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Aged Care Financing in Australia: Individual, Government and Aged Care Provider Perspectives

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Abstract

Aged care financing in Australia presents a complex interplay of considerations across individuals, government policy, and aged care providers. For individuals, the financial risks and costs associated with aged care in later life require careful planning and integration with retirement strategies. Financing strategies should integrate superannuation savings and home equity to fund care needs, with growing importance placed on understanding the timing, affordability, and accessibility of aged care services. As longevity increases, so too does the need for sustainable personal financing models that can accommodate retirement income and both residential and in-home care options. From a government perspective, aged care reform is underway with the introduction of a new Aged Care Act and a shift in policy that places greater financial responsibility on individuals, especially in the Support at Home (SAH) program. This marks a departure from the Aged Care Royal Commission's recommendation for a dedicated aged care levy, instead favouring increased co-contributions. These changes have significant budgetary implications and highlight a contrast with the National Disability Insurance Scheme (NDIS), which operates under a publicly funded, entitlement-based model. Aged care providers must navigate evolving regulatory and financial landscapes, including prudential standards that affect liquidity, investment practices, and operational margins. The aged care sector faces a wide range of financial sustainability pressures, including rising wages, regulatory compliance demands, and tightening margins. At the same time, with the new Aged Care Act prudential rules, the potential phase-out of refundable accommodation deposits (RADs), and changes to Support-at-Home (SAH) pricing and co-payments, providers face challenges in funding future capital requirements, maintaining liquidity, and supporting growth. Providers need to respond with workforce innovation and other strategic financing decisions while balancing care obligations with financial sustainability. Providers, whether for-profit, not-for-profit, or government-operated, face varying pressures in adapting to increased future demand and maintaining service quality. This paper explores these intersecting perspectives to illuminate the challenges and opportunities in aged care financing, offering insights into how actuaries can contribute to shaping resilient and equitable solutions for Australia's ageing population.

Keywords: aged care, government finances, retirement, provider risks, personal finance

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1 Introduction

The Australian aged care system is experiencing a significant transition as demographic aging, fiscal pressure, and evolving community expectations reshape the way care is delivered and financed. The rise in life expectancy and the impact of the increasing risk of functional disability and dementia, mean that a growing proportion of Australians will require aged care services, both in-home and residential, over extended periods of later life. These developments place significant financial, operational, and policy pressures on individuals, governments, and aged care providers. Understanding how these pressures interact is critical to designing a sustainable and equitable aged care system (Productivity Commission (2011), Royal Commission into Aged Care Quality and Safety (2021),

The aged care sector represents a substantial component of Australia's welfare system, supported by significant public expenditure. In 2023–24, Australian governments spent an estimated $36.4 billion on aged care services, with $21.5 billion allocated to residential aged care (59% of total aged care spending) and $11.5 billion to home care and support programs, including approximately $3.0 billion for the Commonwealth Home Support Program (CHSP) (Australian Institute of Health and Welfare (2025c)). The scale of home support is reflected in the 835,000 older Australians who received CHSP services in 2023–24, up from 816,000 in the previous year (Aged Care Decisions (2024)). Financial reporting for the Australian aged care sector indicates improving sector performance in residential and home care financial outcomes (Ma et al. (2025), Department of Health, Disability and Ageing (2025a)). Broader market analysis also highlights ongoing consolidation among providers, persistent financial pressures in residential care, and increased government funding under the Australian National Aged Care Classification (AN-ACC) model (KPMG Australia (2025)). Collectively, these data demonstrate both the economic significance and the evolving financial conditions of Australia's aged care system.

From the perspective of individuals, aged care represents one of the most uncertain and potentially significant financial risks of later life. The timing, duration, and intensity of care needs vary widely, making aged care an inherently uncertain component of retirement planning. Although Australia's superannuation system will increasingly provide an important source of retirement income, it was not designed to incorporate aged care financing explicitly.

Similarly, home equity, the largest store of wealth for many older Australians, plays an increasingly important but multi-faceted role in meeting long-term care needs. Home equity can be used to finance increased consumption early in retirement, provide a hedge against aged care risks and provide a bequest. Integrating aged care financing into holistic retirement planning is essential for affordability, financial resilience, and informed decision-making.

At the same time, the Australian Government is shifting its approach to aged care financing. Major reforms, including a new Aged Care Act and the introduction of the Support at Home (SAH) program, emphasise increased co-contributions from individuals. This represents a notable departure from the Aged Care Royal Commission's recommendation for a levy-based, publicly funded model. These policy choices are in contrast with the National Disability Insurance Scheme (NDIS), which operates under a more explicit entitlement structure. As the aged care system evolves, the Government faces significant challenges in balancing equity, sustainability, and fiscal responsibility.

Aged care providers, spanning for-profit, not-for-profit, and government-run organisations, operate at the frontline of these reforms. They face increasing regulatory oversight, tightening prudential requirements, and mounting financial pressure from wage growth, workforce shortages, and escalating compliance costs. The potential phase-out of Refundable Accommodation Deposits (RADs) raises further questions about capital funding and liquidity management, particularly for providers looking to expand capacity in response to future demand. At the same time, providers are expected to innovate in service delivery, invest in technology including AI, and maintain or improve care quality, all while operating on persistently thin margins.

These challenges are not isolated. Instead, they form an interconnected system of financial flows, risks, and incentives. Individual affordability affects provider revenue, provider viability affects government expenditure and access to services, and government policy settings influence both individual behaviour and provider strategies. Actuaries are uniquely positioned to bring an integrated perspective to these issues—drawing on expertise in long-term forecasting, financial risk management, capital modelling, and system-wide evaluation.

This paper explores aged care financing through the intersecting lenses of individuals, government, and providers, and the sustainability challenges facing the sector. By examining these perspectives collectively, the paper highlights the opportunities for actuarial insight to inform policy design, provider strategy, and retirement planning. Ultimately, the aim is to contribute to a more resilient and equitable aged care financing system that can support Australia's ageing population into the decades ahead. The paper does not provide an in-depth coverage of academic research, although Appendix A provides a short summary of related academic research with collaborators at CEPAR.

2 Individual Perspective

Financing aged care is one of the most significant and least predictable financial challenges faced by older Australians. Unlike regular retirement expenditures such as consumption, housing, or health insurance premiums, aged-care costs exhibit high volatility, uncertain timing, and substantial tail-risk. Individuals face multiple layers of uncertainty: entry-risk (whether care will be needed at all), timing-risk (when functional decline will occur), duration-risk (how long care will be required), severity-risk (the level of support needed, from basic home care to high-acuity residential care), and cost-risk driven by regulated prices, means-tested contributions, and market variation in accommodation and service fees. These risks are tightly linked to idiosyncratic health trajectories and cognitive decline, making them difficult for households to anticipate or self-insure (Warshawsky (2013)). The result is a highly skewed distribution of lifetime aged-care spending, where a minority of individuals incur very large costs while many incur little or none. This combination of unpredictability, concentration of costs, and exposure to policy settings makes aged care one of the most complex and poorly understood financial risks in later life.

2.1 Longevity, Health Transitions, and Uncertain Timing of Care Needs

Increasing longevity has reshaped the later-life profile for Australians. While additional years of life are largely healthy, the prevalence of chronic conditions, functional decline, cognitive impairment, and frailty, rises sharply after age 80. As a result, both the probability of needing care and the potential duration of that care are increasing.

Table 1 shows estimates of these risks for illustration purposes, highlighting the uncertainty, based on the transitions model fitted to Australian data over 20 years from 1998 to 2018 in Park and Sherris (2025). The definition of disability is that of the Survey of Disability, Ageing and Carers (SDAC), defined by the limitations in autonomy of at least two Activities of Daily Living (ADLs), that is, needing aid or assistance with personal tasks such as bathing, dressing, eating, toileting, continence, or meal preparation. This definition is often used as the trigger for payment in private long term care insurance. Illness is defined as having at least one chronic condition, specifically: heart problems, diabetes, lung disease, or stroke. For the static model, without estimated trend, the model average time spent non-disabled (ND) for males aged 65 is approximately 18.5 years with a standard deviation of around 7 years. Average times and standard deviations of time non disabled, time spent with chronic illness and functional disability are higher for females than males with significant standard deviations. The chance of becoming disabled is approximately 59% for males and 74% for females.

