Accommodation revenue from residents only includes daily accommodation payments (DAPs) and does not include imputed interest relating to Refundable Accommodation Deposits (RADs)

Perhaps the most puzzling aspect of the financial analysis by home size is the varying pattern of revenue and expenditure concerning everyday living services. As depicted in Figure 43, on the one hand, as homes get larger, they are able to earn more revenue per resident per day; on the other hand, they also appear to deliver those services at a lower average cost.

Figure 43: Everyday living revenue and expenditure, by home size



Noting that most everyday living revenue is fixed through regulation (i.e. the basic daily fee and hotelling supplement), the differences in revenue are almost entirely driven by the different average rates of fees for additional services. More specifically, while homes in the smallest bracket, on average, earn $1.52 per resident per day for additional services, those in the largest bracket earn almost four times that, averaging $5.85 per resident per day.

Everyday living expenditures vary across home size categories, with notable differences in utilities, administration, and catering costs. For instance, homes in the smallest size category spend an average of $44.61 per resident per day on catering, compared to $40.38 in the largest category. The primary source of this variation is catering labour costs, likely reflecting the differential impact of the head chef award rate increase under Stage 2 of the FWC aged care work value case. As per the discussion regarding occupancy effects above, homes with few residents, in particular, face challenges in spreading the fixed cost of this increase across fewer residents.

Home care analysis

Overview

- The financial performance of home care providers declined in 2023-24. Across participating providers, the average Operating Result was $1.11 per client per day, and the median was $2.82 per client per day.

- The sustained decline in providers' profit margins results from a shrinking gap between the average revenues and expenses, noting that both increased as a result of the Stage 2 FWC wage case.

- It appears that providers have not increased their prices in line with changes in package subsidy rates. In nominal terms, published home care package subsidies prices have increased by 16.5% since 2019-20, yet providers' total average revenue has only grown by 8.7%.

- Revenue utilisation has improved slightly. However, on average, 13.9% of package subsidies are not being used.

- Providers poor financial performance may also reflect the increased reliance on subcontracted or brokered third-parties to deliver services. For example, in 2019-20, subcontracted services represented 12.1% of total revenue; in 2023-24, it represented 19.9%.

- Care management and administration expenditures represent a substantial proportion of providers' operations. In 2023-24, providers' average expenditure on care management services was equivalent to 10.5% of total revenue and administration costs were 26.6%.

Home care provider profiles

The following analysis reports on the full-year outcomes of home care providers offering subsidised in-home services funded through home care packages. The services can include personal and nursing care, domestic and social support activities, home maintenance, and other supports in the home and community. As noted earlier, the StewartBrown dataset does not currently extend to CHSP, STRC and other service providers. However, future changes to the dataset will align with the proposed new Support at Home program for delivering in-home care, starting in July 2025.

Table 16: Profile of surveyed home care providers

	FY23	FY24
Number of home care providers in the dataset	96	83
Total number of packages in dataset	68,129	71,003
Ownership:		
For-profit	3.1%	3.6%
Not-for-profit	96.9%	96.4%
Average number of packages per provider	710	855
Package mix:		
% of Level 1 packages	6.2%	6.3%
% of Level 2 packages	40.4%	40.4%
% of Level 3 packages	32.9%	32.6%
% of Level 4 packages	20.5%	20.6%

The analysis reported in this section relates to 83 home care providers included in the 2023-24 full-year StewartBrown dataset. As shown in Table 16, this dataset includes 71,003 home care packages or approximately 25.8% of the total population of 275,486 home care clients as of 30 June 2024.[162] Most providers in the dataset are not-for-profit (96.4%). The dataset does not include home care package providers that are government agencies.

