Residential Aged Care Pricing Advice 2024–25

Technical Specifications

IHACPA

Residential Aged Care Pricing Advice 2024–25 Technical Specifications − August 2024

Contents

Acronyms and abbreviations

Acronym/abbreviation	Description
ABS	Australian Bureau of Statistics
ACFI	Aged Care Funding Instrument
ACFR	Aged Care Financial Report
ACQSC	Aged Care Quality and Safety Commission
Aged Care Act	*Aged Care Act 1997* (Cth)
Aged Care Award	*Aged Care Award 2010*
Aged Care (Transitional Provisions) Act	*Aged Care (Transitional Provisions) Act 1997* (Cth)
Aged Care Work Value Case	Fair Work Commission Work value case – Aged care industry
AIHW	Australian Institute of Health and Welfare
AIN	Assistant in nursing
AN-ACC	Australian National Aged Care Classification
ANZSCO	Australian and New Zealand Classification of Occupations
ANZSIC	Australian and New Zealand Industrial Classification
BCT	Base care tariff (a component of the AN-ACC funding model)
BDF	Basic daily fee
CPI	Consumer Price Index
EBA	Enterprise bargaining agreement
EN	Enrolled nurse
IHACPA	Independent Health and Aged Care Pricing Authority
MMM	Modified Monash Model
NAPS	National Approved Provider System
NHR Act	*National Health Reform Act 2011* (Cth)
NWAU	National weighted activity unit
OBD	Occupied bed day
PCW	Personal care worker
Pricing Authority	The governing body of IHACPA established under the *National Health Reform Act 2011* (Cth)

Acronym/abbreviation	Description
QFR	Quarterly Financial Report
RACCS	Residential Aged Care Costing Study
RACPA24	Residential Aged Care Pricing Advice 2024–25
RBA	Reserve Bank of Australia
RN	Registered nurse
RUCS	Resource Utilisation and Classification Study
The department	Department of Health and Aged Care
The government	The Australian Government
The Schedule	Schedule 1 — Care and services for residential care services of the *Quality of Care Principles 2014* under section 96-1 of the *Aged Care Act 1997* (Cth)
UOW	University of Wollongong
WPI	Wage Price Index

1 Overview

1.1 Purpose

This document has been produced as an accompaniment to the Residential Aged Care Pricing Advice 2024–25 (RACPA24). It provides the technical specifications for how the Independent Health and Aged Care Pricing Authority (IHACPA) developed the pricing advice provided to the Australian Government (the government).

1.2 Background

IHACPA was established under the _National Health Reform Act 2011_ (Cth) (the NHR Act) and by virtue of section 131A(1) of the NHR Act is invested with the following functions relevant to RACPA24:

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

b) such functions relating to aged care (if any) as are specified in regulations made for the purposes of this paragraph

c) to conduct, or arrange for the conduct of, one or more of the following activities for the purpose of performing a function mentioned in paragraph (a) or (b):

   i) the collection and review of data

   ii) costing and other studies

   iii) consultations

d) to do anything incidental to or conducive to the performance of the above functions.

RACPA24 is an output to the performance of those functions by the Pricing Authority.

1.3 The scope of IHACPA's pricing advice for residential aged care services for 2024–25

Operating under the NHR Act, the Aged Care Act, and the Aged Care (Transitional Provisions) Act, IHACPA will provide the government with advice on the following:

- a national price for residential aged care, based on funding the cost of care
- the gap between the cost of delivering required hotel services and related revenue received
- any recommended adjustments to the Australian National Aged Care Classification (AN-ACC) funding model, such as national weighted activity unit (NWAU) price weights, base care tariff (BCT) categories and AN-ACC classes.

RACPA24 will:

- be evidence-based and developed transparently
- be based on services meeting the standard of care required in government policy and legislation
- aim to account for all costs and revenues for items in Schedule 1 – Care and services for residential aged care services (the Schedule) of the *Quality of Care Principles 2014* under section 96-1 of the Aged Care Act.

1.4 Residential aged care pricing advice process

1.4.1 AN-ACC funding model

A key element of IHACPA's residential aged care and residential respite care pricing advice relates to the AN-ACC funding model.

The University of Wollongong (UOW) was commissioned by the Department of Health and Aged Care (the department) to develop a new classification system for residential aged care and residential respite care in Australia. Following a series of studies known as the Resource Utilisation and Classification Study, UOW developed the AN-ACC. The government introduced the AN-ACC funding model for residential aged care and residential respite care subsidies from 1 October 2022, replacing the Aged Care Funding Instrument (ACFI).

The elements of care that are in-scope for the AN-ACC funding model are specified in Parts 2 and 3 of the Schedule of the *Quality of Care Principles 2014* under section 96-1 of the Aged Care Act.

IHACPA's AN-ACC pricing advice includes the recommended:

- AN-ACC price, which is a single price per NWAU
- AN-ACC price weights for each AN-ACC class and BCT category, measured in NWAU
- adjustments to the BCT categories.

1.4.2 Hotel cost gap

IHACPA is also required to provide advice to the government on the gap between the cost of delivering required hotel services, and specific types of revenue received.

1.4.3 Data sources

RACPA24 was informed by a number of different data sources including the following provided by the department or conducted by IHACPA:

- Residential Aged Care Costing Study (RACCS) 2023
- Aged Care Financial Report (ACFR) 2021–22
- Quarterly Financial Report (QFR), Quarter 2, Quarter 3, and Quarter 4 2022–23
- AN-ACC assessment data
- Services Australia ACFI claims 2021–22
- Services Australia AN-ACC claims 2022–23
- National Approved Provider System (NAPS) service list

- Aged Care Wage Estimation Tool
- [Aged Care Provider Workforce Survey](#) 2023.

In addition, IHACPA relied on other publicly available data sources, including:

- University of Wollongong Resource Utilisation and Classification Study
- Australian Bureau of Statistics (ABS) [Consumer Price Index (CPI) series](#)
- ABS [Wage Price Index (WPI) series](#)
- ABS [Employee Earnings and Hours 2021](#)
- ABS [Income and Work: Census 2021](#)
- Aged Care Quality and Safety Commission [non-compliance decision log](#) 2021–22
- [Care minutes and 24/7 registered nurse responsibility guide](#)
- [Star ratings quarterly data extracts](#), from May 2023 and August 2023
- Australian Institute of Health and Welfare (AIHW) [GEN aged care service lists](#)
- StewartBrown [Aged Care Financial Performance Survey Report](#) December 2023
- minimum award wages, from the [Fair Work Ombudsman](#)
- Fair Work Commission [Annual Wage Review](#) decisions
- Fair Work Commission [Work value case – Aged care industry](#) Stage 2 and 3 decisions
- Reserve Bank of Australia (RBA) [Statement on Monetary Policy – February 2024](#).

Residential Aged Care Costing Study 2023

To support evidence-based pricing advice, IHACPA undertakes cost collections from residential aged care services. IHACPA completed its first RACCS in 2023. This 30-day time and motion study was conducted across 118 participating sites between March and August 2023, and included the collection of cost, time, and activity data.

The full methodology behind the RACCS is elaborated in detail in the final report.

1.4.4 Methodology overview

IHACPA has advanced its methodology for RACPA24 to incorporate the data collected in the RACCS. The recommended AN-ACC price is based on the average cost per NWAU in the 2021–22 financial year, adjusted to account for known cost increases, then indexed to estimate the cost of delivering residential aged care services between 1 October 2024 and 30 September 2025. The recommended price weights for each AN-ACC class and BCT category are based on the relative costs of care as measured in the RACCS.

Figure 1 summarises the processes and key aspects considered in the development of the pricing methodology for RACPA24.

Figure 1: Summary of methodology

Data preparation
- Apply trimming rules
- Sample to population weighting
- Determine in-scope cost
- Escalate ACFR cost to meet care minute targets

Pricing model
- Model individual and shared cost for each AN-ACC class and BCT category
- Calibrate cost to population ACFR
- Derive a reference cost per NWAU
- Calculate price weights

Indexation
- Fair Work Commission Work value case – Aged care industry Stage 2 and 3 decisions
- Superannuation guarantee increase
- Indexation of labour and non-labour cost to 2024–25

Residential Aged Care Pricing Advice 2024–25

IHACPA has also produced an estimate of the gap between the cost of required hotel services and specific types of revenue received, which is provided as a separate output in RACPA24.

2 Data preparation

2.1 Overview

IHACPA relied on 2 main sources of cost data in preparing RACPA24:

- RACCS 2023, to understand differences in the cost of care between AN-ACC classes and BCT categories
- ACFR 2021–22, for population-level cost data.

The methodology used to prepare each of those data sources for modelling is described in the relevant sections below.

2.2 Residential Aged Care Costing Study 2023

The RACCS dataset reported the care, hotel, accommodation, and administrative overhead costs for each participating resident for each day in the data collection period, broken down into various labour and non-labour cost categories.

The RACCS dataset also contained information including participants' AN-ACC classes, entry and exit dates, as well as service characteristics such as the BCT category and Modified Monash Model (MMM) classification.

A series of data cleaning rules were applied in preparing the costed dataset, which are detailed in Section 7.1.2 of the RACCS final report.

2.2.1 Trimming

IHACPA applied additional trimming rules to the RACCS dataset to prepare it for modelling. Residents with missing AN-ACC classes were removed, as well as all data for services that had an overall star rating of one or 2 stars by the Aged Care Quality and Safety Commission (ACQSC) at the time of the costing study data collection period.

The list of rules and their impact on the RACCS sample is shown in Table 1.

Table 1: Summary of RACCS trimming

Trimming Rule	Resident bed days
RACCS dataset	**136,119**
1. Resident missing AN-ACC class	-1,316
2. Service 1- or 2-star rated	-3,744
Trimmed RACCS dataset	**131,059**

2.2.2 Sample weighting

The sample of participating residents in RACCS represented 2.4% of all people living in residential aged care in Australia and 4.2% of residential aged care services. To account for potential sample selection issues and ensure the sample was representative of the population, IHACPA applied sample to population weights. Weights were calculated to align the representativeness of the sample across several categories: MMM, state/territory, service size, provider type, specialisation, and occupancy rate.

Sample weights were calculated using the steps outlined below.

Population dataset

IHACPA constructed a reference dataset containing a list of all residential aged care services that were operational during 2022–23 and characteristics of those services. The list of data sources used to construct this dataset and the relevant variables is shown in Table 2.

Table 2: Data sources used to construct population dataset

Source	Variables Used
Q2, Q3 and Q4 2022–23 QFR	NAPS service ID, service name, NAPS provider ID, provider name, occupied bed days, available bed days
NAPS service list	NAPS service ID, MMM, state, provider type, BCT category
GEN aged care service list	Service name, MMM, state, provider type
Co-located facilities list	NAPS service ID, co-located group ID

The QFR was used to identify services that were operational during 2022–23. Services that appeared on the NAPS service list, GEN aged care service list or co-located facilities list that had not submitted a QFR in any of the 3 quarters (since the AN-ACC funding model was introduced on 1 October 2022) were removed.

Services that were identified as co-located were aggregated and treated as a single facility for the purpose of sample to population weighting.

Service sizes were defined using the number of available bed days in the Q4 QFR divided by 91 as a proxy for the number of operational places. Small services were defined as those with 1-50 places, medium as those with 51-100 places and large as those with more than 100 places.

Occupancy rates were defined as the number of occupied bed days divided by the number of available bed days reported in the Q4 QFR and grouped into services with low (<80%), medium (80-90%) and high (≥90%) occupancy.

Iterative proportional fitting

IHACPA used an iterative proportional fitting (also known as raking) method to weight each resident bed day in the RACCS sample to reflect the true characteristics of residents in the population.

Due to sample size limitations, some MMM classifications and states/territories were aggregated together before calculating the sample weights. A list of service characteristics and groupings is presented in Table 3.

Table 3: Service characteristics

Characteristic	Levels of variable used for weighting
MMM	1, 2, 3, 4, 5, 6/7
State	ACT/NSW, VIC, QLD, WA, SA, NT/TAS
Size	Small (≤50 operational places), medium (51-100 operational places), large (>100 operational places)
Provider type	Government, not for profit, for profit
Specialisation*	Homeless, non-specialised
Occupancy rate	Low (<80%), medium (80-90%), high (≥90%)

*No specialised Aboriginal or Torres Strait Islander services participated in the RACCS.

Sample to population weights were calculated by comparing the number of resident bed days in the RACCS to the total number of occupied bed days reported in the Q4 QFR for services with any given level of a characteristic. Sample weights were adjusted iteratively until the sum of sample weights matched the population distribution, with a tolerance of one bed day for any given level of a characteristic.

2.2.3 In-scope costs

The AN-ACC funding model is underpinned by 3 components:

- AN-ACC classification subsidy (variable component), covering costs of individual care needs
- BCT subsidy (fixed component), linked to the location and specialisation of a service and designed to cover the cost of care which is shared between residents
- initial entry adjustment, in the form of a one-off payment covering costs associated with transitioning a permanent resident into a service.

All care cost categories and associated overheads in the RACCS dataset, excluding payroll tax, were considered in-scope for IHACPA's advice on the recommended AN-ACC price and AN-ACC price weights.