The trend model reflects estimated mortality, chronic illness and disability trends. The most

notable impact of trend is the increase in mean time spent with chronic illness. Recent data confirm that chronic illness continues to rise in Australia, with diabetes showing particularly strong upward trends. The ABS reports that the proportion of Australians with at least one chronic condition increased from 42% in 2007–08 to 50% in 2022, with diabetes among the key contributors to this growth. Dementia is also increasingly prominent in Australia's chronic disease burden: recent national analyses indicate that chronic diseases such as cancers, dementia, and heart disease make up nearly two-thirds of total disease burden and are growing as Australians live longer but not necessarily healthier. This contrasts with past decades, when circulatory and related diseases showed significant declines due to the widespread adoption of statins and improved management of cardiovascular risk; global chronic disease data also reflect substantial reductions in cardiovascular mortality. Looking ahead, the increasing prevalence of overweight and obesity—now the leading modifiable risk factor for disease burden in Australia—suggests continued upward pressure on chronic disease incidence. However, emerging pharmaceutical interventions such as semaglutides offer the potential to limit future growth in diabetes and related metabolic conditions by improving glycaemic control and supporting sustained weight reduction. While their long-term population-level impact remains uncertain, they may play a role analogous to statins in moderating what would otherwise be steeper chronic illness trends.

Table 1: Simulated Times Spent in Health/Disability States (age 65). Columns are Static/Trend by sex; rows show Mean (M) and SD for each state, aggregates, life expectancy, and Dis.% (probability of ever becoming functionally disabled).

	StaticM	**StaticF**	**TrendM**	**TrendF**
H M	10.68	11.93	9.92	11.37
H SD	7.78	8.19	7.42	8.10
D M	0.28	0.50	0.17	0.32
D SD	1.15	1.62	0.69	1.03
I M	7.77	8.22	13.16	13.43
I SD	6.79	7.28	8.93	9.11
DI M	0.91	1.54	0.93	1.43
DI SD	1.51	2.10	1.51	1.99
ND M	18.45	20.16	23.08	24.80
ND SD	7.26	7.28	8.37	7.91
NI M	10.97	12.44	10.09	11.69
NI SD	8.07	8.67	7.55	8.36
LE M	19.64	22.20	24.17	26.56
LE SD	7.41	7.56	8.44	7.99
Dis.%	59.00	74.25	60.57	73.48

Notes: Column keys: **S**=Static (Tbl. 3 coefficients), **T**=Trend (Tbl. 4, 2018 cohort); **M**=Male; **F**=Female. States (Park and Sherris (2025)): H=Healthy; D=Disabled-only (ADL limitation); I=Ill-only (chronic disease: heart disease, diabetes, lung disease, or stroke); DI=Disabled+Ill; X=Dead. ND=H+I; NI=H+D. Simulation: N=80,000 per sex; monthly step ($\Delta t = 1/12$); maximum age 99. Figures simulated to closely match Park and Sherris (2025).

Aged care utilisation exhibits significant heterogeneity. Some individuals require only short periods of low-intensity home support, while others experience prolonged periods in residential care. The probability distribution of aged care expenditures is heavily skewed, with a small proportion of older Australians incurring very high lifetime costs, particularly when dementia is involved. This skewness creates a challenging planning problem, one that long term care

Table 2: Compact summary: entry ages and length of stay (LOS) for Residential Permanent Aged Care (RAC) and Home Care Packages (HCP), Australia. Figures reflect AIHW national reporting and peer-reviewed estimates for RAC LOS.

Item	Residential Permanent (RAC)	Home Care Packages (HCP)
Mean age at entry	∼85–87 years (majority 85+)	∼80–82 years
Median age at entry	**85** years	**81** years
Age distribution at entry	54% of admissions are 85+; right-skewed age profile	35% of new admissions 85+; majority aged 65–84
Mean LOS	∼2.2–3.1 years (varies by age/sex; see notes)	Mean LOS: 23.2 months (95% CI 23.0–23.3)
Median LOS	∼18–24 months (subgroup variation)	∼16.1 months: ∼16.6 months to death, ∼17.7 months to residential care
LOS distribution	Right-skewed; older entrants shorter LOS; widowed/female longer LOS; LOS declining post-2017	Median age at exit 84, right skewed

Notes. RAC entry ages and distributions: AIHW GEN, *Admissions into aged care* (latest release; median 85 for RAC and 81 for HCP; RAC 54% of admissions 85+; HCP 35% 85+); HCP user profiles: AIHW, *Older Australians: Aged care*. RAC LOS: Zhang et al. (2023) estimate expected LOS from AIHW administrative data (Australian Institute of Health and Welfare (2024a)) (mean ≈ 26–37 months by subgroup; females/widowed longer; LOS declining after 2017 See also Xu and Yan (2025)). HCP LOS AIHW GEN People Leaving Aged Care (Australian Institute of Health and Welfare (2025b)).

insurance is designed to manage. Table 2 provides an overview of the entry ages and time spent in residential care and home care packages.

2.2 Financial Risks for Individuals

2.2.1 Affordability and Cash-Flow Strain

The costs associated with both in-home and residential aged care create substantial cash-flow pressures. Even with government subsidies, individuals face means-tested care fees, daily accommodation payments (DAPs) or refundable accommodation deposits (RADs), and out-of-pocket expenses for higher-quality services. These costs often arise late in life, after the point at which individuals can easily adjust their financial strategy (Department of Health, Disability and Ageing (2025d)).

Table 3 summarises the residential age care fees and contributions reflecting the new Aged Care Act 2024. Tables 4, 5 and 6 show illustrative annual estimated costs for full pensioner and self-funded retiree for the Support-at-Home (SAH) program and for residential care prior to new Aged Care Act. Under the new Aged Care Act, residential aged care means testing becomes more complex, with separate and differently structured income and asset assessments for Support at Home (SAH) and residential care co-contributions, creating a challenging landscape for retirees and financial planners navigating thresholds, caps, and new fee categories.

Residential aged-care accommodation is often mistakenly compared with the cost of an average domestic dwelling, yet the two bear little resemblance in either structure or economic purpose. Aged-care facilities must finance and maintain high-intensity, fully compliant built environments that incorporate 24-hour staffing spaces, clinical infrastructure, fire-safety and evacuation systems, dementia-friendly design, infection-control requirements, and communal service areas—none of which are features of standard housing. These capital and regulatory obligations mean that the true cost of providing an aged-care place is substantially higher than the cost of an equivalent-sized private residence, even before accounting for depreciation, financing costs, and mandated refurbishments. This structural gap is often under-recognised, leading to unrealistic expectations about what residents should contribute through RADs/DAPs and obscuring the genuine capital pressures providers face in maintaining a safe, modern, and compliant

accommodation stock.

Fee Type	Amount / Cap	Description (New Aged Care Act from 1 Nov 2025)
Basic Daily Fee	85% of the basic Age Pension	Standard contribution paid by all residents for everyday living. Calculated as 85% of the basic single pension rate.
Means-Tested Care Fee (MTCF)	Means tested (no hard cap)	Applies only to *grandfathered residents* who entered care before 1 Nov 2025 and do not opt into the new fee system. Replaced for new entrants by NCCC.
Non-Clinical Care Contribution (NCCC)	Up to ∼ $107.32 per day; lifetime cap ∼ $137,917 or 4 years	Means-tested contribution for new residents toward non-clinical personal care services (bathing, mobility, lifestyle support). Daily and lifetime caps apply under the new Act.
Hotelling Supplement Contribution (HSC)	Up to ∼ $22.15 per day (indexed)	Means-tested contribution toward everyday living services such as meals, cleaning, laundry, and utilities. Only payable by new residents with sufficient means.
Extra or Optional Service Fees - Higher Everyday Living Fee	Typically $5–$40 per day (varies by provider)	Optional services not covered by the Aged Care Rules (e.g. barista coffee, premium menu items, pay TV, upgraded furnishings). These replace "extra service fees" under the old Act and are resident choice only.

Table 3: Summary of consumer fees and contributions in residential aged care under the new Aged Care Act (effective 1 November 2025). Fees at 20 March 2026. Basic Daily Fee applies to all residents; NCCC and HSC apply only to new residents and are subject to means testing. MTCF remains only for grandfathered residents.