The overall mix of packages across participating home care providers has remained relatively stable. The highest represented package recipients currently receive a Level 2 package (40.4%) or a Level 3 package (32.6%). The survey package mix in the dataset is consistent with sector-level statistics of the national proportion of people with home care packages, by package level, reported by the Department.[163]

162. Department of Health and Aged Care (2024), *Report on the Operation of the Aged Care Act 1997.*
163. Department of Health and Aged Care (2024), *Report on the Operation of the Aged Care Act 1997.*

Key performance indicator summary

Table 17: Key performance indicators of home care providers

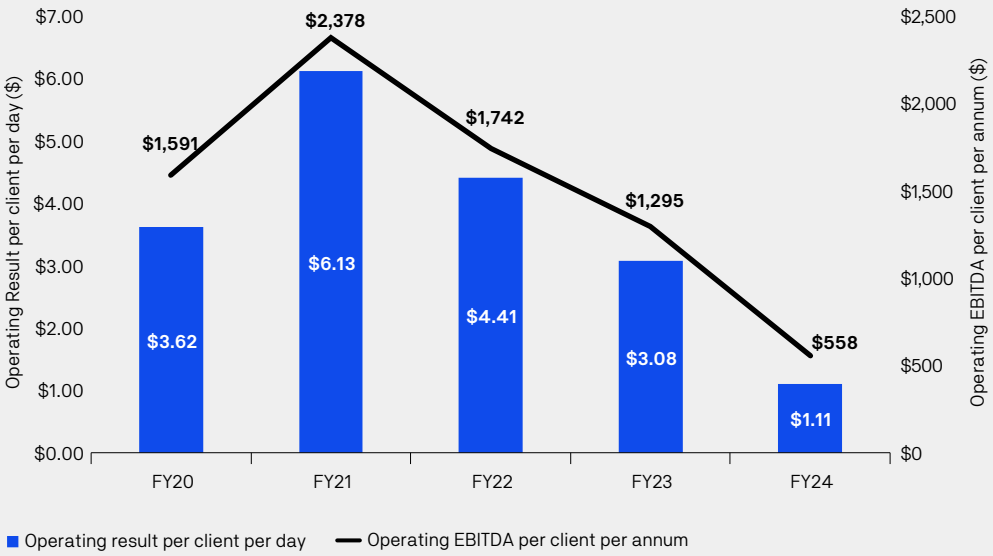
	FY23	FY24
Operating Result per client per day	$3.08	$1.11
Operating EBITDA per client per annum	$1,295	$558
Profit margin (Operating Result) (as % of revenue)	4.3%	1.7%
Revenue per client per day	$68.61	$75.90
Revenue utilisation rate	83.7%	86.1%
Unspent funds per package	$11,838	$13,580
Expenses per client per day	$65.53	$74.78

Providers' slim profit margins signify ongoing viability concerns, which pose potential challenges in funding investments and productivity improvements necessary to meet the future growth in demand for aged care services in the home and community.

Financial performance

The 2023-24 results show a continued deterioration of the financial performance of home care providers, with the average profitability of providers being less than half the year before. Figure 44 shows that the average Operating Result[164] of home care providers was $1.11 per client per day, down from $3.08 in 2022-23 and a recent peak of $6.13 in 2020-21.

Figure 44: Financial results of home care providers



It is important to note that the low average Operating Result for 2023-24 ($1.11 per client per day) is lower than the median estimate ($2.82 per client per day), reflecting the effect of a small number of outlier providers with very poor financial performance. For context, providers' Operating Result at the 25th percentile was a deficit of $2.33 per client per day; at the 75th percentile, it was positive at $6.17.[165]