Variable and fixed costs

Care costs reported in RACCS were split into variable (individual) and fixed (shared) components to model the average cost of each AN-ACC class and BCT category respectively. The allocation of costs was informed by the Resource Utilisation and Classification Study[1] (RUCS) and is summarised in Table 4.

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[1] See Table 3.1 in Report 7

Table 4: RACCS care cost allocation

Cost category	Variable costs (individual)	Fixed costs (shared)
Labour costs		
Registered nurses (RNs)	50%	50%
Enrolled nurses (ENs)	50%	50%
Personal care workers (PCWs)	50%	50%
Allied health	50%	50%
Diversional therapist	50%	50%
Other staff (including care management)	0%	100%
Non-labour costs		
Medical supplies	100%	0%
Incontinence supplies	100%	0%
Nutritional supplies	100%	0%
Pastoral care	50%	50%
Other resident services and consumables	100%	0%

IHACPA calculated the total fixed cost per service per day using the proportions in Table 4 and split this evenly across all residents within that service. The residual cost for each resident bed day was taken to be the variable component. Associated overheads were allocated using the same methodology.

Note the proportions in Table 4 represent the allocation of costs at a service level, but the allocation will vary for individual residents depending on the complexity of their care needs.

Care supplements

In addition to AN-ACC subsidies, the government pays a range of supplements to cover the cost of meeting specific care needs. For people living in residential aged care, the enteral feeding, oxygen, and veterans' supplements assist with covering specific care costs. Costing study participants receiving these supplements were identified from the 2022–23 AN-ACC claims data. The value of care supplements received was subtracted from the daily variable care cost of these residents to ensure that the modelled cost reflected the component of care funded through the AN-ACC funding model.

Initial entry adjustment

An initial entry adjustment of 5.28 NWAU is paid when a permanent care recipient enters a residential aged care service to cover the costs associated with this transition.

Feedback received from stakeholders during consultation noted the substantial clinical and administrative resources involved with the entry of new residents into permanent care such as development of care plans, reconciliation of health records and engaging with families. However, these indirect care costs were not fully captured in the time and motion study.

In the absence of reliable data to understand the costs associated with new residents entering permanent care, IHACPA retained the existing initial entry adjustment price weight recommended by the RUCS.

2.3 Aged Care Financial Report 2021–22

At the time of modelling, the ACFR 2021–22 was the most recent source of cost data for the full population capturing all relevant cost categories. The ACFR provided to IHACPA had undergone cleansing and preparation by StewartBrown in consultation with the Department of Health and Aged Care.

Cost data from the ACFR was linked to supplementary data sources including Services Australia claims data, the AIHW GEN aged care service list, and the ACQSC non-compliance decision log.

IHACPA identified several anomalies in the ACFR dataset and undertook additional cleansing and trimming steps before using it for modelling to ensure that the data was fit for purpose.

2.3.1 Data adjustments

Duplicate service IDs

In cases where a residential aged care service changes ownership during the year, 2 ACFRs may be submitted each covering part of the financial year. For such services, IHACPA aggregated costs, hours, and bed days into a single record for each unique service ID.

Adjustments to bed days

IHACPA identified anomalies in the number of occupied and available bed days reported in the ACFR for some services, whereby reported values differed significantly from alternative data sources.

Occupied bed days were cross-checked against claim days from ACFI payments in 2021–22, while available bed days were checked against residential places from the 30 June 2022 AIHW GEN aged care service list (multiplied by 365). Services were flagged if bed days from these alternative sources differed by more than ±10% compared to the ACFR.

In some cases, IHACPA was able to identify the cause of the reporting error, for example, services that reported operational places instead of occupied bed days, or the number of unoccupied places instead of available bed days. For these services, a series of business rules were applied to correct the reported bed days and maximise the ACFR sample as listed in Table 5.

Table 5: Summary of adjustments to care days

Reporting error	Rule	Treatment	Number of services
1. Operational places reported instead of available bed days	Available bed days outside ±10% threshold AND Available bed days less than or equal to residential places	Available bed days multiplied by 365	25
2. Occupied places reported instead of occupied bed days	Occupied bed days outside ±10% threshold AND Occupied bed days less than or equal to residential places	Occupied bed days multiplied by 365	6
3. Unoccupied bed days reported instead of available bed days	Available bed days outside ±10% threshold AND Sum of occupied bed days and available bed days divided by 365 equal to the number of residential places or approved places	Available bed days set to the reported available bed days plus occupied bed days	15
4. Available bed days and occupied bed days swapped	Available bed days outside ±10% threshold AND Occupied bed days outside ±10% threshold AND Occupied bed days are greater than available bed days AND Available bed days is greater than 730 (assuming a minimum of 2 operational places per service throughout the year)	Available bed days and occupied bed days swapped	13
Total			**49***

*6 services required multiple bed day adjustments.

2.3.2 Supplementary data

New entrants

IHACPA identified new entrants through the 2021–22 ACFI claims data. Residents whose earliest admission date into permanent care for a given service was between 1 July 2021 and 30 June 2022 were flagged as new entrants. The total number of new entrants was counted across each service ID and merged onto the ACFR.

Resident casemix

The casemix profile (that is, the composition of AN-ACC classes of care recipients) for each service was determined from the AN-ACC claims data, using variable subsidy payments to count the number of residents by AN-ACC class. Admission and discharge dates were used to filter for residents in care on 30 June 2023. Using this, the proportion of residents by AN-ACC class was derived for each service. Note that as the cost data from 2021–22 predates the introduction of the AN-ACC funding model, IHACPA used the proportions of residents per AN-ACC class as at 30 June 2023 multiplied by the number of occupied bed days in 2021–22 as a proxy.

2.3.3 Trimming

Following the data adjustments, IHACPA applied 2 sets of trimming rules to the ACFR. First, a number of rules were applied to exclude erroneous reporting, summarised in Table 6.

Table 6: Errors identified in the ACFR

Rule	Records
ACFR 2021–22 following bed day adjustments	**2,708**
1. No occupied or available bed days reported	-60
2. Unknown casemix on 30 June 2023	-60
3. Service was not listed on the NAPS service list	-12
4. Occupied bed days reported are not within 10% of claim days (after bed day adjustments)	-141
5. Available bed days reported are not within 10% of residential places (after bed day adjustments)	-3
6. No RN cost reported	-7
7. No EN or PCW cost reported	-2
8. Labour costs are reported with zero care hours, or care hours reported with zero cost	-48
Cleansed ACFR dataset	**2,375**

Further trimming was applied to identify and exclude sanctioned services, as well as those with costs identified as outliers. The ACQSC non-compliance decision log was used as the ACFR reference period pre-dates the introduction of star ratings. The trimming rules and their impact on the ACFR sample are summarised in Table 7.

Table 7: Summary of ACFR trimming rules

Trimming rule	Records
Cleansed ACFR dataset	**2,375**
1. Service had a sanction imposed by the ACQSC in 2021–22	-16
2. Service received a notice of requirement to agree from the ACQSC in 2021–22	-21
3. Service received a non-compliance notice from the ACQSC in 2021–22	-122
4. RN cost per hour less than minimum award rate plus 10% superannuation and 20% on-costs	-51
5. EN cost per hour less than minimum award rate plus 10% superannuation and 20% on-costs	-109
6. PCW cost per hour less than minimum award rate plus 10% superannuation and 20% on-costs	-53
7. RN cost per hour more than 3 times median RN cost per hour (grouped by MMM 1-5, MMM 6-7)	-8
8. EN cost per hour more than 3 times median EN cost per hour (grouped by MMM 1-5, MMM 6-7)	-31
9. PCW cost per hour more than 3 times median PCW cost per hour (grouped by MMM 1-5, MMM 6-7)	-11
10. Total care labour cost per resident per day more than 3 times median (grouped by MMM 1-5, MMM 6-7)	-4
11. Consumables cost per resident per day more than 3 times median (grouped by MMM 1-5, MMM 6-7)	-31
12. Other care costs per resident per day more than 3 times median (grouped by MMM 1-5, MMM 6-7)	-80
13. Administration cost per resident per day more than 3 times median (grouped by MMM 1-5, MMM 6-7)	-14
Final trimmed ACFR dataset	**1,824**

2.3.4 Adjustments for care minute targets

Care minute target calculations

IHACPA calculated care minute targets for each service based on the care minute requirements for each AN-ACC class applicable from 1 October 2023 to 30 September 2024, listed in Appendix 5 of the Care minutes and 24/7 registered nurse responsibility guide, and the casemix profile of each service determined in Section 2.3.2.

From 1 October 2024, minimum care minute requirements will increase to a sector-wide average of 215 minutes per resident per day, including 44 minutes of RN care. For the purpose of determining care minute targets for each service applicable from 1 October 2024, IHACPA assumed that the increase in mandated care minutes would be applied uniformly across all AN-ACC classes relative to the care minute requirements from 1 October 2023, and adjusted care minute targets accordingly.

These 2 sets of care minute targets are subsequently referred to as the 1 October 2023 and 1 October 2024 care minute targets.

Cost adjustment in the ACFR

IHACPA adjusted the labour costs in the ACFR in recognition that care minute targets were not mandated in 2021–22, and the labour costs reported in the ACFR may be not representative of the

costs that would have been occurred had the minimum care targets been met. IHACPA has retained the methodology used in the Residential Aged Care Pricing Advice 2023–24 to estimate the expected increase in labour costs to meet minimum care requirements.

This adjustment used the occupied bed days OBD_s, and the following care expenses from the ACFR:

- RN labour cost (C_R)
- EN labour cost (C_E)
- PCW labour cost (C_P)
- RN labour hours (H_R)
- EN labour hours (H_E)
- PCW labour hours (H_P).

For each residential aged care service, IHACPA calculated the RN care minute target per occupied bed day (OBD), denoted $M_{R,D}^T$, and the total direct (including RNs, ENs and PCWs) care minute target per OBD, denoted $M_{L,D}^T$.

The average actual RN care minutes per OBD $M_{R,D}$, was calculated as:

$$M_{R,D} = \frac{60 \times H_R}{OBD_s}.$$

The average EN and PCW care minutes per OBD, denoted $M_{E,D}$ and $M_{P,D}$ respectively, were calculated similarly.

The care minute adjustment to the ACFR data was implemented in 4 steps. For each service in the ACFR, IHACPA:

a) identified the increase required in RN care minutes per OBD, if any, for the RN care minutes to be at least $M_{R,D}^T$
b) inflated both RN care minutes and RN labour cost by the factor identified in (a)
c) identified the increase required in residual (EN and PCW), care minutes, if any, for the total care minutes to be at least $M_{L,D}^T$ minutes
d) inflated the residual care minutes and costs (after accounting for step (b) above) by the factor identified in (c).

These steps were accomplished as follows. k_R was defined to be the increase required for RN care minutes to be at least $M_{R,D}^T$ minutes. That is:

$$k_R = \max\left(1, \frac{M_{R,D}^T}{M_{R,D}}\right).$$

Then the imputed RN care minutes per occupied bed day were calculated as $M'_{R,D} = k_R M_{R,D}$, or:

$$M'_{R,D} = k_R M_{R,D}$$
$$= \begin{cases} M_{R,D} & \text{if } M_{R,D} \geq M_{R,D}^T, \\ M_{R,D}^T & \text{otherwise.} \end{cases}$$

Similarly, the imputed RN labour cost was calculated as $C'_R = k_R C_R$.

The required increase in residual care minutes k_L was then calculated as:

$$k_L = \max\left(1, \frac{M_{L,D}^T - M_{R,D}'}{M_{E,D} + M_{P,D}}\right).$$

Note that if $M_{R,D}' + M_{E,D} + M_{P,D} \geq M_{L,D}^T$, then $k_L = 1$. The imputed EN and PCW care minutes per occupied bed day were than calculated as $M_{E,D}' = k_L M_{E,D}$ and $M_{P,D}' = k_L M_{P,D}$.

Similarly, the imputed EN and PCW labour costs were calculated as $C_E' = k_L C_E$ and $C_P' = k_L C_P$.

The process described above was used to escalate RN, EN and PCW labour costs to meet both the 1 October 2023 and 1 October 2024 care minute targets.

The impact of the adjustments to RN and total direct care costs for the services in the trimmed ACFR is shown in Table 8. The total additional cost to meet the mandatory care minute requirements applicable from 1 October 2023 is $1,379 million compared to what was reported in the ACFR 2021–22, with a further $533 million required to meet the increased care minute requirements from 1 October 2024.

Table 8: Effect of care minute targets on labour costs in the ACFR 2021–22

	1 October 2023 target		1 October 2024 target	
	Service count	Additional cost (compared to ACFR 2021–22)	Service count	Additional cost (compared to ACFR 2021–22)
Registered nurses				
Services meeting target	371	-	251	-
Services not meeting target	1,453	$630m	1,573	$831m
Total direct care (after RN adjustment)				
Services meeting target	578	-	372	-
Services not meeting target	1,246	$749m	1,452	$1,081m
Total*	-	$1,379m	-	$1,912m

*Components may not add due to rounding.

For all aspects of the RACPA24 calculations hereafter, the imputed RN cost (C_R') and care minutes ($M_{R,D}'$), imputed EN cost (C_E') and care minutes ($M_{E,D}'$) and imputed PCW cost (C_P') and care minutes ($M_{P,D}'$) are used in place of their source counterparts reported in the ACFR.