Table 4: Illustrative costs: Support at Home — Full pensioner (annual co-contributions, standard rates)

Usage profile	Personal care†	Everyday living‡	Total
Light (3 + 2 hrs/wk)	$14,820 × 5% = $741	$8,320 × 17.5% = $1,456	**$2,197**
Moderate (7 + 5)	$34,580 × 5% = $1,729	$20,800 × 17.5% = $3,640	**$5,369**
High (14 + 6)	$69,160 × 5% = $3,458	$24,960 × 17.5% = $4,368	**$7,826**

How costs were estimated: Personal care annual bill = $95 × hours/week × 52; Everyday living annual bill = $80 × hours/week × 52.
† Personal care (Independence category) co-contribution for a **full pensioner** is **5%** (standard rates).
‡ Everyday living co-contribution for a **full pensioner** is **17.5%** (standard rates).
Clinical supports are always **0%** co-contribution.
Hours are in brackets - personal care first number, everyday living second number.
Lifetime cap on Support at Home contributions (standard rates) ≈ **$137,917** (indexed).

2.2.2 Liquidity and Asset Allocation

Many older Australians hold significant wealth in illiquid assets, predominantly the family home, while maintaining relatively conservative liquid portfolios in retirement income streams. Aged care events often require sudden liquidity, either to fund a daily accommodation payment (DAP), pay for home modifications, or cover short-term costs. This can disrupt long-term investment strategies, create suboptimal drawdowns, or force rushed financial decisions. Choosing between paying a daily accommodation payment (DAP) or a refundable accommodation deposit (RAD) is influenced by the Maximum Permissible Interest Rate (MPIR). The MPIR is a government-set interest rate used to calculate daily accommodation payments (DAP) for residential aged care, calculated as (Agreed Room Price × MPIR) ÷ 365 and intending to reflect an opportunity cost of capital to the provider. Higher MPIRs make DAPs significantly more expensive over time,

Table 5: Illustrative costs: Support at Home — Self-funded retiree (annual co-contributions, standard rates)

Usage profile	Personal care†	Everyday living‡	Total
Light (3 + 2 hrs/wk)	\$14,820 × 50% = \$7,410	\$8,320 × 80% = \$6,656	**\$14,066**
Moderate (7 + 5)	\$34,580 × 50% = \$17,290	\$20,800 × 80% = \$16,640	**\$33,930**
High (14 + 6)	\$69,160 × 50% = \$34,580	\$24,960 × 80% = \$19,968	**\$54,548**

How costs were estimated: Personal care annual bill = \$95 × hours/week × 52; Everyday living annual bill = \$80 × hours/week × 52.
† Personal care (Independence category) co-contribution for a **self-funded retiree** is **50%** (standard rates).
‡ Everyday living co-contribution for a **self-funded retiree** is **80%** (standard rates).
Clinical supports are always **0%** co-contribution.
Hours are in brackets - personal care first number, everyday living second number.
Lifetime cap on Support at Home contributions (standard rates) ≈ **\$137,917** (indexed).

Table 6: Illustrative costs: Residential aged care prior to new Aged Care Act — Annual costs using a \$750,000 RAD priced via DAP

Component	Full Pensioner - not Low Means	Self-funded retiree
Basic Daily Fee (BDF)	\$65.55/day ≈ \$23,860/year(1)	\$23,860/year(1)
Means-Tested Care Fee (MTCF)	Usually \$0 (or minimal)(2)	∼\$14,560–\$43,680/year(2)
Accommodation (DAP)(3)	\$56,919/year	
Total / year (no optionals)	**≈ \$80,779**	**≈ \$95,339 – \$124,459**

(1) BDF is 85% of the single Age Pension (indexed Mar/Sep).
(2) MTCF depends on a Services Australia means assessment (income and assets) with annual/lifetime caps; values shown are realistic sector ranges.
(3) DAP priced from a \$750,000 RAD using MPIR ≈ 7.61%: DAP = (RAD × MPIR)/365 = \$156.37/day ⇒ \$2,189.18/fortnight ⇒ **\$56,919/year**.
Providers may set RADs up to **\$750,000** without IHACPA approval from 1 Jan 2025.
If a resident pays part RAD and part DAP, the DAP reduces proportionally (same formula).

forcing retirees to balance liquidity needs against the capital tied up in a RAD and the broader asset management implications for their long-term financial planning including bequests. Means tests can tend to favour paying a RAD, since a RAD reduces assets for the Age Pension, although it does not reduce assets for aged care co-contributions.

2.2.3 Longevity and Sequencing Risk

Aged care costs typically occur at advanced ages when financial buffers may already be diminished. Individuals who experience poor investment returns early in retirement or who draw down assets aggressively may lack the resources to fund care at older ages. Integrating longevity and sequencing risk into aged care planning is therefore critical.

2.3 Funding Sources for Individuals

2.3.1 Superannuation

Table 7 shows illustrative older age wealth distributions for Australians sourced from available data (Australian Institute of Health and Welfare (2024b), Australian Bureau of Statistics (2022), KPMG Australia (2025)). Superannuation forms a central part of retirement financing, yet it is rarely framed explicitly as a funding source for aged care. Most retirees draw down their superannuation to support general living costs, often with limited consideration for possible late-life care expenses. Retirement income products, such as account-based pensions, lifetime

Wealth Component	Age 65–74	Age 85+
Home equity / dwelling wealth	∼ $1.3m average property wealth for Baby Boomers (KPMG/ABS analysis).	No direct ABS figure; most remain homeowners but with lower liquid wealth.
Superannuation balance	Average Men: $448,518; Women: $392,274 (Ages 65-69, ABS data).	No specific estimate; AIHW shows 78% rely mainly on Age Pension, implying small remaining balances.
Other financial assets	Boomers: ∼ $641k in non-property, non-super assets (ABS/KPMG).	Drawdown reduces assets substantially after age 80; housing dominates portfolio.
Total household net worth	ABS: mean net worth ∼ $1.04m (2019–20), Boomers generally above this.	Net worth declines in late retirement; majority of wealth held as home equity.

Table 7: Indicative household-level wealth distributions for Australians aged 65–74 and 85+, using the most recent ABS, AIHW, APRA and sector data (2024–2025). Figures for 85+ highlight key features.

income streams, and deferred products, can be used to hedge longevity and cash-flow risks, but uptake of longevity products remains low.

2.3.2 Home Equity

Home equity is the largest source of wealth for many older Australians and therefore plays a central role in funding aged care needs. Equity-release mechanisms, including reverse mortgages or home reversion schemes, offer a potential funding pathway but are underutilised due to concerns about cost, complexity, consumer distrust, and lack of awareness. Policy settings around home means-testing and the treatment of housing assets can also affect optimal strategies (Lyu et al. (2026), Xu et al. (2023)).

2.3.3 Means-Tested Co-contributions

Government subsidies reduce financial burdens but do not eliminate them. The means-tested care fee in home care, the means-tested non-clinical care contribution (NCCC), optional extras and hotel services contribution in residential care, accommodation payments, and the basic daily fees create a complex set of co-contributions. The interaction of these fees with the assets test, income test, and treatment of the family home can create incentives that shape individual behaviour, sometimes in ways that distort optimal financial decisions (Department of Health, Disability and Ageing (2025b).

2.4 Role of Informal Care

Informal care plays a central role in the financing of aged care in Australia, functioning as the largest and most immediate source of support for older people and substantially reducing the demand for formal services. Most care is provided by family members—predominantly spouses and adult children—whose unpaid labour effectively substitutes for, and cross-subsidises, the formal aged care system. This has significant implications for individual financing: the availability of informal care can delay or avoid entry into residential care, reduce out-of-pocket costs for home-based services, and shape the timing and intensity of formal care use. At the same time, reliance on informal care embeds financial and wellbeing risks within households, including lost earnings, reduced labour-force participation, and long-term impacts on carers' retirement savings. As Australia's population ages and family structures change, the sustainability of informal care becomes a critical determinant of future aged care expenditure and the design of financing mechanisms that balance public, private, and family contributions.

2.5 Integrating Aged Care into Retirement Planning

Most individuals do not engage in meaningful aged care planning until a care event is imminent, often triggered by declining health or a family crisis. This delay limits financial flexibility and can lead to suboptimal outcomes.