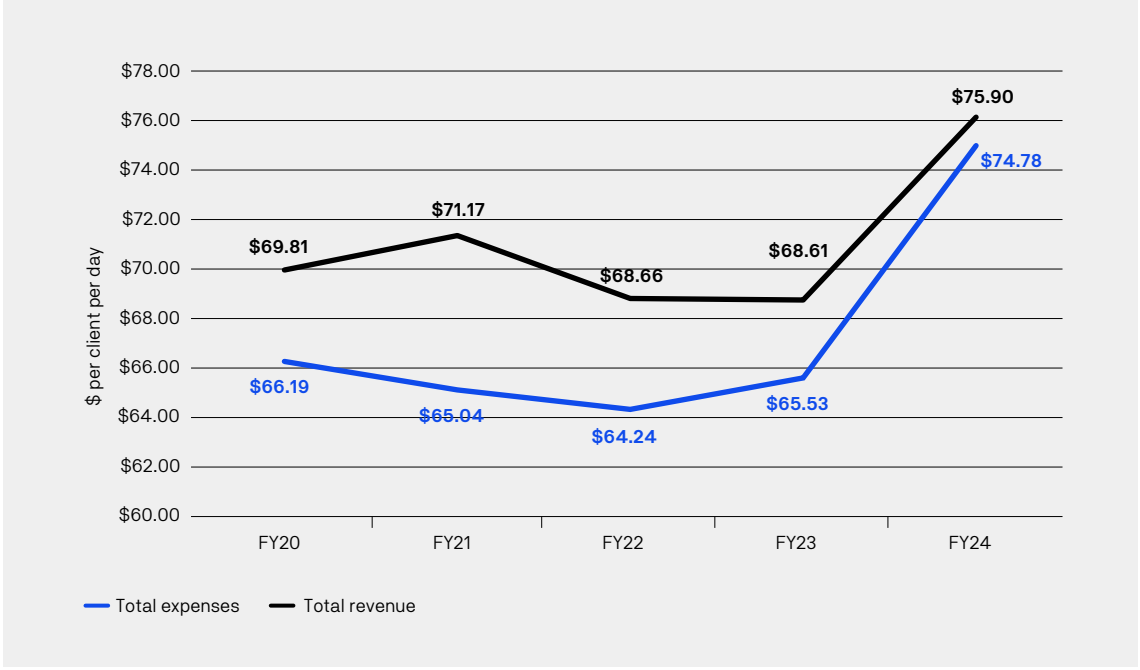
The Operating EBITDA has followed a similar pattern. In 2023-24, the average result was $558 per client per annum, down from $1,295 in 2022-23.

Likewise, providers' average profit margin has declined from 4.3% in 2022-23 to 1.7% in 2023-24 (Table 17). This slim profit margin highlights providers' ongoing viability concerns, which pose potential challenges in funding investments, such as in technology to improve service efficiency, necessary to meet the future growth in demand for aged care services in the home and community.

164. Operating Result refers to the Net Profit Before Tax (NPBT) earned by a home care service provider.

165. The effect of the outliers also explains differences between the estimate of the average Operating Result provided by UARC ($1.11) and StewartBrown ($2.76), noting that the two reports use a different method for calculating averages (i.e. UARC calculates the average across the 83 participating providers, whereas StewartBorwn calculates the average across the 71,003 packages). These differences are described in the Appendix.

Figure 45: Home care revenue and expenditure, per client per day



The long-term trends in providers' revenue and expenses are shown in Figure 45. This illustrates the sustained decline in providers' profit margins as a shrinking gap between the average revenues and expenses.

The marked shift in 2023-24 in the levels of both revenue and expenses reflects the response to Stage 2 of the FWC aged care work value case, which resulted in a 15% increase in award rates for direct care workers.[166] To fund this pay rise, the Government increased the value of home care package subsidies by 11.5%. However, total expenses grew at an even faster pace, thus resulting in a decline in average profitability. This also suggests that in 2023-24, providers did not increase their service prices sufficiently to compensate for the increase in their costs, despite their discretion to do so.

This partly explains one of the puzzling aspects of the revenue trend discussed in Part 1, which is the relatively slow growth in revenue earned compared to the increase in the pricing of home care package subsidies over the last 5 years. In nominal terms, providers' total average revenue has grown by 8.7% since 2019-20. Yet over the same period, published home care package subsidies prices have increased by 16.5%.[167]

166. Wage subsidy increase in the Home Care Packages Program | Australian Government Department of Health and Aged Care.
167. For example, in 2019-20, the annual subsidy value of a Level 4 package was $51,130, and in 2023-24, it was $59,544.