2.3.5 In-scope costs

After adjusting for the additional cost to meet the mandated care minute requirements, the final step in preparing the ACFR data for modelling was calculating the total in-scope care cost for funding under AN-ACC.

Administration costs

Administration costs reported in the ACFR, excluding payroll tax, were apportioned between the care, hotel, and accommodation expense streams as:

- 37.0% care
- 33.6% hotel
- 29.4% accommodation.

This apportionment is based on financial reporting from the December 2023 StewartBrown [Aged Care Financial Performance Survey Report](). The portion of administration costs allocated to care were considered in-scope for modelling costs funded under AN-ACC.

Care supplements

Analogous to the treatment in the RACCS, IHACPA calculated the total enteral feeding, oxygen, and veterans' supplements by service from the 2021–22 ACFI claims data.

Note that historical payments such as the homeless and viability supplements paid under ACFI remained in-scope as these were rolled into higher BCT payments for specialised homeless and MMM 5-7 services under the AN-ACC funding model.

Total in-scope cost

The total in-scope cost was calculated for each service from the ACFR as the total care cost excluding payroll tax, plus associated administration costs, minus the value of care supplements. In calculating the total care cost, IHACPA used the escalated labour costs after adjusting for care minute targets. For each service, 2 totals were calculated: one using the imputed labour costs to meet care minute targets applicable from 1 October 2023 and one to meet the increased care minute targets from 1 October 2024.

3 Pricing model

3.1 Overview

The RACPA24 pricing model is the first annual pricing model that IHACPA has produced using data from a costing study of residential aged care services. The pricing model comprises the AN-ACC price and price weights for each AN-ACC class and BCT category and is based on cost and activity data from the RACCS and the ACFR 2021–22.

Cost and activity data from the RACCS was primarily used to determine the relative costs of care for each AN-ACC class and BCT category. These costs were calibrated to the ACFR to ensure that the total modelled cost equalled the total actual cost across all services in the trimmed ACFR and to derive the reference cost.

There are 6 steps in the cost model and transformation into the associated pricing model, namely:

   a) base cost model, to determine the relative costs of care for each AN-ACC class and BCT category
   b) derivation of the reference cost, which is the average cost per NWAU
   c) calibration of the cost model to the ACFR
   d) calculation and stabilisation of price weights, limiting the movement in any given AN-ACC class or BCT category weight to ±20% of the previous year's weight
   e) indexation, to inflate the modelled costs to a level reflective of the estimated cost of delivering aged care services in 2024–25
   f) transformation of the cost model to the pricing model using the results of the previous 5 steps.

In this document, the 2023–24 AN-ACC price weights are referred to as NWAU23, with the recommended price weights for 2024–25 referred to as NWAU24.

Modified BCT categories

IHACPA reviewed the appropriateness of the existing BCT categories covering non-specialised services in MMM 1-5. IHACPA's analysis showed significant variability in the average cost per resident bed day across MMMs and that the existing BCT categories do not adequately address these differences in terms of funding. Therefore, IHACPA has recommended changes to the BCT definitions as part of RACPA24 to improve funding sufficiency and efficiency for metro, regional and rural services.

IHACPA recommends replacing BCT categories 6 (Standard MMM 1-4) and 7 (Standard MMM 5) with 3 new BCT categories: BCT category 6 (Standard MMM 1), 4 (Standard MMM 2-3) and 7 (Standard MMM 4-5). These changes are summarised in Table 9.

IHACPA has not recommended changes to the Standard MMM 6-7 or specialised services BCT definitions.

Table 9: Summary of BCT changes

| MMM | Existing BCT category | | | Modified BCT category | | |
	Description	Services Australia payment statement code	Description	Services Australia payment statement code	Funding basis
1	Standard MMM 1-4	6	Standard MMM 1	6	Occupied places
2			Standard MMM 2-3	4	Occupied places
3					
4			Standard MMM 4-5	7	Occupied places
5	Standard MMM 5	7			
6	Specialised Aboriginal or Torres Strait Islander MMM 6	2	Specialised Aboriginal or Torres Strait Islander MMM 6	2	Operational places
	Standard MMM 6-7	3H and 3L	Standard MMM 6-7	3H and 3L	Operational places
7	Specialised Aboriginal or Torres Strait Islander MMM 7	1	Specialised Aboriginal or Torres Strait Islander MMM 7	1	Operational places
N/A	Specialised homeless	5	Specialised homeless	5	Occupied places

References hereafter to BCTs 4, 6 and 7 relate to the modified definitions unless specified otherwise.

3.2 Base cost model

The prepared RACCS dataset containing 131,059 resident bed days from Section 2.2 was used to model the average cost of care per day for each AN-ACC class and BCT category.

3.2.1 Variable care cost

A multiple weighted linear regression was performed to estimate the average variable care cost per resident bed day for each AN-ACC class a, using the sample weights described in Section 2.2.2.

The model takes the form:

$$\text{variable cost}_x = \alpha_a + \varepsilon_x$$

where:

- variable cost_x is the variable care cost for resident bed day x in AN-ACC class a
- α_a is the average variable care cost for AN-ACC class a (modelled cost)
- ε_x is the error term.

Note that the regression model uses the variable care cost per resident bed day, meaning that each participating resident contributed up to 30 data points depending on the number of days they participated in RACCS.

Permanent classes with insufficient data

AN-ACC classes 1, 98, 99 and 100 had limited coverage in the RACCS sample. These classes were therefore pegged to other classes with the same NWAU23 price weights. Note that the NWAU23 price weights were obtained through the University of Wollongong's Resource Utilisation and Classification Study.

For example, the average cost for AN-ACC class 1 was set to the modelled average cost for AN-ACC class 13.

Table 10: Pegged permanent classes

AN-ACC class	Pegged to class
Class 1, Class 98	Class 13
Class 99	Class 8

Respite classes with insufficient data

There were a limited number of residents in residential respite care that participated in the RACCS. Due to the small sample size for the respite classes, IHACPA calculated an average cost for each respite class using the ratio of the NWAU23 price weight for that respite class to the weighted average NWAU23 price weight for permanent classes within the same mobility level (independently mobile, assisted mobility, or limited mobility) per the AN-ACC class descriptions. This ratio was multiplied by the weighted average modelled cost per resident bed day for the relevant permanent classes.

Table 11: Mobility level and care type AN-ACC class mapping

Mobility level	Care Type	
	Respite class	Permanent classes
Independently mobile	101	2, 3
Assisted mobility	102	4, 5, 6, 7, 8
Limited mobility	103	9, 10, 11, 12, 13

For each mobility level, IHACPA calculated the weighted average NWAU23 price weight as:

$$\overline{\mathrm{NWAU}_m} = \frac{\sum_m \mathrm{NWAU}_a \times n_a}{\sum_m n_a}$$

where:

- $\overline{\mathrm{NWAU}_m}$ is the weighted average NWAU23 price weight across permanent AN-ACC classes with mobility level m (either independently mobile, assisted mobility or limited mobility)

- NWAU_a is the NWAU23 price weight for AN-ACC class a
- n_a is the total number of residents in AN-ACC class a using the casemix calculated in Section 2.3.2.

This calculation was similarly repeated to determine the weighted average variable cost per resident bed day:

$$\overline{\alpha_m} = \frac{\sum_m \alpha_a \times n_a}{\sum_m n_a}$$

where:

- $\overline{\alpha_m}$ is the weighted average modelled variable care cost for residents with mobility level m
- α_a is the modelled variable care cost per day for residents in AN-ACC class a.

The modelled variable daily care cost for each respite class a with mobility level m was then calculated as:

$$\alpha_a = \frac{\text{NWAU}_a}{\text{NWAU}_m} \times \overline{\alpha_m}.$$

Respite class 100, the default class for residents entering respite care, was pegged to class 102, as they have the same NWAU23 price weights.

3.2.2 Fixed care cost

To model the average fixed care cost for each BCT category, IHACPA first assigned each non-specialised service in MMM 1-5 to the relevant modified BCT category (4, 6 or 7) based on its location. Services were classified according to these modified BCT categories in determining the average fixed care cost.

Analogous to the method used for variable costs, IHACPA modelled the average fixed cost β_b per resident bed day for each BCT category b using weighted multiple linear regression:

$$\text{fixed cost}_x = \beta_b + \varepsilon_x.$$

Insufficient data was collected in the RACCS to confidently estimate the average fixed care cost for BCT categories 1, 2 or 3. This is addressed later in Section 3.4.2.

3.3 Derivation of a reference cost

After estimating the average cost for each AN-ACC class and BCT category, the next step was the derivation of a reference cost per NWAU. This forms the basis for the recommended AN-ACC price and is used to convert the average cost parameters to price weights.

IHACPA calculated the reference cost using the total in-scope cost in the trimmed ACFR as defined in Section 2.3.5 divided by the total NWAU23 for 2021–22. This is to ensure that the total NWAU remains constant over time, and changes in the reference cost reflect changes in unit costs, excluding any influence of underlying changes in activity over time (whether that be casemix, service BCT categories or the number of recipients of initial entry adjustment payments).

Note that the total NWAU23 for 2021–22 was calculated based on the existing BCT category definitions and AN-ACC and BCT price weights for this reason.

3.3.1 Total NWAU

The total NWAU for each service in 2021–22 comprises the sum of the NWAU23 from the variable (AN-ACC) and fixed (BCT) components, plus any initial entry adjustment payments.

Variable component (AN-ACC)

To calculate the total variable component NWAU23, the number of occupied bed days in 2021–22 per AN-ACC class was required for each service. Since this breakdown is not reported in the ACFR or claims data, it was estimated using the service casemix and total occupied bed days.

For each service s, the proportion of residents in each AN-ACC class a (see Section 2.3.2) was multiplied by the number of occupied bed days reported in the ACFR. The resulting estimates of the number of occupied bed days in each AN-ACC class were multiplied by the NWAU23 price weights to get the total variable component NWAU23 in 2021–22:

$$\text{variable NWAU}_s = \sum_a P_{s,a} \times \text{OBD}_s \times \text{NWAU}_a$$

where:

- variable NWAU_s is the total variable component NWAU23 for service s in 2021–22
- $P_{s,a}$ is the proportion of residents in service s in AN-ACC class a
- OBD_s is the number of occupied bed days in service s
- NWAU_a is the NWAU23 price weight for AN-ACC class a.

Fixed component (BCT)

The fixed component NWAU23 for a service is dependent on the BCT category and either the number of occupied or available bed days, depending on whether the service is funded based on occupied or operational places. The number of bed days for service s in BCT b was defined as follows:

$$D_{s,b} = \begin{cases} OBD_s, & BCT = 5,6,7 \\ ABD_s, & BCT = 1,2 \\ \min(ABD_s, 29 \times 365), & BCT = 3H \\ \max(ABD_s - 29 \times 365, 0), & BCT = 3L \end{cases}$$

where:

- $D_{s,b}$ is the number of bed days allocated to BCT category b in service s
- OBD_s is the number of occupied bed days in service s
- ABD_s is the number of available bed days in service s.

Analogous to the calculation above for variable component NWAU23, IHACPA multiplied the number of occupied or available bed days by the NWAU23 price weights to get the total fixed component NWAU23 for each service in 2021–22:

$$\text{fixed NWAU}_s = \sum_b D_{s,b} \times NWAU_b$$

where:

- fixed NWAU_s is the total fixed component NWAU23 for service s in 2021–22
- NWAU_b is the NWAU23 price weight for BCT category b.

Note that the NWAU23 for each service was calculated based on its existing BCT category.

Initial entry adjustment

An initial entry adjustment of 5.28 NWAU is payable when a new resident enters permanent care. IHACPA calculated the number of new entrants into each service in 2021–22 by counting the number of permanent residents who had an admission date between 1 July 2021 and 30 June 2022 in the ACFI claims data. This was multiplied by 5.28 to calculate the total NWAU attributable to initial entry adjustment payments over the 2021–22 year.

3.3.2 Reference cost

To calculate the average cost per NWAU, also known as the reference cost, IHACPA divided the total in-scope cost by the total NWAU23 across all services in the trimmed ACFR 2021–22. This process was repeated using the imputed labour costs adjusted to meet both the 1 October 2023 and 1 October 2024 care minute targets. The results are summarised in Table 12.

Table 12: Reference cost

Care minute target	Total cost (2021–22 ACFR)	Total NWAU	Average cost per NWAU (2021–22 dollars)
1 October 2023 (sector average of 200 minutes per resident day, including a minimum of 40 minutes of RN)	$10,688m	52.38m	$204.05
1 October 2024 (sector average of 215 minutes per resident day, including a minimum of 44 minutes of RN)	$11,221m	52.38m	$214.21

By design, the total NWAU is constant when the existing NWAU23 and updated NWAU24 price weights are applied to the population. NWAU may be reallocated between AN-ACC classes and BCT categories to reflect changes in the relative costs of care, however there is no impact on the total NWAU across all residents and residential aged care services.