Incorporating aged care into holistic retirement planning benefits from anticipating potential care needs through stochastic scenarios rather than single-point estimates, modelling the distribution of possible lifetime care costs, including tail risks, balancing liquid and illiquid assets, ensuring sufficient liquidity for unplanned care events, understanding how means-testing rules interact with retirement income streams, and preparing households and families for decision-making under stress.

Financial modelling tools, including microsimulation models, transition probability models, and scenario analysis offer structured ways to quantify aged care risks within retirement planning frameworks. By integrating these models into financial advice and retirement adequacy assessments, individuals can make more informed decisions about savings behaviour, product selection, and drawdown strategies.

Recent policy reforms emphasise increased co-contributions, shifting greater responsibility to individuals. This trend increases the need for reliable information, accessible financial advice, and clear guidance on how to integrate aged care funding into long-term financial plans.

2.6 Means Testing for Support at Home and Residential Aged Care

Under the Support at Home (SAH) program, income and asset assessments determine the level of co-contributions for in-home services. Assessments are carried out by Services Australia and are based on existing pension means-test data for full or part pensioners. Non-pensioners must lodge full income and asset details, and those who choose not to be assessed may be charged the maximum contribution rate.

Residential aged-care means testing combines both income and assets to determine contributions toward daily fees and accommodation costs. The assessment determines whether a person qualifies as "low-means" and therefore eligible for government support with accommodation costs. From 1 November 2025, additional means-tested fees applied for new entrants, including the Hotelling Supplement Contribution (HSC) and the Non-Clinical Care Contribution (NCCC). These fees are indexed and depend on thresholds for both income and assets. The former Means Tested Care Fee (MTCF) continues only for grandfathered residents.

The SAH and residential-care means-test systems are structurally related but not fully harmonised. SAH uses the age pension means testing, whereas residential care incorporates both income and assets, including the family home. Rules, thresholds, and assessment methods differ, and households must navigate separate determinations rather than a unified framework. This inconsistency complicates retirement planning, as individuals face substantially different co-contributions when transitioning from home care to residential care.

The family home is treated differently depending on residency and who continues to live there. In residential aged care, the home is either exempt (if a protected person resides there) or counted up to a capped value. A protected person may include a spouse, dependent child, long-term co-resident relative, or eligible carer who has lived with and supported the resident in the required period. If a protected person continues residing in the home, the property may be fully exempt from the means-test for the duration of the resident's stay in care. However, if the protected-person circumstances change, the exemption can be lost, potentially leading to large increases in assessed means and aged-care fees.

Home equity release strategies, such as selling, renting, or drawing against home equity, directly influence the aged-care means assessment. Selling the home converts the exempt or capped home value into assessable financial assets, typically increasing assessed means and potential contributions. Renting may increase assessable income, requiring careful modelling to

avoid unintended increases in fees. Because SAH and residential aged-care assessments differ, households must model both systems before initiating equity-release decisions, particularly when planning transitions into residential care.

The interaction of income tests, asset tests, home equity rules, and the new fee structures highlights the need for comprehensive retirement planning. Individuals must account for possible transitions from home care to residential care, the impact of the protected-person rule on the treatment of the home, and how unlocking home equity may alter means-tested fees. Given the complexity of thresholds, indexation, and grandfathering arrangements, financial modelling and professional advice are essential to avoid adverse cost outcomes and ensure sustainable funding of aged-care needs.

3 Government Perspective

Australia's aged care system is in the midst of one of its most significant policy transitions since the introduction of the Aged Care Act 1997. The Government's agenda, shaped by the findings of the Royal Commission into Aged Care Quality and Safety and subsequent policy work, is moving toward a rights-based system with reformed financing, strengthened regulation, and a reshaping of in-home and residential care funding. These reforms have far-reaching implications for the sustainability of public spending and for the balance of cost responsibilities between government and individuals (Royal Commission into Aged Care Quality and Safety (2021), Duckett et al. (2021)).

The aged care sector is heavily regulated. Australia's national regulator for Commonwealth-funded aged care services is the Aged Care Quality and Safety Commission (ACQSC) whose aim is protect and improve the safety, health, well being and quality of life for people receiving aged care services. It is, amongst others, responsible for approving providers for funding, accrediting residential, home, and community care services, as well as monitoring and enforcing the Aged Care Quality Standards to ensure providers deliver safe, quality care.

In response to the recommendations of the Royal Commission into Aged Care Quality and Safety, the Independent Health and Aged Care Pricing Authority (IHACPA) had its role expanded to include the provision of annual independent aged care pricing and costing advice to the Minister for Health and Ageing. IHACPA is an independent government agency that assists the Australian Government to fund hospital and aged care services more efficiently by providing evidence-based price determinations and pricing advice. It provides advice to the Australian Government on pricing for the Support at Home (SAH) program and pricing and costing advice on the Australian National Aged Care Classification (AN-ACC) funding model for residential aged care and residential respite care.

3.1 Government Responsibilities and the Overall Funding Framework

The Commonwealth Government remains the primary funder of aged care services, supporting clinical services, residential care subsidies, and a broad range of in-home care programs. The new Aged Care Act 2024, which commenced on 1 November 2025, embeds a rights-based foundation for the system and provides a new regulatory and funding framework.

Central to these legislative changes is the introduction of a Statement of Rights that places older Australians at the centre of the system and requires providers to operate under strengthened oversight and compliance arrangements, enforced by the Aged Care Quality and Safety Commission. This regulatory shift interacts with financing arrangements by tightening accountability on providers while reinforcing expectations of accessible, equitable care for consumers. Despite this, the Inspector-General of Aged Care (2025) raises shortcomings in that these rights are not enforceable, relying on older people to self-initiate complaints despite cognitive or functional barriers with no dedicated mechanisms enabling individuals to claim these rights.

3.2 Key Policy Shifts: Reforming Aged Care Financing Transition to the Support at Home Program

One of the most significant financing reforms is the introduction of the Support at Home (SAH) program, replacing the Home Care Packages Program and the Short-Term Restorative Care Program from 1 November 2025. The program consolidates in-home services under a unified funding and assessment system, with expanded care classifications, new quarterly budget structures, and a shift toward means-tested co-contributions. It is designed to provide more transparent pricing and a more flexible allocation of funding to meet individual needs (Department of Health, Disability and Ageing (2025b)).

3.3 Increased Co-Contributions and a Levy-Based Funding Model

The Aged Care Taskforce (2024) supported expanding co-contributions from consumers, introducing a more refined user-pays structure while maintaining full public funding for clinical care. Under the new Support at Home (SAH) arrangements, individuals will be required to contribute toward non-clinical support services, including independence (personal care) and everyday living assistance, subject to means-testing. The Aged Care Taskforce (Aged Care Taskforce (2024)) proposed a sustainable funding model where individuals with means contribute more for daily living and independence supports, increasing RAD caps to $750k with a long-term move away from RADs, and the Support at Home (SAH) being the core mechanism enabling Australians to age in place.

This policy approach contrasts with the Royal Commission's recommendation for a dedicated levy-funded model (Royal Commission into Aged Care Quality and Safety (2021)) and has raised concerns about affordability and access, particularly for low-income older Australians who may struggle with administrative hardship provisions in the co-contributions framework (Inspector-General of Aged Care (2025)).

3.4 Transition from CHSP to Support at Home

The Australian Government has confirmed that the Commonwealth Home Support Programme (CHSP) will continue in its current form until at least 1 July 2027, with a staged transition into the new Support at Home (SAH) program to follow. Unlike the earlier integration of Home Care Packages (HCP) and Short-Term Restorative Care (STRC), CHSP clients will not be automatically migrated. Instead, existing recipients will be reassessed under the revised national assessment framework to determine their eligibility for SAH care budgets or entry-level supports.

Evidence presented to the Senate Community Affairs References Committee (2025) indicates that this transition is one of the most contested elements of the broader aged-care reform agenda. Providers, peak bodies, and local governments have raised concerns about the potential loss of entry-level, low-intensity, and episodic supports that currently characterise CHSP. Many fear that the SAH model—built around individualised care budgets—may not adequately accommodate clients who receive only occasional domestic assistance, social support, meals, or transport, and who may not meet the threshold for a formal care budget. Stakeholders have also highlighted operational risks, including uncertainty about future funding arrangements, the viability of block-funded service models, and the capacity of the assessment system to manage large-scale reassessment without service disruption.