Revenue analysis

Under the current Home Care Package program, approximately 97% of providers' revenue is provided by the Government in the form of package subsidies and supplements, with the small remainder comprising contributions from clients.[168]

Providers' revenue is earned as charges for a range of services, including:

- Direct care service provision. This includes services delivered by the providers' internal staff and services provided by third-parties (i.e., subcontracted and brokered service arrangements).[169]
- Care management services. These services involve working with clients to ensure that services align with their assessed needs, goals, and preferences, fit within their package budget, and comply with the Aged Care Quality Standards.
- Package management services. These services comprise the administrative and compliance services that support the delivery of home care packages, which include managing budgets, preparing monthly statements, handling invoices, and claims to Services Australia.

Table 18 shows the average breakdown of these charges per client per day. In 2023-24, providers earned on average $75.90 per client per day, half of which (50.1%) was from direct service revenue, 19.9% from subcontracted services, 18.1% for care management and 12.0% for package management.

Currently, care management charges are capped at 20% of the total value of clients' home care package levels. However, under the new Support at Home program starting in July 2025, care management fees will be capped at 10% of clients' package subsidies. Also, in the new program, providers can no longer charge separate fees for package management services. Instead, these fees will be subsumed within the maximum prices set for each service delivered.

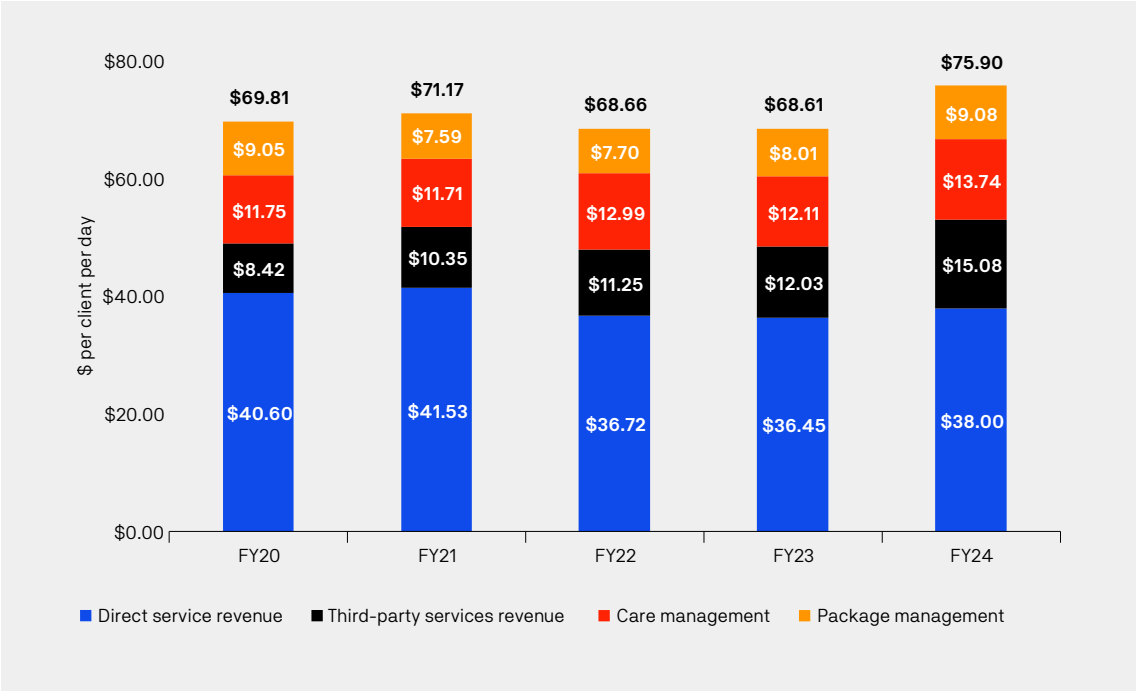
168. Department of Health and Aged Care (2024), *Financial Report on the Australian Aged Care Sector 2022-23*.

169. Sub-contractor and brokered service arrangements occur when third-parties are engaged to provide services to the client. Common examples include when providers use a brokered labour hire company to provide client services on a permanent basis, or when a subcontractor provides gardening, home maintenance or allied health services. It also includes when a third-party is engaged to install home modifications that support the independence of home care clients.