Note that the recommended AN-ACC price from 1 October 2024 is based on the average cost per NWAU of $214.21 in 2021–22 dollars, adjusted to meet the increased care minute requirements, indexed to the relevant period. The average cost per NWAU of $204.05 in 2021–22 dollars is used to calculate the difference in funding had the AN-ACC price been updated from 1 July 2024, as this period precedes the uplift in mandatory care minutes. This process is described in Section 4.5.

3.4 Cost calibration

Given the average cost for each AN-ACC class and BCT category were calculated from RACCS representing only a small sample of the population, a recalibration step was required to ensure that the total modelled cost equalled the actual in-scope cost when applied to the full population in the ACFR 2021–22.

The total in-scope cost used the imputed RN, EN and PCW labour costs adjusted to meet the mandatory care minute targets from 1 October 2024.

3.4.1 Services funded based on occupied places (BCTs 4, 5, 6 and 7)

There was insufficient data in RACCS to model the costs for BCT categories 1, 2 and 3. Therefore, the model was initially calibrated to the subset of services in BCT categories 4, 5, 6 and 7. The treatment of BCT 1, 2 and 3 is discussed in Section 3.4.2.

In-scope cost

As discussed in Section 2.2.3, IHACPA has retained the existing price weight for the initial entry adjustment payment. Therefore, the costs relating to new entrants were excluded before the model calibration, using the total NWAU associated with initial entry adjustment payments and the reference cost. The in-scope cost excluding costs associated with new entrants for service s was calculated as follows:

$$\text{in scope cost excluding new entrants}_s = \text{in scope cost}_s - \text{new entrant NWAU}_s \times \text{reference cost.}$$

Modelled cost

The average cost parameters for each AN-ACC class a and BCT category b derived in Section 3.2. were multiplied by the number of bed days to determine the total modelled cost for each service s:

$$\text{modelled cost}_s = \sum_a P_{s,a} \times OBD_s \times \alpha_a + \sum_b D_{s,b} \times \beta_b.$$

Given no average costs for BCT categories 1, 2 or 3 could be calculated from RACCS, this process was restricted to the services in BCT categories 4, 5, 6 and 7.

Cost calibration

IHACPA then calculated the ratio of the total in-scope cost, excluding costs associated with new entrants, to total modelled cost, including fixed and variable components, across all services in BCT categories 4-7. This cost ratio represents the amount by which average costs should be adjusted to ensure that the total modelled cost equals the actual cost when restricted to those BCT categories.

The average variable and fixed costs for each AN-ACC class a and BCT category b (4, 5, 6 or 7) were then re-calibrated by multiplying by the cost ratio.

3.4.2 Services funded based on operational places (BCTs 1, 2 and 3)

IHACPA used the ACFR to model the average cost for BCT categories 1, 2 and 3 where insufficient data was available in RACCS.

The BCT subsidy for services in MMM 6 and 7 is based on the number of operational places rather than occupied bed days, and thus the modelled cost is sensitive to the occupancy rates of those services. Given the limited number of services in MMM 6 and 7 and sensitivity to occupancy rates, IHACPA maintained the existing relativities between BCTs 3H, 3L, 1 and 2 to ensure price stability, particularly for the limited number of specialised Aboriginal or Torres Strait Islander services in remote and very remote locations.

Standard MMM 6-7 (BCT 3)

The total fixed cost for each service s in BCT category 3 was calculated by subtracting the modelled variable cost after calibration from the total in-scope cost excluding new entrants:

$$\text{fixed component of in scope cost}_s = \text{in scope cost excluding new entrants}_s - \sum_a P_{s,a} \times OBD_s \times \alpha\_\text{adj}_a$$

where α_adj_a is the average individual modelled cost for AN-ACC class a after calibration.

IHACPA then modelled the average fixed cost per available bed day for BCTs 3H and 3L using the total fixed cost and number of available bed days across all BCT 3 services in the ACFR. Two conditions were enforced:

1. The total modelled cost across all BCT 3 services must equal the total actual cost in the ACFR. That is, the modelled cost for BCT 3H multiplied by the number of available bed days plus the modelled cost for BCT 3L multiplied by the number of available bed days equals the fixed component of in-scope costs:

$$\sum_{s(bct=3)} \text{fixed component of in scope cost}_s = \sum_{s(bct=3)} D_{s,3H} \times \beta\_\text{adj}_{3H} + D_{s,3L} \times \beta\_\text{adj}_{3L}$$

where β_adj_{3H} and β_adj_{3L} are the average fixed care costs for BCT categories 3H and 3L.

2. The ratio of price weights between BCTs 3L to 3H was maintained:

$$\frac{\beta\_\text{adj}_{3L}}{\beta\_\text{adj}_{3H}} = \frac{NWAU_{3L}}{NWAU_{3H}} = \frac{0.52}{0.68}.$$

Here $NWAU_{3L}$ and $NWAU_{3H}$ refer to the NWAU23 price weights.

The average cost parameters β_adj_{3L} and β_adj_{3H} were calculated to satisfy those conditions.

Specialised Aboriginal or Torres Strait Islander MMM 6-7 (BCT 1 and 2)

Insufficient data was available in the trimmed ACFR to confidently model the average shared cost for services in BCT categories 1 and 2. IHACPA therefore maintained the existing relativities to services in BCT 3 to estimate the average fixed cost per available bed day for these services.

The average fixed cost per available bed day for services in BCT 1 was calculated as:

$$\beta\_\text{adj}_1 = \beta\_\text{adj}_{3H} \times \frac{NWAU_1}{NWAU_{3H}} = \beta\_\text{adj}_{3H} \times \frac{1.80}{0.68}.$$

The modelled cost for BCT category 2 was calculated similarly.

3.4.3 Cost calibration to ACFR

The adjusted costs for each AN-ACC class and BCT categories 4-7 from Section 3.4.1 and BCT categories 1-3 from Section 3.4.2 were re-calibrated to ensure that modelled costs were equivalent to actual costs across all services in the population.

Following the same process described in Section 3.4.1, IHACPA calculated the total in-scope cost and modelled cost for all services in the trimmed ACFR. The individual and shared cost parameters were re-calibrated by multiplying by the cost ratio.

3.5 Price weights

The final price weights, measured in NWAU, were calculated by dividing the stabilised costs by the reference cost per NWAU, adjusted to meet the 1 October 2024 care minute targets.

Consistent with IHACPA's National Pricing Model Stability Policy used for public hospital pricing, price weight movements for AN-ACC classes and BCT categories were restricted to be ±20% of the previous weight. The price weights for the modified BCT categories 6 (Standard MMM 1), 4 (Standard MMM 2-3) and 7 (Standard MMM 4-5) were stabilised against the weighted average price weight based on those services' existing BCT classifications. Price weights were stabilised using an iterative process, whereby after each iteration the unstabilised price weights were recalibrated to ensure that the total modelled cost matched the total actual cost.

4 Indexation

4.1 Overview

Following the calculation of the reference cost in 2021–22 dollars, IHACPA made adjustments to account for known cost increases then indexed the reference cost to determine the recommended AN-ACC price per NWAU for 2024–25.

The key aspects considered by IHACPA in the indexation methodology included:

- Fair Work Commission Work value case – Aged care industry (subsequently referred to as the Aged Care Work Value Case) Stage 2 decision to increase wages for direct care workers and recreation/lifestyle officers
- Aged Care Work Value Case Stage 3 decision to further increase wages for direct and indirect care aged care workers and adjust the classification structure
- superannuation guarantee increase
- indexation of historical cost data to account for underlying price inflation
- changes to the AN-ACC pricing cycle.

To account for the compounding impact of each of these factors, IHACPA applied labour cost adjustments for 3 distinct time periods:

a) Step 1: indexation and adjustments to 1 October 2024
    i) Adjust for Aged Care Work Value Case Stage 2 decision
    ii) Adjust for superannuation guarantee increases from 2021–22 to 2024–25
    iii) Indexation from 2021–22 to 2024–25
b) Step 2: indexation and adjustments to 1 January 2025
    i) Adjust for Aged Care Work Value Case Stage 3 decision
c) Step 3: indexation and adjustments to 1 July 2025
    i) Adjust for superannuation guarantee increase from 2024–25 to 2025–26
    ii) Indexation from 2024–25 to 2025–26.

The labour component of the recommended AN-ACC price was calculated as the weighted average labour cost over the periods from 1 October 2024 to 31 December 2024, 1 January 2025 to 30 June 2025, and 1 July 2025 to 30 September 2025.

Non-labour costs were treated separately and indexed to the period from 1 October 2024 to 30 September 2025.

4.2 Cost proportions

To apply these adjustments and index costs to the period from 1 October 2024 to 30 September 2025, IHACPA first disaggregated the reference cost of $214.21 into labour and non-labour components.

IHACPA calculated the proportion of total costs associated with each expense category from the ACFR, after trimming and adjustments to reflect the cost of meeting the Department of Health and Aged Care's mandatory care minute targets.

As discussed in Section 2.3.5, all care expense items in the ACFR except payroll tax have been considered in-scope in RACPA24, plus the component of administration costs allocated to care. The total in-scope costs from the ACFR, disaggregated into labour and non-labour components, are summarised in Table 13.

Table 13: Summary of in-scope costs from the trimmed ACFR

Cost component	Total (ACFR 2021–22)	Proportion	Reference cost (2021–22 dollars)
Labour cost	$10,067.8m	89.62%	$191.97
Non-labour cost	$1,166.4m	10.38%	$22.24
Total*	**$11,234.2m**	**100.00%**	**$214.21**

*Components may not add due to rounding.

4.3 Labour cost indexation and adjustments

4.3.1 Step 1: indexation and adjustments to 1 October 2024

Fair Work Commission Aged Care Work Value Case Stage 2 decision

The Fair Work Commission Aged Care Work Value Case relates to applications to vary the minimum wages for aged care employees in 3 Awards:

- *Aged Care Award 2010* (Aged Care Award)
- *Nurses Award 2010* (Nurses Award)
- *Social Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award).

On 21 February 2023, in the Stage 2 decision, the Fair Work Commission announced an increase of 15% to the minimum wages of the following employees under the awards listed above:

- direct care workers under the awards (defined as registered nurses, enrolled nurses, and personal care workers / assistants in nursing)
- recreation activity officers and lifestyle officers
- cooks and chefs at level 4-7, provided they are the most senior chef or cook engaged at the service.

Note that the final item does not affect the RACPA24 calculation but may influence the hotel cost gap analysis.

Per the Fair Work Commission's decision, the Stage 2 wage increases applied from 30 June 2023.

The Commonwealth's submission to the Aged Care Work Value Case states that most of the aged care workforce are covered by enterprise bargaining agreements (EBAs), the majority of which have passed their nominal expiring dates. Therefore, most workers under EBAs are paid at the award wage by default, as annual increases to the award have surpassed the EBA rate.

The submission goes on to state that significant proportion of aged care nurses are on active EBAs and are broadly paid 15% above awards. Estimates in 2021–22 based on survey data indicated that 23.43% of nurses were on active EBAs which are 15% or more above the award.

IHACPA applied the increase to the labour cost proportions given in Table 13 using the following methodology:

- 23.43% of nursing and care management costs are not inflated, and the remainder (76.57%) are inflated in line with the 15% wage increase
- personal care worker / assistant in nursing and recreation activity officer labour costs are inflated by 15%
- other labour costs are not inflated.

The effect of this increase on the labour component of the reference cost is shown in Table 14.

Table 14: Fair Work Commission Aged Care Work Value Case Stage 2 decision

Labour cost component	Reference cost (2021–22 dollars)	Stage 2 decision adjustment	Cost after Stage 2 adjustment (2021–22 dollars)
Registered nurses, enrolled nurses, and care management staff	$70.16	11.49%	$78.22
Personal care workers, assistants in nursing and recreational activity officers	$111.14	15.00%	$127.81
Administration, allied health, and other staff	$10.67	-	$10.67
Total*	**$191.97**	**12.88%**	**$216.70**

*Components may not add due to rounding.

Superannuation guarantee increase 2021–22 to 2024–25

Section 19(2) of the *Superannuation Guarantee (Administration) Act 1992* stipulates increases in the minimum amount of superannuation an employer pays (the guarantee rate) by 0.5% each year from 1 July 2021 until 1 July 2025.

IHACPA does not have data on which providers are paying superannuation at the guarantee rate and which are on EBAs paying above the guarantee rate.

In the absence of any data on superannuation contributions above the guarantee rate in the aged care workforce, IHACPA has assumed that the workforce is paid at the guaranteed rate. This implies that there will be a 0.5% (50 basis points) increase in the superannuation component of labour costs per annum, or a 1.5% increase between 2021–22 and 2024–25. This represents a 15% increase in the overall superannuation component.

As increases to the superannuation guarantee are not captured in the Wage Price Index or Annual Wage Review decisions, a separate adjustment is required. This adjustment was made by increasing the superannuation component of labour costs from 10.0% in 2021–22 to 11.5% for 2024–25. The effect of this adjustment on labour costs is shown in Table 15.

Table 15: Superannuation guarantee increase

Labour cost component	Cost after Stage 2 adjustment (2021–22 dollars)	Superannuation guarantee adjustment	Cost after superannuation guarantee adjustment (2021–22 dollars)
Non-superannuation labour cost	$197.00	-	$197.00
Superannuation component	$19.70	+15.00%	$22.65
Superannuation proportion	10.00%	+1.50%	11.50%
Total*	**$216.70**	**1.36%**	**$219.65**

*Components may not add due to rounding.