It is expected, although not confirmed, that CHSP participants with more complex or ongoing needs will transition into Support at Home (SAH) care budgets, while those whose needs remain entry-level will continue to receive lower-intensity support similar to their existing CHSP services, such as domestic assistance, meals, social support, and transport within the Support at Home (SAH) program.

3.5 Fiscal Sustainability Pressures

The Government faces growing expenditure pressures as demand increases with population ageing and care expectations evolve. The Royal Commission into Aged Care Quality and Safety (2021) called for a demand-driven system guaranteeing timely access, but this was rejected by the Government, instead maintaining rationed care with a home care waiting time goal of 3 months. Based on the Report on Government Services Aged Care Services 2026 (Productivity Commission (2026)) the median waiting times for the Support at Home program (All Priority Groups) are: from assessment approval to package assignment - 204 days, from assignment to service commencement - 28 days with total time from assessment approval to service start: approximately 245 days (or around 8 months).

3.5.1 Growing Public Expenditure

The Federal Budget 2024–25 included a $2.2 billion commitment to aged care, supporting wage reforms and implementation of Royal Commission recommendations, reflecting the scale of current and future financial demands on the system. In 2023–24, governments spent $36.4b on aged care, with 59% residential and 32% home care/support. These allocations are part of a broader recognition that aged care funding needs to expand to preserve quality and safety. Australian Government spending on aged care is projected to more than double as a share of GDP from 1.1% in 2022-23 to 2.5% by 2062-63; growth is driven largely by the tripling of the 80+ population and heavier use of residential care in the later decades. The Inter-Generational Report IGR (The Treasury, Australian Government (2023)) emphasises the five long-run budget pressures of health, aged care, NDIS, defence, and interest costs, and explicitly flags rising demand for care and support services as a structural force on the Budget.

3.5.2 Residential Aged Care Funding

Residential aged care remains the largest component of government aged care expenditure, driven primarily by the cost structure of the Australian National Aged Care Classification (AN-ACC) funding model. Under AN-ACC, providers receive a daily casemix-adjusted subsidy comprising a fixed Base Care Tariff and a variable payment linked directly to the assessed care needs of each resident. Residents are independently assessed and assigned to an AN-ACC class based on their physical, cognitive, and behavioural characteristics, with each class associated with a National Weighted Activity Unit (NWAU) that reflects the relative cost of care. These NWAU weightings are then applied to the annually updated AN-ACC price—which increased to $295.64 per resident per day on 1 October 2025—resulting in significantly higher government outlays for residential care compared with home-based programs such as Support at Home.

The Support at Home (SAH) program allocates significantly lower, capped annual budgets across eight funding classifications, ranging from $10,731 to $78,106 per year, designed to support older people to live independently at home. As a result, SAH funding is far less intensive and places much lower fiscal pressure on government compared with the substantially higher cost structure embedded in the AN-ACC residential care model.

3.5.3 Balancing Entitlement and Sustainability

The contrast between aged care funding and the fully entitlement-based National Disability Insurance Scheme (NDIS) highlights the ongoing policy debate: whether aged care should remain a needs-tested, means-tested system, or evolve toward a universal entitlement. Current reforms affirm the former: the Government is explicitly reinforcing means-testing and co-contributions while tightening eligibility and assessment pathways under the Aged Care Act's new single assessment model and classification systems.

3.5.4 Risks of Cost Shifting

Increasing co-contributions create behavioural responses, such as delayed access to care, that could be expected to shift costs to other systems, including hospitals, if not carefully monitored. This risk is particularly important given the new rules' potential impact on individuals ageing in place, as identified by the Inspector-General's progress report on co-contributions (Inspector-General of Aged Care (2025)).

3.6 Government supported age care residents

Residential aged care providers in Australia are significantly affected by the government's arrangements for supported (low-means) residents, particularly through subsidised accommodation payments and the 40% supported-resident threshold. Providers receive the concessional resident supplement to help cover accommodation costs for eligible residents who cannot pay an accommodation bond or charge. The supplement's full rate is only paid when at least 40% of residents are supported or concessional over a calendar month; otherwise, payments are reduced by 25% for the entire month.

The impact of these rules differs between types of providers. Larger metropolitan providers can often maintain a resident mix that avoids falling below the 40% threshold, thereby preserving the full supplement. Smaller regional or rural providers, serving populations with higher financial disadvantage, regularly exceed the 40% threshold and thus benefit from the full supplement, yet still struggle financially because the supplement does not fully cover the true cost of accommodation provision. By contrast, premium providers in higher-income areas may fall below the threshold, losing 25% of the supplement even though they often face higher capital and operating costs.

The concessional resident maximum accommodation supplement, $70.94 per day at 1 November 2025, aims to assist with accommodation costs for low-means residents. The exact rate is published in the government's Schedule of Subsidies and Supplements and varies depending on whether the facility is new or significantly refurbished. However, accommodation supplements often fall short of covering actual capital and maintenance costs.

Supported residents themselves pay minimal accommodation costs. If their means-tested amount (MTA) is below the Maximum Accommodation Supplement (MAS), they qualify as low means and receive government assistance for accommodation. While they remain responsible for general fees such as the basic daily fee, and under the post 1 November 2025 arrangements may pay capped contributions toward hotelling and non-clinical care depending on their income and assets, supported residents do not pay Refundable Accommodation Deposits (RADs), Daily Accommodation Payments (DAPs), or full accommodation charges. These are funded through the government's accommodation supplement.

The Government's approach to aged care financing has shifted toward a more integrated, rights-based system supported by strengthened oversight and targeted co-contributions. These changes reflect the competing imperatives of consumer empowerment, fiscal sustainability, and equitable access.

3.7 Assessment of Long Run Aged Care Costs

Shirodkar (2021) assesses the long run cost of the Australian aged care government funding prior to the new Aged Care Act using a range of alternative mortality, morbidity and migration assumptions. Informal care is not included in this analysis, which would meet a large portion of the demand for aged care assumed to be met by government funded programs. As the older age dependency ratio increases, the role of informal care would be expected to reduce in future years. If access is demand-based (uncapped), with aged care needs met by government funded support programs, then projected government-financed of aged-care costs are forecast to rise

well above the Intergenerational Report (IGR) forecasts unless financing is reformed to include a levy and re-designed co-contributions.

The dominant risk driver considered is the interaction of mortality and disability trends. Figure 1 shows estimated total demand based government aged-care costs as a share of GDP. Under "dynamic equilibrium" (slow disability improvement), costs are approximately 50% higher by 2040 than under "compression of morbidity". By 2080 the gap across these scenarios widens to 3.37–8.0% of GDP.

Shirodkar (2021) suggests an estimated fixed-rate Aged Care Levy of approximately 1.5–3%, depending on disability trend, would be needed to maintain government outlays in line with the 2021 IGR forecasts. An estimated levy of approximately 5% would be required for full public coverage if co-contributions were removed. Co-contributions remain essential for sustainability and equity. A flat levy shifts a higher lifetime share of costs onto younger cohorts, means-testing improves intra- and inter-generational equity (older cohorts pay more when consuming care), but a cohort-staggered levy would avoid a "double burden" during transition.