Table 18: Detailed financial results of home care providers, per client per day

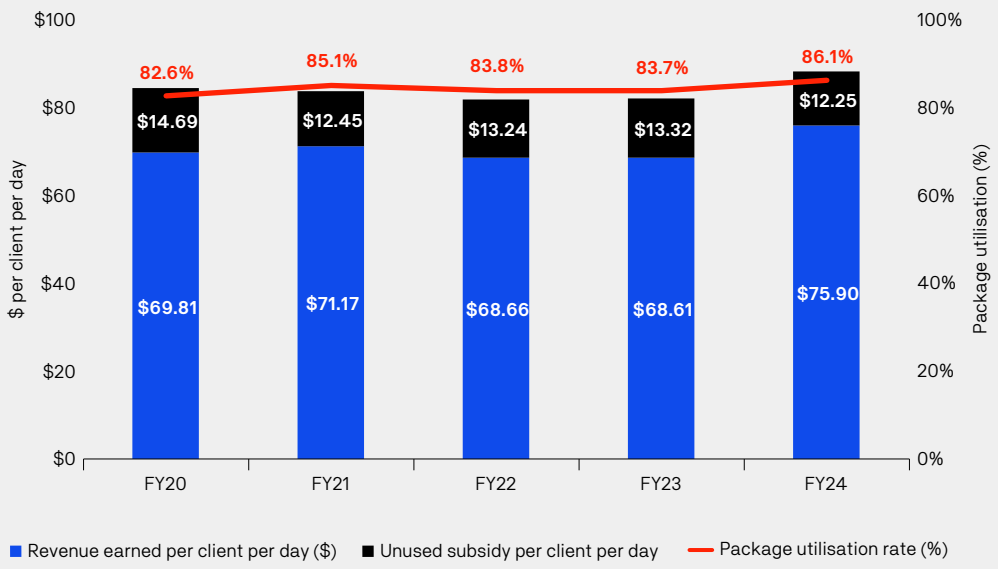
	FY23	FY24
Number of providers in dataset	96	83
Revenue		
Direct services	$36.45	$38.00
Third-party services	$12.03	$15.08
Care management	$12.11	$13.74
Package management	$8.00	$9.08
Total recurrent revenue	**$68.60**	**$75.90**
Expenditure		
Direct care and brokered services:		
Internal direct care:		
Staffing	$21.21	$24.35
Agency costs	$1.07	$1.02
Consumables	$0.96	$0.67
Transport	$1.09	$1.09
Other	$1.10	$1.31
Internal direct care	$25.43	$28.45
Third-party services	$16.04	$18.19
Direct care services	**$41.47**	**$46.64**
Care management:		
Staffing	$7.16	$7.86
Transport	$0.12	$0.09
Care management	**$7.27**	**$7.94**
Administration & support services:		
Administration recharges	$6.77	$8.19
Staffing	$4.98	$6.11
Other administration	$4.56	$5.49
Administration & support services	**$16.31**	**$19.79**
Depreciation	**$0.47**	**$0.41**
Total expenditure	**$65.53**	**$74.78**
TOTAL OPERATING RESULT	**$3.06**	**$1.11**

Figure 46: Home care revenue, per client per day



Taking a longer-term perspective, Figure 46 shows that over the last five years, there has been a small contraction in the revenue earned from direct services (i.e., by the provider's staff). At the same time, third-party services revenue (i.e. revenue from subcontracted and brokered services that third-parties deliver) has increased substantially, signifying a growing reliance on external parties to deliver home care services. For example, in 2019-20, subcontracted services represented 12.1% of total revenue; in 2023-24, it represented 19.9%. This trend may also explain providers' lower margins as brokered services are often charged at cost (i.e. with smaller margins) than those delivered by internal staff.

Figure 47: Revenue and unused subsidy, per client per day



From a provider's perspective, unspent funds represent unrealised revenue, a portion of which could have been additional net surplus. Furthermore, from a policy perspective, unspent funds represent an inefficient apportionment of taxpayer funds, particularly when many individuals are waiting to be allocated a package.