Indexation 2021–22 to 2024–25

To determine the underlying growth rate for labour costs, IHACPA used quarterly index numbers from the ABS index time series 6345.0 WPI, Australia, December 2023.

As approximately 90% of aged care providers are private entities, it is reasonable to expect that public providers are competitive with private wages. Therefore, IHACPA has selected the series *Quarterly Index; Total hourly rates of pay excluding bonuses; Australia; Private; Health care and social assistance* (Series ID A2602929A) to determine wage price growth.

All earnings statistics published by the ABS, including the WPI exclude employers' social contributions such as superannuation[2], and therefore the superannuation increase will not be double counted through this indexation process.

WPI deflation

Due to the composition of the *Quarterly Index; Total hourly rates of pay excluding bonuses; Australia; Private; Health care and social assistance* WPI, aged care workers eligible for the Fair Work Commission Aged Care Work Value Case Stage 2 wage increase only represent a minority of the sample. Therefore, the impact of this decision on labour costs in residential aged care was only partially reflected in the index.

As an adjustment for the Stage 2 decision has already been applied, IHACPA has deflated the WPI series to remove the impact of the wage increase for aged care workers, to avoid double counting when adjusting for underlying inflation. No adjustments were made for the Stage 3 decision, as it has no impact on the historical index series. IHACPA has applied the same methodology to the *Quarterly Index; Total hourly rates of pay excluding bonuses; Australia; Private and Public; All industries* (Series A2603609J) ("headline WPI").

The WPI is weighted based on the weighted sum of weekly total cash earnings from the Survey of Employee Earnings and Hours. Through analysis of data accessed via TableBuilder, earnings can be disaggregated into divisions, subdivisions, groups and classes of the Australian and New Zealand Standard Industrial Classification (ANZSIC) to determine the relative contributions of different industries to the WPI.

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[2] https://www.abs.gov.au/statistics/understanding-statistics/guide-labour-statistics/earnings-guide

The *Private; Health care and social assistance* WPI index series corresponds to division *Q Health care and social assistance* in the ANZSIC classification. Employees working in aged care are classified under class *8601 Aged care residential services*, group *860 Residential care services* and subdivision *86 Residential care services* within *Q Health care and social assistance*.

Private sector employees in the health care and social assistance industry comprise 8.19% of *Private and Public; All industries* (that is, the classification grouping used for the headline WPI) weighted sum of weekly total cash earnings. Disaggregating further, private *Residential care services* comprises 19.68% of the *Private; Health care and social assistance* industry, and 1.61% of *Private and Public; All industries*. This is summarised in Table 16

Table 16: Weighted sum of weekly total cash earnings, ABS Employee Earnings and Hours, May 2021

ANSZIC	Weighted sum of weekly total cash earnings	Proportion of *Private; Health care and social assistance*	Proportion of *Private and Public; All industries*
86 Residential care services, private sector	$260.1m	19.68%	1.61%
Q Health care and social assistance, private sector	$1,321.7m	100.00%	8.19%
All industries, public and private	$16,143.1m	-	100.00%

*Components may not add due to rounding.

To estimate the proportion of workers eligible for the Aged Care Work Value Case Stage 2 decision minimum wage increase within *Residential care services*, IHACPA analysed occupation data based on the Australian and New Zealand Classification of Occupations (ANZSCO).

Like the industrial classifications (ANZSIC), ANZSCO classifications are hierarchical. Occupations are classified into major groups (for example, major group 2 – professionals), sub-major groups (for example, sub-major group 25 – health professionals), minor groups (for example, minor group 254 – midwifery and nursing professionals) and unit groups (for example, unit group 2544 – registered nurses).

IHACPA sourced data from TableBuilder on the weighted sum of weekly total cash earnings within *Residential care services* disaggregated by occupation sub-major groups. As earnings data was not available at the minor group or unit group level, IHACPA extracted more granular occupation data from the 2021 Census to determine the proportion of workers in *Residential care services* within each sub-major group who would be eligible for the Stage 2 decision minimum wage increase.

First, IHACPA identified the ANZSCO unit groups corresponding to occupations eligible for the 15% wage increase. The number of employees in each of these unit groups working in Aged Care Residential Services is summarised in Table 17.

Table 17: ANZSCO occupation groups eligible for Aged Care Work Value Case Stage 2 decision minimum wage increase

Occupation	ANZSCO Sub-Major Group	ANZSCO Unit Group	Number of employees in *Aged Care Residential Services*	Proportion
Registered nurses (including nurse practitioners)	25 Health Professionals	2543 Nurse Managers 2544 Registered Nurses	36,470	14.12%
Recreational activities officers	27 Legal, social and Welfare Professionals	272612 Recreation Officer	199	0.08%
	41 Health and Welfare Support Workers	411311 Diversional Therapist	3,479	1.35%
Enrolled nurses		4114 Enrolled and Mothercraft Nurses	10,042	3.89%
Personal care workers	42 Carers and Aides	4231 Aged and Disabled Carers 423313 Personal Care Assistant 4230 Personal Carers and Assistants	94,651	36.65%
Assistants in nursing		4233 Nursing Support and Personal Care Workers not further defined 423312 Nursing Support Worker	25,579	9.90%
Head chefs and cooks (one per service)	35 Food Trades Workers	3513 Chefs 3514 Cooks	5,275	2.04%
All other occupations	-	-	82,579	31.97%
Total*	-	-	**258,274**	**100.00%**

*Components may not add due to rounding.

In line with the Commonwealth's submission to the Aged Care Work Value Case, IHACPA assumed that all personal care workers, assistants in nursing, recreational activities officers, and 76.57% of registered and enrolled nurses in the residential aged care industry received the full 15% wage increase from the Stage 2 decision. In addition, 2,640 head chefs and cooks, equivalent to one per residential service from the 30 June 2023 AIHW GEN aged care service list, were assumed to be eligible.

The number of eligible employees compared to the total number of employees the *Residential care services* subdivision is summarised in Table 18.

Table 18: Aged care residential services employees eligible for minimum wage increase under Aged Care Work Value Case Stage 2 decision

ANZSCO Sub-Major Group	Weighted sum of weekly total cash earnings (A)	Total employees in 86 Residential Care Services (B)	Total employees in 8601 Aged Care Residential Services (C)	Number of employees in 8601 Aged Care Residential Services eligible for 15% wage increase (D)	Proportion of 86 Residential Care Services employees eligible for 15% wage increase (E=D/B)
25 Health Professionals	$35.6m	42,048	36,470	27,925	66.4%
27 Legal and Welfare Professionals	$4.3m	6,807	199	199	2.9%
41 Health and Welfare Support Workers	$30.9m	21,835	13,512	11,168	51.1%
42 Carers and Aides	$118.5m	134,291	120,230	120,230	89.5%
35 Food Trades Workers	$3.6m	5,435	5,275	2,640	48.6%
Other	$67.1m	69,655	82,579	-	-
Total^	$260.1m	280,071	258,274	162,162	56.7%*

*Weighted by weighed sum of weekly total cash earnings.
^Components may not add due to rounding.

In Table 18, columns A and B show the weighted sum of weekly total cash earnings and the total number of employees working in the *Residential Care Services* subdivision. The number of employees in *Aged Care Residential Services*, a class of this subdivision, are presented in column C, and align with the results in Table 17. IHACPA multiplied these numbers by the proportions of employees eligible for a wage increase under the Aged Care Work Value Case Stage 2 decision to get the number of eligible employees in column D. For example, 76.57% of registered nurses are earning less than 15% above the award rate, so the number of eligible employees presented in column D is $36,470 \times 76.57\% = 27,925$.

For each ANZSCO sub-major group in Table 18, IHACPA then calculated the proportion of employees working in the *Residential Care Services* subdivision who were eligible for the Stage 2 decision wage increase.

These proportions were then multiplied by the weighted sum of weekly total cash earnings (column A), which showed that 56.7% of total earnings within the *Residential Care Services* ANZSIC sub-division are attributable to employees impacted by the Stage 2 decision.

IHACPA applied this result to the previous results in Table 16, which showed that 11.15% of the *Private; Health care and social assistance* index and 0.91% of the *Australia; Private and Public; All industries;* (headline WPI) represent employees who were eligible for the 15% increase.

The *Private; Health care and social assistance* and headline WPI values were adjusted for September 2023 and December 2023 to remove the impact of the 15% increase in minimum wages for aged care workers effective from 1 July 2023. Index values were adjusted as follows:

$$\text{adjusted index}_n = \frac{\text{index}_n}{1 + \text{proportion of index eligible for Stage 2 decision minimum wage increase} \times 0.15}$$

where:

- index_n is the value of the index series at time n
- adjusted index_n is the value of the index series at time n after adjusting to remove the impact of the Aged Care Work Value Case Stage 2 decision.

Annual Wage Review impact

IHACPA undertook analysis of the impact of the Fair Work Commission's Annual Wage Review decisions on the *Private; Health care and social assistance* WPI sub-index.

Figure 2: Comparison of Annual Wage Review decisions and annual *Private; Health care and social assistance* WPI growth
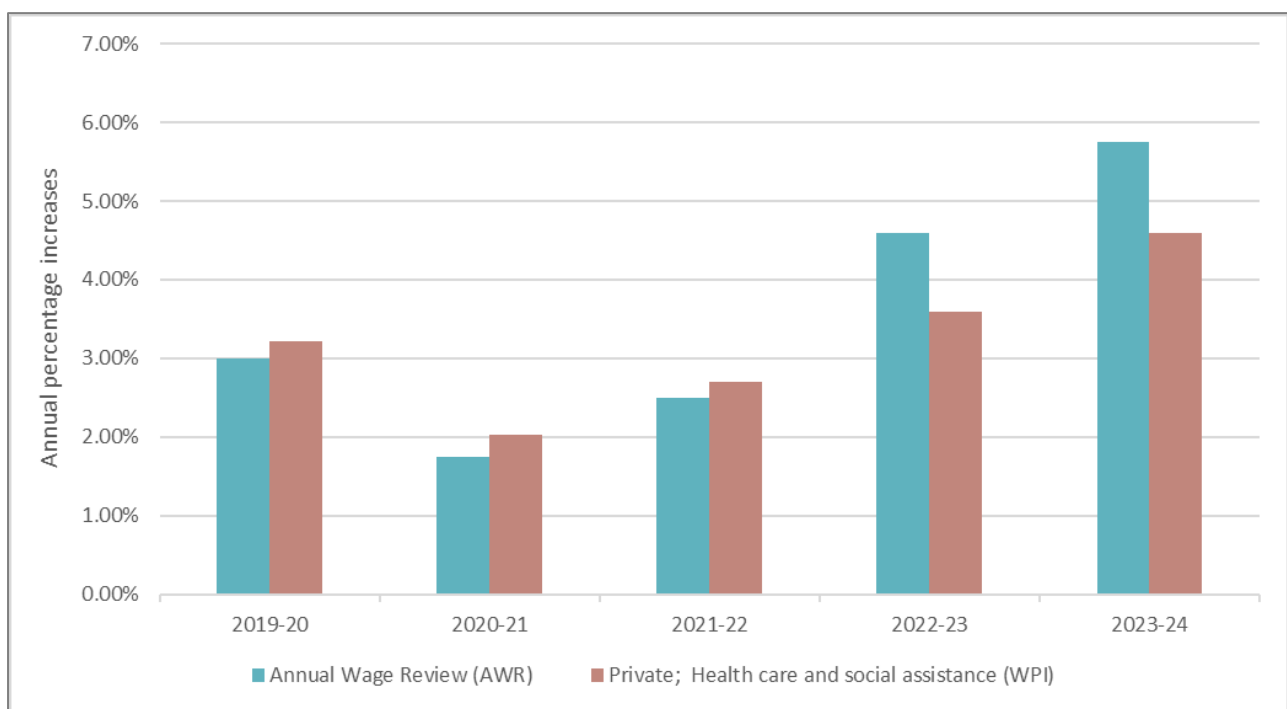
In Figure 2, the columns compare Annual Wage Review decisions mandated by the Fair Work Commission with the annual growth in the *Private; Health care and social assistance* index series to the December quarter. These 2 values being equal would indicate that the *Private; Health care and social assistance* index series increased at the same rate as the minimum wage as determined by the Fair Work Commission.

In 2019–20 to 2021–22, the annual growth in the *Private; Health care and social assistance* index was higher than the Annual Wage Review decision, suggesting that workers on average received above award wage increases. This trend appears to have reversed in 2022–23 and 2023–24, suggesting that workers on average received a lower wage increase relative to the award rate.

Over the past 5 years, there has been an average of 97.83% passthrough of the Annual Wage Review increase to the annual growth to the December quarter in the *Private; Health care and social assistance* WPI index.

Labour cost indexation

As previously discussed, most of the aged care workforce are paid at the award wage. It was therefore assumed that aged care wages rise would increase on 1 July each year in line with Fair Commission Annual Wage Review decisions, and that wages do not increase throughout the year outside of the cycle of reviews (with the exception of wage increase as a result of Aged Care Work Value Case decisions).