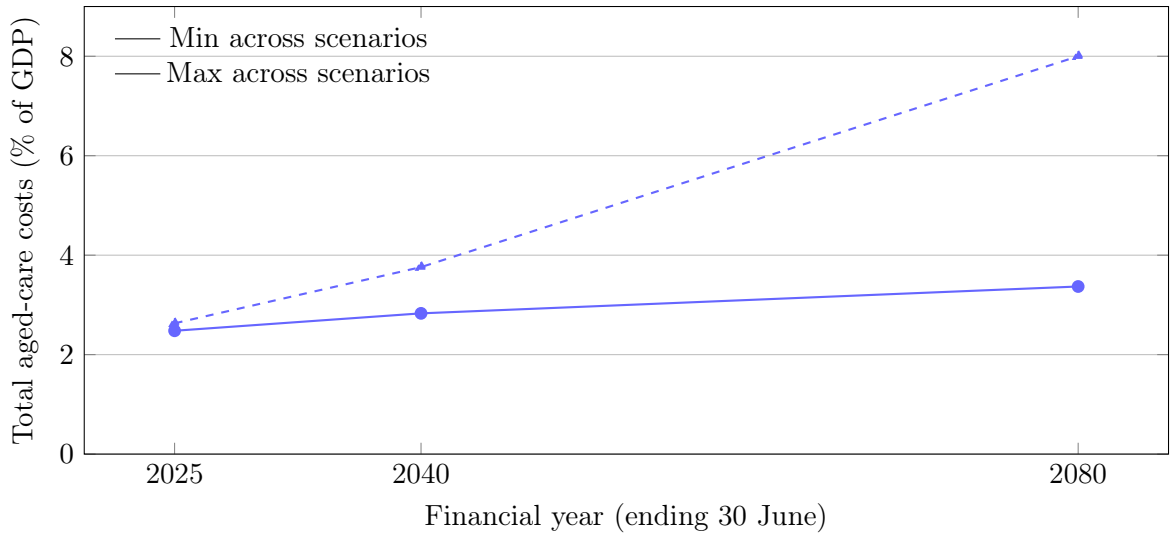

Figure 1: Estimated total demand based government aged-care costs as a share of GDP at selected years under alternative disability/mortality improvement and indexation assumptions. Band shows the min–max range reported for 2025 (2.48–2.63%), 2040 (2.83–3.76%), and 2080 (3.37–8.00%). Source: Shirodkar (2021) thesis results.

3.8 Migration, population dynamics, and aged care costs as a share of GDP.

The long–run expenditure on aged care as a share of GDP depends on the relative growth rates of (i) the older population, driven by demographic ageing and net overseas migration (NOM), and (ii) the real unit cost of aged care services, which is closely linked to wages in the labour–intensive aged-care sector.

If C_t denotes total aged care expenditure and Y_t real GDP then aged care costs as a share of GDP increase whenever

$$\frac{C_t}{Y_t} \text{ rises} \quad \Longleftrightarrow \quad g_C > g_Y,$$

where g_C is the long-run growth rate of aged-care costs and g_Y the growth rate of GDP. Since aged-care expenditure grows approximately as

$$g_C \approx g_{\text{older pop}} + g_{\text{unit cost}},$$

the ratio C_t/Y_t tends to increase when the combined effect of (a) demographic growth in the older population (including the future ageing of migrants) and (b) real increases in labour-intensive care costs exceeds long–run GDP growth.

Shirodkar (2021) modelling is consistent with this in the Australian context. Although migration initially increases the working-age population, higher NOM ultimately results in a larger older population several decades later, increasing aged-care utilisation and aggregate expenditure.

Higher migration raises future aged-care expenditure by increasing the population size and the future number of older Australians; while GDP also rises, the net effect is a *modest but positive* increase in long-run aged-care spending as a share of GDP. This aligns with the theoretical condition $g_{\text{older pop}} + g_{\text{unit cost}} > g_Y$ for rising expenditure shares.

3.9 Impact of Informal Care on Aged Care Costs

Informal care represents one of the largest implicit financing mechanisms in Australia's aged-care system, with a scale and economic value that far exceed the Commonwealth's formal expenditure. National data indicate that around 2.65–2.7 million Australians provide informal care, including approximately 420,700 primary carers supporting older people. For older Australians receiving community-based assistance, roughly 80% rely primarily on unpaid carers. Deloitte Access Economics (2020) estimated the replacement cost of informal care at $77.9 billion, with $60.3 billion in primary care, in 2020. If we use the five-year nominal GDP growth of 38% as a proxy for economy-wide labour-cost growth to increase the 2020 estimates to 2025 values, then we would have an estimate of primary informal care of $83.2 billion and of all informal care of $107.4 billion. Using GDP of $2.6 trillion, the 2025 estimated replacement cost of all informal care would be approximately 4.1% of GDP.

If we focus on the informal care provided to Australians over age 65 with severe or profound disability who would otherwise draw on government aged care funding, then an estimate of replacement-cost value in 2025 values is $62.5 billion or 2.4% of GDP[1]. If we based the estimate on government spending avoided in 2025 values it would be $46.1 billion or 1.8% of GDP. This figure contrasts with the Commonwealth's estimated formal aged-care spending of $38.5 billion in 2025. By contrast, the Commonwealth's direct fiscal support for informal carers, through the Carer Payment, Carer Allowance, and Carer Supplement, is estimated at $5.3 billion annually, based on current payment rates and estimated uptake among primary carers of older people.

Formal aged care depends on informal carers. Informal carers reduce demand for residential aged care by enabling older people to remain at home longer, reduce demand for formal home care hours, allowing packages to stretch further and provide continuity and personalisation that formal services cannot replicate at scale. Without informal carers, the aged care system would face higher residential care admissions, increased wait times for home care, substantially higher government expenditure, and increased workforce shortages, which is already a major constraint. Informal carers play a critical role in limiting government expenditure. The sustainability of this unpaid workforce is thus a central determinant of long-term aged-care financing and the fiscal viability of future reforms.

4 Provider Perspective

Aged care providers operate at the intersection of rising costs, tightening regulation, evolving pricing and contribution rules, and shifting consumer preferences for in-home support. Recent reforms—anchored by the Aged Care Act 2024 (commenced 1 November 2025) and the Support at Home (SAH) program, reshape provider obligations, funding flows and risk management,

[1] Author's calculations - details available if requested

with material implications for liquidity, capital investment, pricing, margins and service mix (StewartBrown (2025))

4.1 Market Structure and Operating Context

The sector continues to consolidate under reform and financial pressure with a gradual reduction in provider numbers and increased M&A activity. Not-for-profits (religious, charitable and community based) continue to dominate with 53.1% of the home care market, and 55.8% of the residential aged care market. Not-for-profits retain a majority share across residential and home care with demand growth in home care outpacing residential admissions, reinforcing a strategic shift toward in-home services for many providers (KPMG Australia (2025)).

Figure 2 shows how the number of residential care providers in the aged care sector is continuing to shrink with 707 residential care providers in 2024-2025. Residential care beds were 224,492. Residential occupancy sits at 89.9% according to the figures (Department of Health, Disability and Ageing (2025b)). Home care providers grew by just 1.5% to 923 nationally. Figure 4 shows the residential aged care places by Not-for-profit, For-profit and Government over the most recent five years. The Commonwealth Home Support Program (CHSP) has been extended from 1 July 2025 to 30 June 2027 and it supported 838,694 clients costing $3.3 billion in funding.

Providers and users of aged care services are spread geographically across Australia covering metropolitan areas, regional centres, rural towns and remote communities. Geographical spread in Australia creates acute aged care challenges, where providers face high service delivery costs and staff shortages in remote areas, while users face limited access to services and local care options.

Dementia is a leading driver of entry into Australian residential aged care, with the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare (2025a), Australian Institute of Health and Welfare (2024a)) reporting that around 131,000 residents, 54% of all people in permanent residential aged care—were living with dementia in 2021–22. Residential care remains a critical service for people with moderate to advanced dementia, who often require 24-hour supervision, support with daily activities, and safe accommodation. Dementia prevalence rises sharply with age, ranging from fewer than 1% of Australians under 65 to more than 27% among those aged 95 and over, contributing substantially to aged-care admissions as the population ages. With national dementia cases estimated at 421,000 in 2024 and projected to nearly double by 2054, demand for dementia-specialised aged-care services will continue to increase.

Regulatory and transparency expectations have also risen. Quarterly and annual Government reporting and sector performance publications provide more information on provider performance, quality and complaints, lifting accountability while increasing administrative load.

4.2 Prudential and Financial Standards: Liquidity, Investment and Governance

From 1 November 2025, new Aged Care Financial and Prudential Standards 2025 applied (via the Aged Care Act 2024), consolidating requirements into three core standards: Financial and Prudential Management, Liquidity, and Investment. These mandate documented systems for financial governance, minimum liquidity settings and written investment strategies, including where refundable accommodation deposits are invested (Australian Aged Care Quality and Safety Commission (2025).