Figure 47 illustrates the average value of unused funds relative to the revenue earned by providers. It also shows the trend of a related measure, 'revenue utilisation', which is calculated as the proportion of the total package subsidies used by home care clients and realised as revenue by providers.

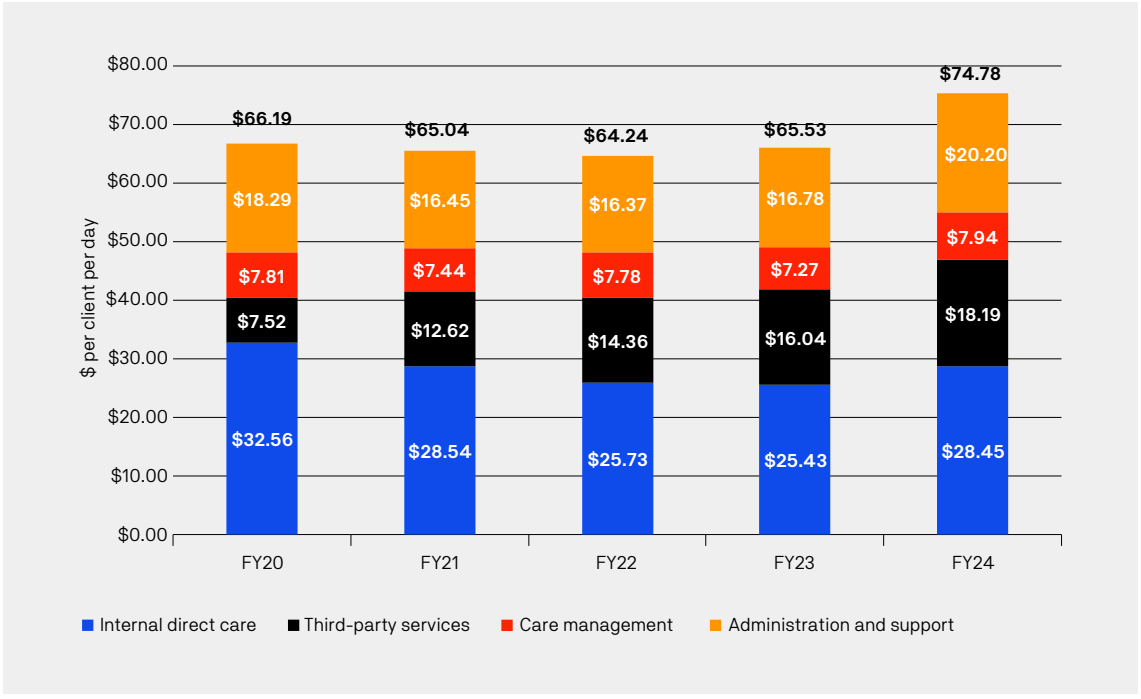
In the context of the previous 5 years, the 2023-24 results exhibit a modest improvement, with a contraction in the average daily value of unused subsidies to $12.25 per client per day and an increase in the rate of revenue utilisation to 86.1%. Nonetheless, it is still relatively low. As it stands, on average, 13.9% of package subsidies are not being used.

Cost analysis

Providers' costs in delivering home care services can be disaggregated into three basic categories:

- Direct care service provision (including services provided by internal staff as well as those provided through third-parties). This typically includes workforce costs (including personal care workers, nursing and allied health workers and other workers), consumables, travel and home modifications.
- Care management. This typically relates to the labour and transport costs of staff who help manage and coordinate services for clients, including managing the delivery of services from third-parties.
- Administration and support. This typically includes the costs of administration staff, centralised scheduling of services, education and quality control, insurance, utilities, rent, information technology, interest and motor vehicles and other 'back-office' costs relating to the provider organisation running its services.

Figure 48: Home care expenditure, per client per day



Trends in providers' average expenditure in each of these categories are shown in Figure 48.

As mentioned previously, the recent increase in expenditure on internal direct care services and third-party services reflects the increase in home care worker wages as a result of the FWC decision.

Expenditures on care management, together with administration and support have also grown. While both categories have remained relatively stable as a proportion of revenue, they constitute substantial components of home care providers' business model. In 2023-24, providers' average expenditure on care management services was equivalent to 10.5% of total revenue and administration costs were 26.6%.