The indexation rate applied to labour costs from 2021–22 to 2024–25 compounds the impact of 3 years of wage increases on 1 July 2022, 1 July 2023, and 1 July 2024:

- the actual value of the *Private; Health care and social assistance* index series in December 2022 (mid-point of 2022–23) divided by the actual value in December 2021 (mid-point of 2021–22)
- the adjusted value of the *Private; Health care and social assistance* index series in December 2023 (mid-point of 2023–24) divided by the actual value in December 2022 (mid-point of 2022–23)
- 2023–24 Annual Wage Review, which increased minimum wages by 3.75% effective 1 July 2024, multiplied by the 97.83% pass-through rate.

The total indexation rate for labour costs from 2021–22 to 2024–25 is therefore:

$$(1 + 3.60\%) \times (1 + 4.59\%) \times (1 + 3.67\%) - 1 = 12.33\%.$$

Indexation has an overall impact of 12.33% on labour costs after the superannuation guarantee adjustment has been applied. This results in a labour cost of $246.73 in 2024–25 dollars.

4.3.2 Step 2: indexation and adjustments to 1 January 2025

Fair Work Commission Aged Care Work Value Case Stage 3 decision

The Stage 3 Fair Work Commission decision on 15 March 2024 dealt with further wage adjustments for direct and indirect care employees, with a detailed consideration of the classification definitions and structures, in the 3 awards listed in Section 4.3.1.

Personal care workers (PCWs) and assistants in nursing (AINs) received a further wage increase beyond the 15% announced in the Stage 2 decision. The extent of these further wage increases varies by level under the updated classification structure.

Indirect care workers such as laundry hands, cleaners and food service assistants received a 6.96% increase, while other indirect care workers received 3%.

On 27 June 2024, the Fair Work Commission announced the operative date and phasing-in of the Stage 3 decision, with the full increases passed on to indirect care workers from 1 January 2025, and increases for direct care workers split over 2 tranches, effective from 1 January 2025 (subsequently referred to as tranche 1) and 1 October 2025 (subsequently referred to as tranche 2). Only tranche 1 is relevant for RACPA24.

There are 3 categories for tranche 1 for direct care workers:

- if the total increase is more than 6%, half of the total increase should take effect on 1 January 2025
- if the total increase is more than 3% but less than 6%, a 3% increase should take effect on 1 January 2025
- if the total increase is less than 3%, the total increase should take effect on 1 January 2025.

The adjustments applied to each labour cost category and the impact on the total labour cost are summarised in Table 19.

Table 19: Fair Work Commission Aged Care Work Value Case Stage 3 decision (tranche 1)

Labour cost component	Cost after indexation (2024–25 dollars)	1 January 2025 adjustment	Cost after Stage 3 adjustment (2024–25 dollars)
Personal care workers, assistants in nursing and recreational activity officers	$145.52	3.45%	$150.54
Administration and other staff	$4.51	3.00%	$4.64
Registered nurses, enrolled nurses, care management and allied health staff	$96.70	-	$96.70
Total*	**$246.73**	**2.09%**	**$251.89**

*Components may not add due to rounding.

The 3.45% increase for personal care workers, assistants in nursing and recreational activity officers represents the weighted average increase relative to wages as at 1 July 2024 based on the number of full time equivalent (FTE) employees at each classification level.

IHACPA calculated the number of FTE in 2024–25 at each PCW and AIN classification level using the department's Aged Care Wage Estimation Tool and data from the Aged Care Provider Workforce Survey 2022–23 to estimate the proportion of PCWs holding a Certificate IV qualification.

These FTE were multiplied by the annualised pay rates from the Fair Work Ombudsman to estimate the proportion of total personal care worker / assistant in nursing labour costs attributable to each level of the awards, and then by the tranche 1 percentage increases to get the weighted average increase for PCWs and AINs.

Under the updated classification structure, personal care workers, assistants in nursing and lifestyle staff are all classified as direct care employees covered by the Aged Care Award. For this reason, labour costs for these employees have been combined and adjusted by the same amount.

4.3.3 Step 3: indexation and adjustments to 1 July 2025

Superannuation guarantee increase 2024–25 to 2025–26

From 1 July 2025, the superannuation guarantee will increase by a further 0.5% (50 basis points) from 11.5% to 12.0%. IHACPA adjusted the superannuation component of labour costs accordingly, using the same methodology described in Section 4.3.1. The effect of this adjustment on labour costs is shown in Table 20.

Table 20: Superannuation guarantee increase

Labour cost component	Cost after Stage 3 adjustment (2024–25 dollars)	Superannuation guarantee adjustment	Cost after superannuation guarantee adjustment (2024–25 dollars)
Non-superannuation labour cost	$225.91	-	$225.91
Superannuation component	$25.98	+4.35%	$27.11
Superannuation proportion	11.5%	+0.50%	12.0%
Total*	**$251.89**	**0.45%**	**$253.02**

*Components may not add due to rounding.

Indexation 2024–25 to 2025–26

Due to changes in the AN-ACC pricing cycle, the price from 1 October 2024 to 30 September 2025 will remain in effect after 1 July 2025 when the Fair Work Commission's 2024–25 Annual Wage Review decision takes effect. However, this decision will not be handed down until June 2025, so IHACPA has relied on forecast growth in labour costs between 2024–25 and 2025–26 to reflect this in the recommended AN-ACC price.

WPI forecast

At the time of modelling, ABS WPI data was available up to the December 2023 quarter. IHAPCA used the RBA's headline WPI forecast from the Statement on Monetary Policy – February 2024 to forecast values of the *Private and Public; All industries* WPI from March 2024 to June 2026.

Following deflation of the headline WPI and *Private; Health care and social assistance* indexes to remove the impact of the Stage 2 decision, as per Section 4.3.1, IHACPA undertook analysis of the relative growth rates of the 2 indexes. Over the past 3 years, the *Private; Health care and social assistance* index has increased at an annual rate of approximately 0.35% higher than the headline WPI.

For each quarter n, IHACPA forecast the value of the *Private; Health care and social assistance* index based on growth in the headline CPI:

$$\text{adjusted Private; Health care and social assistance index}_n$$
$$= \text{adjusted Private; Health care and social assistance index}_{n-4} \times \frac{\text{adjusted WPI}_n}{\text{adjusted WPI}_{n-4}}$$
$$\times 1.0035$$

where $\text{adjusted Private; Health care and social assistance index}_n$ and $\text{adjusted WPI index}_n$ are the values of the respective index series in quarter n after adjusting to remove the impact of the Stage 2 decision.

The adjusted index, re-referenced to the December 2020 quarter, is shown in Figure 3.

Figure 3: Headline WPI and *Private; Health care and social assistance* time series
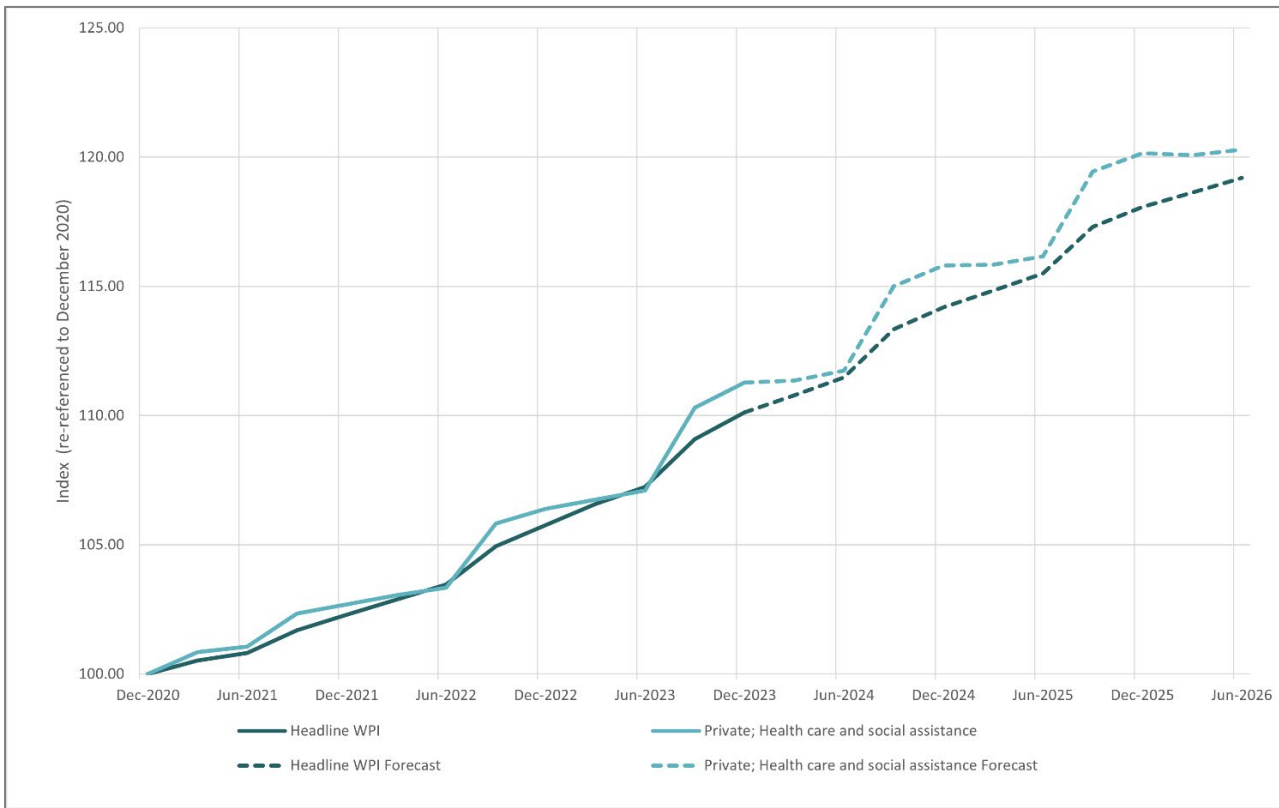
Labour cost indexation

The increase in labour costs on 1 July 2025 was then estimated using the forecast value of the adjusted *Private; Health care and social assistance* index series in December 2025 (mid-point of 2025–26) divided by the forecast value of the index in December 2024 (mid-point of 2024–25). This resulted in an estimated 3.76% increase in labour costs, which results in a labour cost of $262.54 in 2025–26 dollars.

4.3.4 Summary of labour cost indexation and adjustments

Adjustments and indexation of the labour component of the reference cost are summarised in Table 21.

Table 21: Summary of labour cost indexation and adjustments

Step	Labour cost	Change
Reference cost (2021–22 dollars)	$191.97	-
Aged Care Work Value Case Stage 2 decision (effective 30 June 2023)	$216.70	12.88%
Superannuation guarantee increase from 2021–22 to 2024–25	$219.65	1.36%
Indexation from 2021–22 to 2024–25	**$246.73**	**12.33%**
Aged Care Work Value Case Stage 3 tranche 1 (effective 1 January 2025)	**$251.89**	**2.09%**
Superannuation guarantee increase from 2024–25 to 2025–26	$253.02	0.45%
Indexation from 2024–25 to 2025–26	**$262.54**	**3.76%**

IHACPA determined the labour component of the recommended AN-ACC price from 1 October 2024 to 30 September 2025 price using a weighted average of the labour cost over the periods from 1 October 2024 to 31 December 2024, 1 January 2025 to 30 June 2025, and 1 July 2025 to 30 September 2025 by the number of days in each period. This is summarised in Table 22 below.

Table 22: Summary of labour cost indexation and adjustments

Period	Labour cost	Days
1 October 2024 to 31 December 2024	$246.73	92
1 January 2025 to 30 June 2025	$251.89	181
1 July 2025 to 30 September 2025	$262.54	92
1 October 2024 to 30 September 2025 (weighted average)*	**$253.27**	**365**

*Weighted average may not match due to rounding.

4.4 Non-labour cost indexation

4.4.1 Non-labour indexation rate

The non-labour component of direct care costs in the ACFR 2021–22 consists of:

- resident expenses, including medical supplies, incontinence supplies, oral nutritional supplements, oral health living expenses and other resident services and consumables
- insurance expenses, such as WorkCover premiums, including those associated with the care allocation of administration costs
- other direct care expenses, including agency (non-salary) fees, external costs for quality and compliance and training, chaplaincy/pastoral care, other direct care expenses, and the care component of non-labour administration costs.

As there is no single index that reflects this mix of products, IHACPA constructed a composite index from CPI subgroups to measure inflation of input costs in residential aged care. IHACPA has used the quarterly index numbers from ABS index time series 6041.0 CPI, Australia, December 2023. The subgroups were then weighted according to the proportions of total costs in the trimmed ACFR.

The composition of this index is summarised in Table 23.

Table 23: Summary of non-labour cost index

CPI Index subgroup	Series ID	Cost component	Total (ACFR 2021–22)	Proportion
Index Numbers; Medical products, appliances, and equipment; Australia	A3604438R	Resident expenses	$355.5m	30.48%
Index Numbers; Insurance; Australia;	A3602878J	Insurance	$196.9m	16.88%
Index Numbers; Other financial services; Australia	A2332776R	Other direct care expenses	$614.0m	52.64%
Total*			**$1,166.4m**	**100.00%**

*Components may not add due to rounding.