Under the new *Aged Care Act 2024* and the *Aged Care Financial and Prudential Standards 2025*, aged care providers must comply with a strengthened *Liquidity Standard* that requires them to maintain sufficient cash or cash–equivalent resources to meet all financial obligations as they fall due, including operating expenses and refundable deposits. All non-government residential aged care providers (Registration Category 6) must calculate a *Minimum Liquidity Amount*

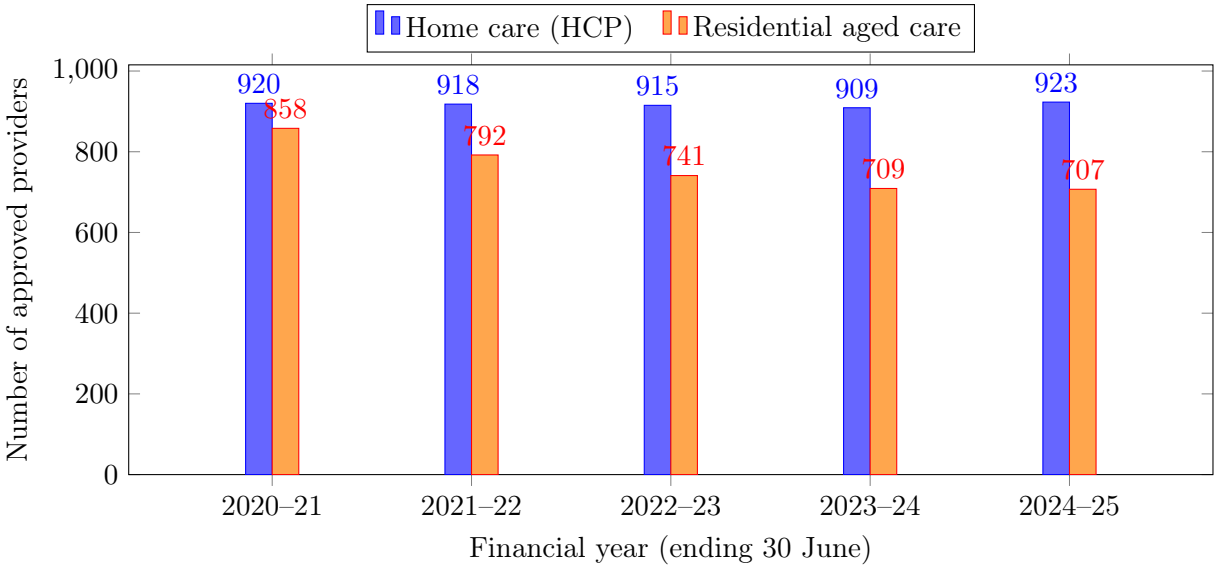

Figure 2: Approved aged care providers in Australia at 30 June (last 5 financial years). Source: 2024–25 *Report on the Operation of the Aged Care Act* (ROACA).

(MLA) each quarter and hold at least this level of liquidity. The default MLA is determined by the "35% and 10%" formula released by the Aged Care Quality and Safety Commission:

$$\text{MLA} = 0.35 \times (\text{quarterly cash operating expenses}) \; + \; 0.10 \times (\text{refundable deposit liabilities}).$$

There is a 2% liquidity requirement for Independent Living Unit and retirement village deposits.

This default threshold ensures that providers retain liquidity equal to 35% of previous quarter cash expenditures together with 10% of any refundable accommodation deposits (RADs) or equivalent liabilities.

Providers must maintain a written Liquidity Management Strategy (LMS), updated annually, and notify the regulator if they fail to meet their elected MLA or experience material changes affecting liquidity. These reforms form part of a broader prudential framework aimed at improving financial resilience and ensuring the continuity of safe, high-quality aged care. The Department's guidance frames these prudential measures as central to continuity of care and risk minimisation (including risks to the Accommodation Payment Guarantee Scheme), and the Government has signalled ongoing financial monitoring and intervention capacity under the Act's framework.

The Accommodation Payment Guarantee Scheme is an Australian Government guarantee that protects aged-care residents from losing money if their aged-care provider becomes insolvent or is unable to refund a lump-sum accommodation payment such as a RAD (Refundable Accommodation Deposit) or RAC (Refundable Accommodation Contribution). If the provider cannot refund the RAD because of financial failure or liquidation, the Commonwealth steps in and pays the resident (or estate) the RAD balance, then recovers the debt from the provider. It does not cover Daily Accommodation Payments (DAPs), other daily fees (basic daily fee, means-tested fees, Non-Clinical Care Contribution (NCCC), Hotelling Supplement Contribution (HSC) contributions under new Act) or extra or optional service fees.

The implications for providers are that minimum liquidity requirements lock up cash, constrain working capital and potentially slow redevelopment pipelines or new residential accommodation supply, particularly for operators with high RAD balances and thin margins, while investment rules tighten governance around deposit-backed portfolios. Strategic treasury planning covering diversified committed facilities, contingency lines, and dynamic cash forecasting, becomes critical under these standards.

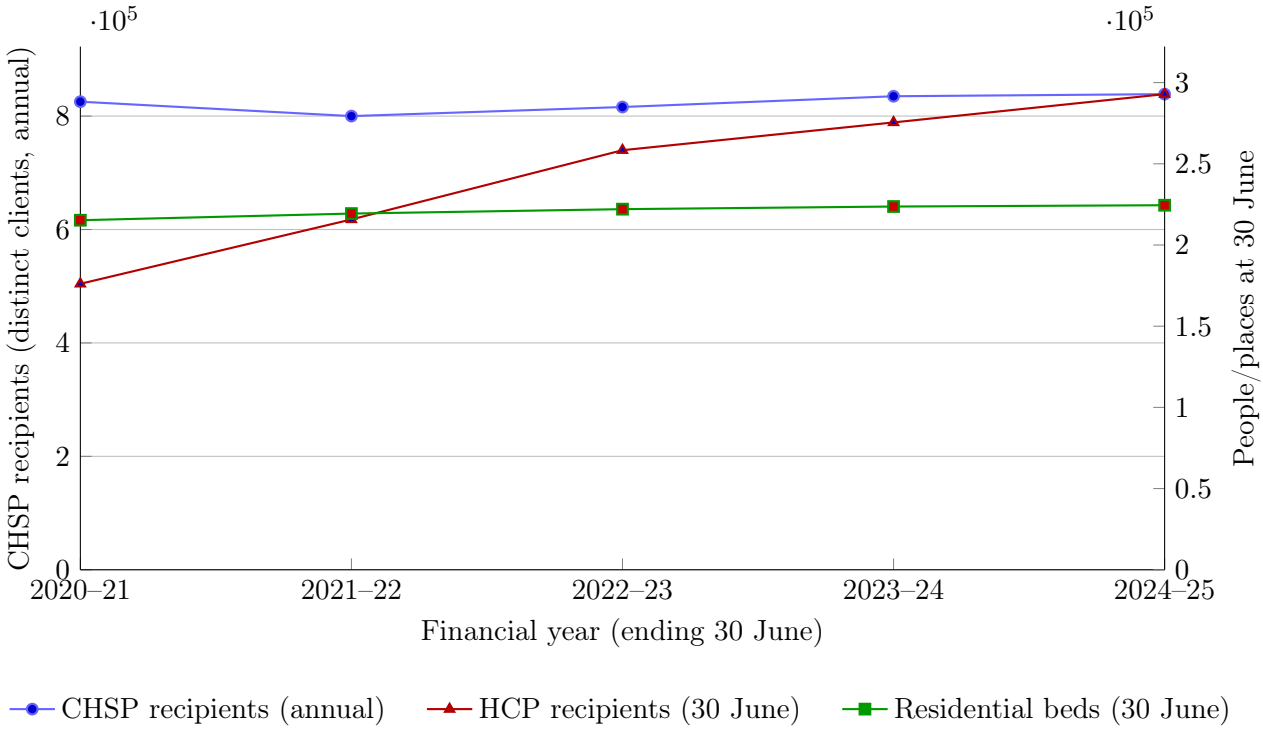

Figure 3: Australian aged care over the most recent five years: CHSP recipients (annual, left axis), and Home Care Package recipients plus operational residential places (30 June snapshots, right axis).

4.3 Accommodation Funding: RADs, Retention and Pricing Parameters

Residential providers rely on accommodation payments (RAD/DAP) and subsidies alongside care funding. From 1 January 2025 the maximum accommodation price requiring approval was lifted from $550,000 to $750,000 (with indexation thereafter), and from 1 November 2025 new RAD/RAC retention rules apply with daily accrual at 2% p.a., capped at five years, changing refund dynamics and supporting capital reinvestment.