Echoing the trends in revenue, one of the most marked trends in expenditure patterns is the gradual decrease in expenditure on internal direct care services (i.e. by the provider to the client directly) and a substantial uptick in expenditure on third-party services. It is unclear whether this increased reliance on subcontracting is due to providers' changing business models or clients choosing to use alternative contractors or types of services that typically require a third-party (e.g., allied health). Considering the implications this may have for providers' financial viability of services, this issue warrants closer attention to understanding the costs and appropriate pricing of the new Support at Home program.

Editorial Board

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Professor Mike Woods is a Professor of Health Economics at the UTS Centre for Health Economics Research and Evaluation, focusing on aged care and is a member of IHACPA's Aged Care Advisory Committee. He was a former Deputy Chair of the Productivity Commission and has held appointments to Government Boards, health and aged care policy reviews, multilateral development agencies and foreign government reform programs.

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Professor Michael Woods

As above

Appendix: Method

The numbers provided in this report for aged care providers or homes are calculated at the unit specified in the sample summary of each section and aggregated using averages or medians as stated. Ratios are calculated using the same methodology. Numbers applicable to all providers (e.g., service revenue) and totals (e.g., EBITDA) are averaged across only those aged care providers or homes that provide data for that line item, which may differ from the headline sample size provided. All other measures are averaged across all the homes in the particular group that incur the cost. The average by line item is particularly useful for line items such as contract catering, cleaning and laundry, property rental, extra service revenue and administration fees, as these items are not supplied by all survey participants. Below is a detailed description of the methodology for each section.

Provider analysis

For aged care providers, provider-level averages are calculated using the aggregate averages of any one line item across all providers and dividing by the number of providers in the sample.

Residential care analysis

For residential care, all home-level averages are calculated, in general, by using the aggregate of all averages of any one line item across all aged care homes in the group, and dividing by the number of aged care homes in the sample. For many line items, the home-level raw data is first transformed into a rate per resident per day. For example, the home-level average for contract catering would be calculated by first transforming the raw total amount submitted for that line item into a rate per resident per day for each aged care home, and then used to calculate the average rate per resident per day across all homes in the sample.

Home care analysis

For home care, all provider-level averages are calculated, in general, by using the aggregate averages of any one line item across all home care providers, and dividing by the number of home care providers included in the sample. For many line items, the provider-level raw data is first transformed into a rate per client days, by dividing the raw data submitted for any one line item by the number of client days for that home care provider. For example, the provider-level average for subcontracted and brokerage costs would be calculated by first transforming the raw total amount submitted for that line item into a rate per client day for each home care provider, and then used to calculate the average rate per client day across all providers in the sample.

Methodological variation between UARC and StewartBrown

Despite using the same underlying dataset, UARC and StewartBrown analyses often return minor variations due to a difference in methodology concerning the unit of analysis in which averages are calculated.

Both analyses express most items as a rate per individual, for example, EBITDA per client per annum, staffing minutes per resident per day, and Operating Result per resident per day. The intent of expressing the results as rates is to account for the effects of organisational size differences and provide comparable metrics across organisations.

In general, StewartBrown calculates these rates by taking the aggregate line item values across all providers in the dataset (e.g. the total EBITDA for all home care providers in their sample) and dividing by the aggregate of all individuals (e.g. the total number of clients for home care providers in their sample). This approach provides the average profitability of any given individual, place or client.

By comparison, UARC first calculates the rate for each organisation (e.g. EBITDA per client per annum for each home provider) and then calculates the average of that rate across all providers in the dataset. This approach provides the average profitability of any given provider or aged care home.

Owing to this methodological difference, the average rates calculated by StewartBrown and UARC will vary, particularly when there are differences in the performance of homes or providers of different sizes within the sample.

To ensure integrity in data transfer and analysis, UARC replicates the StewartBrown analysis, reconciles figures to StewartBrown's published results and reviews all line items individually to identify erroneous sources of variation.

For more information

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