Composing index series

The CPI series are generally referenced to 2011–12 financial year. That is, they are expressed such that the annual index for 2011–12 is equal to 100.0. For example, the other financial services index number for December 2023 is 128.5, indicating that the consumer price for that subgroup is 28.5% higher in December 2023 than in the 2011–12 financial year.

If index series for subgroups published by ABS are combined directly, there is an implicit assumption that the relative cost for each group has been equal since the reference year in 2011–12. This in general is not the case, so each index series must be weighted before combining to reflect the cost proportions in the period of interest.

IHACPA has addressed this in 2 stages. Firstly, each index series was re-referenced to the latest available quarter. Then the re-referenced indexes series were weighted and combined.

Example of re-referencing index

For example, the index series A3604438R (Medical products, appliances and equipment; Australia) used for resident non-labour expenses had a value of 107.4 in December 2022, and 108.0 in December 2023, giving a growth of 0.6% in that year. To re-reference this index to 100.0 in December 2023, all index numbers were divided by the December 2023 index value and multiplied by 100. Then the new December 2022 index value was 99.4, and the new December 2023 value was 100.0. The change between the 2 quarters is still 0.6%.

Then, each of the re-referenced index series were weighted according to the relative costs in each group, calculated using the trimmed, adjusted ACFR 2021–22 as summarised in Table 23 above.

4.4.2 Indexation

The average annual growth rate of the weighted index was determined by fitting an exponential regression model. The model takes the form:

$$\text{index}_n = b \times r^n + \epsilon_n$$

where:

- index_n is the value of the underlying index series at time n
- n is the time unit, in this case the year and quarter for the index value

- b is the estimated value of the index when $n = 0$ (the intercept)
- r is the growth rate per unit change in n (in this case, per quarter)
- ϵ_n is the error term.

The coefficient of interest in this model is the term r, which is the best estimate of the growth rate per quarter. This was then converted to an annual indexation rate $i = r^4$.

IHACPA fit an exponential growth curve to the non-labour composite index series to measure average annual growth. The non-labour direct care cost index series along with the 3 contributing CPI subgroups is shown in Figure 4.

Figure 4: Index series used for non-labour direct care cost growth
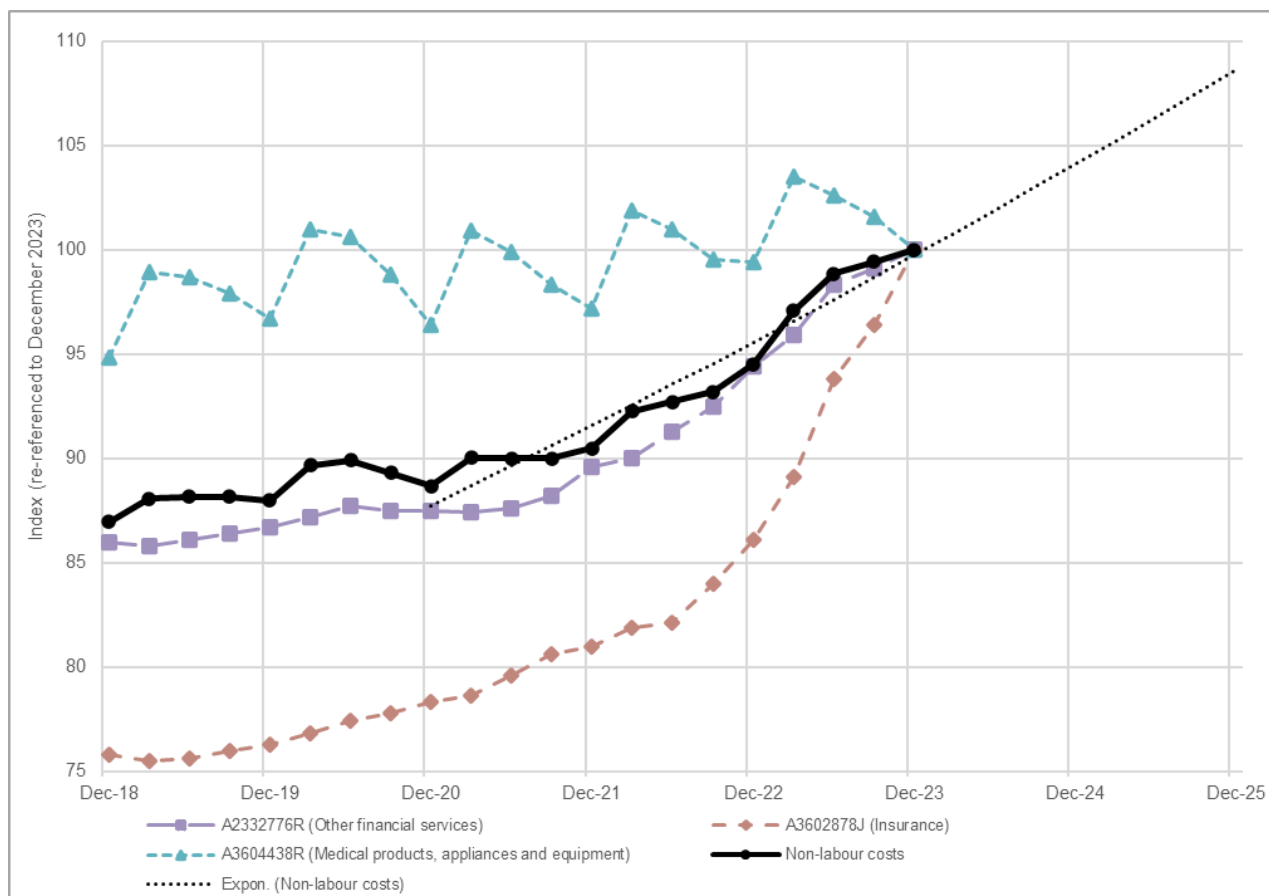
IHACPA notes the clear seasonality of the medical products index, which is driven by variation in consumer pharmacy costs, likely due to the effect of the Pharmaceutical Benefits Scheme's Safety Net.

The dotted line shows the exponential regression curve fit to the non-labour direct care index as a best estimate of average annual non-labour direct care cost over that period.

The resulting model is:

$$\text{index}_n = 99.7380 \times 1.0108^n.$$

This model gives an annual non-labour direct care cost indexation rate i_C of:

$$i_C = 1.0108^4 = 1.0437.$$

Note that this expression may not evaluate as written due to rounding. Therefore, the annualised growth rate used for inflation in non-labour direct care costs is 4.37%. This rate was then used to index the non-labour direct care component of the reference cost.

As shown in Table 13, non-labour care costs were estimated to be $22.24 per NWAU in 2021–22. This value was indexed by approximately 3.25 years from 30 December 2021 (the midpoint of the 2021–22 financial year) to 1 April 2025 (the midpoint of 1 October 2024 to 30 September 2025).

The non-labour component of the recommended AN-ACC price from 1 October 2024 to 30 September 2025 is therefore:

$$\$22.24 \times 1.0437^{3.253} = \$25.56.$$

4.5 Loading for the period from 1 July 2024 to 30 September 2024

For RACPA24, IHACPA has advised on the recommended AN-ACC price from 1 October 2024 to 30 September 2025. This takes into consideration changes made by the government to the AN-ACC pricing cycle and represents a change compared to the Residential Aged Care Pricing Advice 2023–24, which advised on the recommended AN-ACC price from 1 July 2023 to 30 June 2024.

In recognition of this change and the fact that the AN-ACC price applicable from 1 December 2023 has not been updated following the 2023–24 Annual Wage Review and 1 July 2024 superannuation guarantee increase, IHACPA has added a loading to the recommended AN-ACC price to account for the difference between the AN-ACC price applicable from 1 December 2023 and the cost of care over the 3 months from 1 July 2024 to 30 September 2024. This ensures providers are compensated for the difference in funding had the AN-ACC price been updated from 1 July 2024.

As described in Section 3.3.2, the reference cost, adjusted to meet the mandatory care minute requirements applicable from 1 October 2023, is $204.05 per NWAU in 2021–22 dollars. Following the same process outlined for the price from 1 October 2024 to 30 September 2025, IHACPA calculated the proportion of costs associated with each expense category from the ACFR 2021–22 and separately indexed the labour and non-labour components.

IHACPA indexed the labour component of $181.80 in 2021–22 dollars by a total of 28.49% to the period from 1 July 2024 to 30 September 2024. This is a combination of:

- Aged Care Work Value Case Stage 2 decision (effective 30 June 2023) (12.85%)
- superannuation guarantee increase from 2021–22 to 2024–25 (1.36%)
- indexation from 2021–22 to 2024–25 (12.33%).

After applying these adjustments and indexation, the labour component is $233.60.

Non-labour costs comprised $22.24 of the reference cost in 2021–22 dollars. The non-labour cost was indexed by 2.625 years from 30 December 2021 (the midpoint of the 2021–22 financial year) to 15 August 2024 (the midpoint of 1 July 2024 to 30 September 2024) at an annualised rate of 4.37%. This is the same indexation rate applied in Section 4.4.2, and takes the non-labour component to $24.88.

Thus, the cost of care was estimated to be $258.49 per NWAU over the 3 months from 1 July 2024 to 30 September 2024.

This represents a $4.67 difference compared to the AN-ACC price applicable from 1 December 2023 of $253.82. To determine the loading to be applied to the AN-ACC price, IHACPA calculated the total difference in funding over the 92 days from 1 July 2024 to 30 September 2024 and spread this over the 365 days from 1 October 2024 to 30 September 2025 as follows:

$$(\$258.49 - \$253.82) \times \frac{92}{365} = \$1.18.$$

The resulting loading is $1.18 per NWAU.

4.6 Summary of indexation

After the labour and non-labour components were separately adjusted and indexed, IHACPA re-combined these to calculate the recommended AN-ACC price per NWAU.

Table 24: Summary of labour and non-labour costs

Residential aged care price	Labour	Non-labour	Total	Change
Reference cost (2021–22 dollars)	$191.97	$22.24	$214.21	-
Indexed to 1 October 2024 to 30 September 2025	**$253.27**	**$25.56**	**$278.84**	**30.17%**
Loading for the period from 1 July 2024 to 30 September 2024	-	-	+$1.18	-
Recommended AN-ACC price	**-**	**-**	**$280.01**	**-**

*Totals may not match due to rounding.

The recommended AN-ACC price from 1 October 2024 to 30 September 2025 is **$280.01** per NWAU.

Impact of Fair Work Commission Work value case – Aged care industry Stage 3

The net impact of the Aged Care Work Value Case Stage 3 decision on the recommended AN-ACC price from 1 October 2024 to 30 September 2025 is $3.91. As the wage increases are effective from 1 January 2025 and only apply for 9 months of the AN-ACC cycle, this represents an averaging of the $5.23 impact from 1 January 2025 over the full 12 months for which the price is appliable.

5 Hotel cost gap

5.1 Overview

IHACPA is required to provide advice to the government on the gap between the cost of delivering required hotel services, and specific types of revenue received.

The ACFR includes all necessary data items related to the cost and the revenue received for hotel services. These items together allow the gap between hotel costs and revenue to be calculated as expenses, less revenue. RACPA24 assumes that the government will continue to provide a hotelling supplement.

IHACPA's approach to quantifying hotel costs and revenue is detailed in the respective sections below.

5.2 Hotel costs

Elements of in-scope hotel costs are outlined in Part 1 of Schedule 1 – Care and services for residential care services (the Schedule) of the *Quality of Care Principles 2014* under section 96-1 of the *Aged Care Act 1997* (Cth). While the Schedule includes maintenance as part of hotel costs, maintenance can be considered as an accommodation cost depending on the intended application. For RACPA24, maintenance costs have been separated in consideration of the gap between the cost of required hotel services and specific types of revenue received.

The hotel costs considered in RACPA24 comprise:

- labour for catering, cleaning and laundry
- catering consumables and contracts
- cleaning consumables and contracts
- laundry consumables and contracts
- utilities, including electricity, gas, council rates and rubbish removal
- motor vehicle operation, maintenance, and repair
- other hotel expenses not covered above
- administrative expenses.

Of total administrative expenses, 33.6% were apportioned to hotel, based on financial reporting from the December 2023 Aged Care Financial Performance Survey Report by StewartBrown.

For calculating the hotel gap, IHACPA considered all residential aged care services that submitted an ACFR in 2021–22 in-scope other than those excluded through the following trimming rules:

- errors, as per the rules in Table 6
- services that had a sanction imposed by the Aged Care Quality and Safety Commission in 2021–22

- services that received a notice of requirement to agree from the Aged Care Quality and Safety Commission in 2021–22
- services that received a non-compliance notice from the Aged Care Quality and Safety Commission in 2021–22.

IHACPA determined the average hotel cost per resident day by dividing the total hotel cost reported in the ACFR 2021–22 ($4,223.4 million) by the total number of occupied bed days (58.8 million). Similar to care, hotel costs including administrative expenses were disaggregated into labour and non-labour cost components and indexed separately to estimate the hotel gap in the 2024–25 financial year. These components are summarised in Table 25.

Table 25: Summary of hotel costs

Hotel cost component	Total (ACFR 2021–22)	Cost per resident bed day (2021–22)	Proportion
Labour cost	$1,832.3m	$31.18	43.38%
Non-labour cost	$2,391.1m	$40.69	56.62%
Total*	**$4,223.4m**	**$71.87**	**100.00%**

*Components may not add to total due to rounding.

5.2.1 Labour cost indexation

The Commonwealth's submission to the Aged Care Work Value Case notes that the majority of the aged care workforce covered by the Aged Care Award are on enterprise bargaining agreements that have passed their nominal expiry dates, so are paid the award rate by default. Therefore, to index hotel labour costs, IHACPA has assumed that all hotel and administration staff are paid the award wage.

Labour costs have been indexed in line with Annual Wage Review decisions determined by the Fair Work Commission, with adjustments for the Aged Care Work Value Case Stage 2 and Stage 3 decisions, and superannuation guarantee increases.

Fair Work Commission Work value case – Aged care industry

The Aged Care Work Value Case Stage 2 decision included a 15% increase to minimum wages for head chefs and cooks at level 4–7 of the Aged Care Award, provided they are the most senior chef or cook engaged at the service.

IHACPA quantified the impact by multiplying the annual award wage for a level 7 aged care employee by the number of services in the trimmed ACFR. IHACPA isolated this estimate of the total wages paid to head chefs and cooks from the aggregate catering labour cost and increased this component of the cost by 15%.

The Aged Care Work Value Case Stage 3 decision mandated a 6.96% wage increase for laundry hands, cleaners, and food assistants (excluding head chefs and cooks), and a 3% wage increase for other indirect care workers from 1 January 2025. The impact on the hotel cost per resident bed day in 2024–25 was estimated using a weighted average of the estimated hotel costs over the 6 months from 1 July 2024 to 31 December, prior to the Stage 3 decision taking effect, and the estimated hotel costs over the 6 months from 1 January 2025 to 30 June 2025, adjusted for the increase in labour costs resulting from the Stage 3 decision.

Superannuation guarantee increase

Consistent with the methodology for care labour costs in Section 4.3.1, IHACPA has adjusted the superannuation component of hotel and administration labour costs by 0.5% per annum in line with increases in the superannuation guarantee.

Indexation

As noted above, it was assumed that all hotel and administration staff were employed on award wages, and therefore labour costs increase in line with Fair Work Commission Annual Wage Review decisions. IHACPA has therefore indexed labour costs to account for the cumulative impact of:

- 2021–22 Annual Wage Review, which increased minimum award wages by 4.60% effective 1 July 2022
- 2022–23 Annual Wage Review, which increased minimum award wages by 5.75% effective 1 July 2023
- 2023–24 Annual Wage Review, which increased minimum award wages by 3.75% effective 1 July 2024.

The total indexation rate for hotel and administration labour costs from 2021–22 to 2024–25 is therefore:

$$(1 + 4.60\%) \times (1 + 5.75\%) \times (1 + 3.75\%) - 1 = 14.76\%.$$

Summary of labour cost indexation

The adjustments and indexation IHACPA applied to the labour component of hotel cost are summarised in Table 26.

Table 26: Summary of hotel labour indexation

Step	Total	Cost per resident bed day	Change
Hotel labour cost in 2021–22	$1,832.3m	$31.18	-
Aged Care Work Value Case Stage 2 decision for head chefs and cooks*	$1,849.6m	$31.48	0.94%
Superannuation guarantee increase to 2024–25	$1,874.8m	$31.91	1.36%
Indexation to 2024–25	$2,151.6m	$36.62	14.76%
Aged Care Work Value Case Stage 3 decision for indirect care workers (excluding head chefs and cooks)	**$2,215.9m**	**$37.71**	**2.99%**

*One per service

5.2.2 Non-labour cost indexation

IHACPA indexed the non-labour component of hotel costs using the same methodology as non-labour direct care costs described in Section 4.4 above. A composite index series was constructed using relevant CPI subgroups weighted by the relative cost proportions in the trimmed ACFR and re-referenced to equal 100.0 in the December 2023 quarter. These cost proportions are summarised in Table 27.

Table 27: Summary of hotel non-labour index

CPI Index subgroup	Series ID	Cost component	Total (ACFR 2021–22)	Proportion
Index Numbers; Food and non-alcoholic beverages; Australia;	A2325891R	Catering	$931.2m	38.94%
Index Numbers; Furnishings, household equipment and services; Australia;	A2326026R	Cleaning	$238.2m	9.96%
Index Numbers; Cleaning, repair and hire of clothing and footwear; Australia;	A2328051C	Laundry	$108.0m	4.52%
Index Numbers; Utilities; Australia;	A2326521X	Utilities	$406.4m	17.00%
Index Numbers; Private motoring; Australia;	A2326656J	Motor vehicles	$12.9m	0.54%
Index Numbers; Insurance; Australia;	A3602878J	Insurance	$69.3m	2.90%
Index Numbers; Audio, visual and computing equipment and services; Australia;	A3604423X	Other hotel costs	$27.8m	0.39%
Index Numbers; Newspapers, books and stationery; Australia;	A3604408A			0.39%
Index Numbers; Other recreation, sport and culture; Australia;	A2331381C			0.39%
Index Numbers; Other financial services; Australia;	A2332776R	Administration	$597.4m	24.98%
Total*			**$2,391.1m**	**100.00%**

*Components may not add due to rounding.

Using the same method described for direct care non-labour costs, IHACPA fitted an exponential growth curve to the hotel cost index services to measure average annual growth. The hotel cost index series along with the highest contributing index series are shown in Figure 5.

Figure 5: Index series used for hotel non-labour cost growth
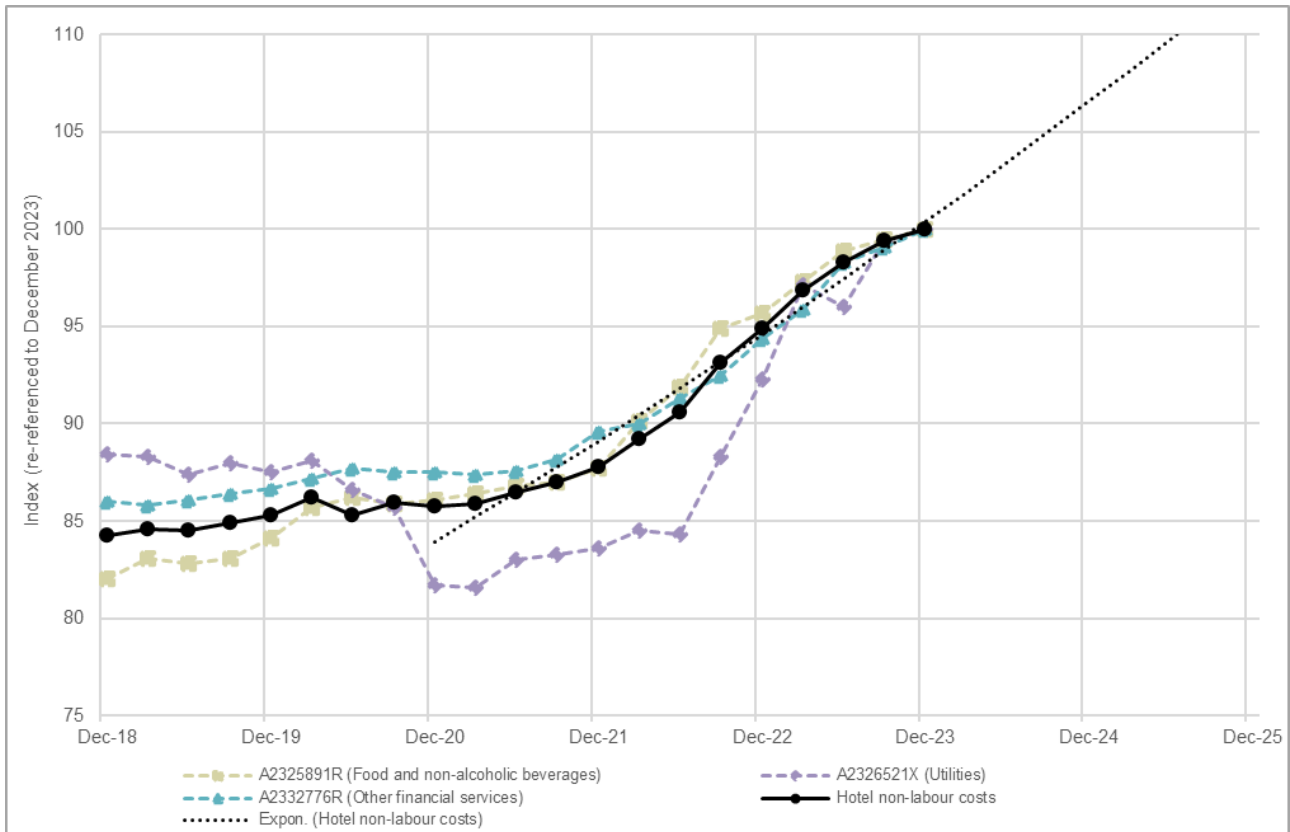
The hotel cost index series shows that more recent observations reflect the higher inflation rate observed in the Australian economy. For this reason, IHACPA used only the past 3 years of data when fitting the growth model for hotel costs. This ensures that recent inflation is more accurately reflected when indexing costs from 2021–22 to 2024–25.

The resulting model is:

$$\text{index}_n = 100.4000 \times 1.0150^n.$$

This model gives an annual hotel cost indexation rate i_H of:

$$i_H = 1.0150^4 = 1.0615.$$

Note that this expression may not evaluate exactly as written due to rounding. Therefore, the annualised growth rate used to index hotel non-labour costs is 6.15%. The equivalent indexation rate for maintenance non-labour costs was 5.48%.

Non-labour hotel costs were estimated to be an average of $40.69 per resident bed day in 2021–22. To estimate non-labour costs per resident bed day in 2024–25, this value was indexed by 3 years as follows:

$$\$40.69 \times 1.0615^3 = \$48.67.$$

5.2.3 Total hotel cost

Combining the indexed labour and non-labour components of hotel costs gives an estimated cost of $86.37 per resident bed day in 2024–25, as summarised in Table 28.

Table 28: Summary of hotel costs

Hotel cost component	2021–22 cost per resident bed day	Estimated 2024–25 cost per resident bed day
Labour cost	$31.18	$37.71
Non-labour cost	$40.69	$48.67
Total*	**$71.87**	**$86.37**

*Components may not add due to rounding.

5.3 Hotel revenue

Hotel costs are primarily funded through payment of the basic daily fee (BDF). The BDF is set at 85% of the basic Age Pension with all residents required to pay or apply for hardship or alternative payment options. The Age Pension is indexed twice a year to the higher of the CPI or Pensioner and Beneficiary Living Cost Index.

In addition to revenue received through the BDF, on 1 July 2021, the basic daily fee supplement was introduced in response to the Royal Commission into Aged Care Quality and Safety in the form of a $10 supplement per resident per day, intended predominantly to improve the quality of food and nutrition for residents. This was replaced with a $10.80 hotelling supplement on 1 July 2023. The hotelling supplement is indexed in March and September each year to CPI.

Additional and/or extra hotel services, such as higher quality meals, bedding, furnishings, or preferred brands of toiletries can be offered and paid for by residents through additional service fees, and/or extra service fees. While the fees for the delivery of services in additional to required hotel services are out of scope for IHACPA's advice on hotel funding, the costs associated with these services cannot be isolated in the data available. For this reason, IHACPA has included additional service fees and/or extra service fees as hotel revenue.

The following types of hotel related revenue were considered in IHACPA's analysis:

- BDF
- hotelling supplement
- additional service fees
- extra service fees
- other hotel related revenue.

The ACFR provides information on the BDF, extra service fees, additional service fees and other hotel related revenue. The revenue from the hotelling supplement can be estimated based on total occupied bed days reported in the ACFR. The estimate of hotel revenue is shown in Table 29.

To estimate future revenue, IHACPA interpolated CPI forecasts from the RBA's Statement on Monetary Policy – February 2024 to estimate indexation of the BDF and hotelling supplement in September 2024 and March 2025. As these fees comprise the majority of hotel revenue (91.44% in 2021–22 dollars), IHACPA has applied the same indexation rate to all hotel revenue.

A weighted average was calculated over the 2024–25 financial year to account for the bi-annual indexation of the BDF and hotelling supplement.

Table 29: Summary of hotel revenue

Hotel revenue component	Total revenue	Revenue per resident bed day	
	ACFR 2021–22	2021–22	2024–25 (estimate)
Basic daily fee	$3,186.6m	$54.23	$63.60
Extra services fees	$115.1m	$1.96	$2.30
Additional services fees	$166.2m	$2.83	$3.32
Other hotel revenue	$72.0m	$1.23	$1.44
Supplement^	$587.6m	$10.00	$11.42
Total*	**$4,127.6m**	**$70.24**	**$82.07**

*Components may not add due to rounding.

^The Basic Daily Fee supplement was introduced on 1 July 2021. This was replaced with the hotelling supplement on 1 July 2023.

5.4 Hotel gap

Comparing Table 28 and Table 29 shows that in 2024–25, hotel costs are estimated to be $86.37 with hotel revenue to be $82.07 per resident bed day. The subsequent gap is estimated to be **$4.30** per resident bed day. Note, this gap excludes maintenance costs which are estimated to be **$11.07** per resident bed day in 2024–25.

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