The new November 2025 fee structure with revised non-clinical contributions and "no worse off" grandfathering for existing residents, signals a clear delineation between publicly funded clinical care and consumer contributions for everyday living and personal support. Government funding support has shifted from ageing in place home care to a subsidy basis for part and self-funded retirees in the Support at Home program.

RAD retention and DAP indexation will modestly improve internal funding of capital and operating resilience, but interacts with liquidity standards and refund governance. It will potentially alter price signals and may change room standards, amenities and consumer payment preferences. Providers will need to assess balance-sheet sensitivity to reduced net RAD outflows, liquidity buffers under prudential rules, and potential portfolio re-weighting toward DAPs.

4.4 Residential care demand and supply

Recent evidence indicates that Australia's residential aged care capacity is tightening. Net additions of operational places have slowed to their lowest level in a decade: *about 800* new places in 2024–25, down from 2,200 in 2023–24 and an average of roughly 1,500 per year between 2020–21 and 2022–23. This compares with ∼5,000 per year during 2015–16 to 2019–20 (peaking near 6,500 in 2018–19) (Bolton Clarke Research Institute (2025)). Over the same period, the number of residents has been increasing by about *5,000 per year* (2022–23 to 2024–25), pushing available-bed occupancy near **94%** by late 2024. The combination of high occupancy and limited

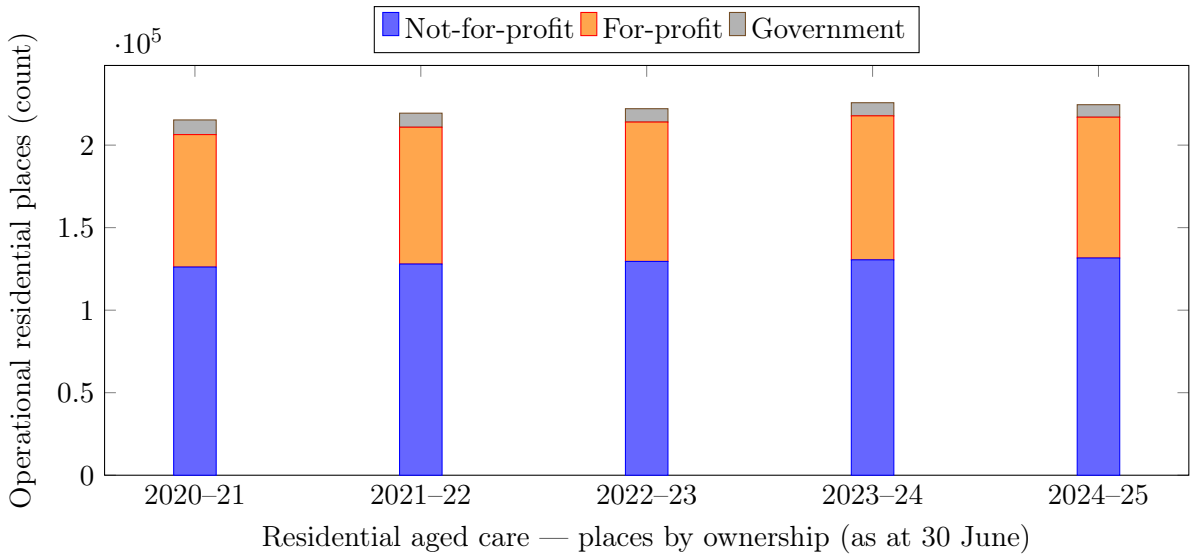

Figure 4: Operational residential aged care places by ownership, Australia, 2020–21 to 2024–25 (as at 30 June). 2024–25 composition from ROACA 2024–25; earlier years from AIHW GEN Stocktake.

online capacity contributes to delayed hospital discharges, "bed blocking", raising system-wide costs.

Residential aged-care planning has long used target provision ratios (TPRs) - residential places per 1,000 people aged 70+. The national TPR was 78.0/1,000 (70+) for many years and was temporarily lowered to 60.1/1,000 (70+) from 1 July 2024 pending new allocation settings (Cooper-Stanbury (2025)). Current observed provision is near 67/1,000 (70+) nationally, with most Aged Care Planning Regions (ACPRs) in the range 60/1000–70/1000.

Figure 5 highlights how assessments of future residential aged–care demand differ depending on the projection framework used. Recent operational data indicate that residential care places have grown only modestly, rising from around 201,000 places in 2017 to 223,691 places in 2024 (Australian Institute of Health and Welfare, 2024d). Over the same period, the number of people actually using permanent residential care increased gradually, from approximately 179,000 in 2017 to 190,000 in 2024, reflecting later entry to care and the shift toward home-based support (Australian Institute of Health and Welfare, 2024c). Headline "vacant" beds (around 21,100) overstate true capacity because a material share are offline due to refurbishment, conversion of shared rooms to singles, and staffing constraints, with geographic mismatch exacerbating access issues. Ageing-in-place lifts acuity at residential entry; staffing minutes and space standards per resident rise, effectively lowering serviceable capacity per built bed.

The resident-based projection shows comparatively moderate growth, estimating 192,664 residents by 2030 and 220,194 by 2040. In contrast, the planning-ratio approach benchmarks capacity against the rapidly growing population aged 70+, applying a standard of 60–65 places per 1,000 older Australians (McGrathNicol Advisory, 2024).

When taken together, the two approaches imply different timing and scale of required investment. The resident-based method suggests a constrained but roughly manageable trajectory for providers, whereas the population-ratio view highlights emerging structural shortfalls unless sector-wide supply expands materially. This difference is especially relevant given the recent slowdown in net additions of places and the presence of "offline" beds due to staffing and refurbishment pressures (Bolton Clarke Research Institute, 2025; StewartBrown, 2025).

From a provider perspective, relying solely on observed resident trends risks underestimating latent demographic demand, while planning exclusively on a population-ratio basis signals the potential scale of capital investment and workforce expansion that will be needed to maintain

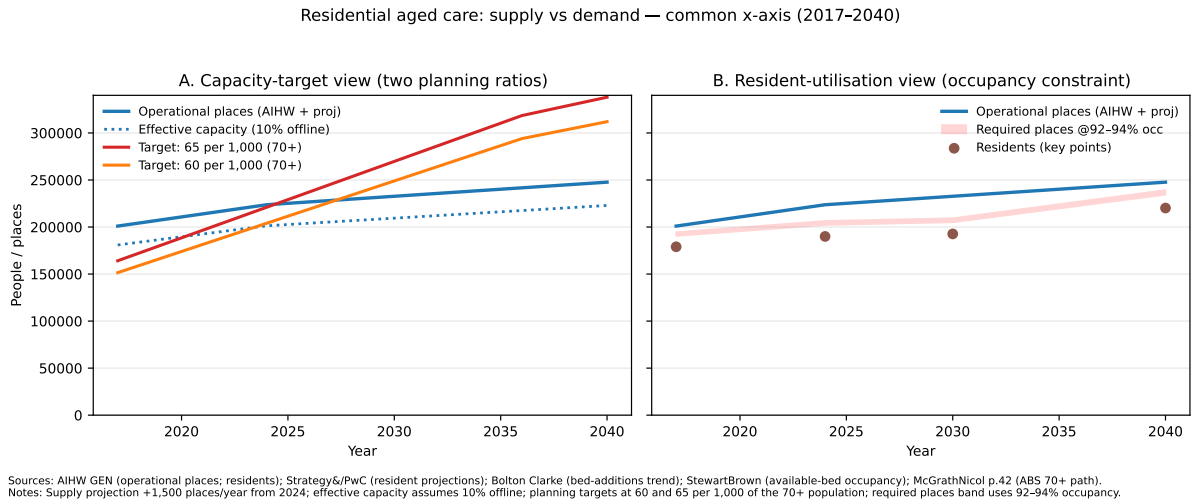

Figure 5: Residential aged care supply versus demand in Australia (common x-axis 2017–2040). **Panel A** shows operational places (AIHW) and an effective-capacity line (assumes 10% of places offline) against two planning targets: *60* and *65* places per 1,000 people aged 70 + (ABS path shown in McGrathNicol). **Panel B** converts residents (AIHW historical with projections) to required places at 92–94% occupancy (shaded band) and compares to operational places. Supply growth assumes +1,500 places per year from 2024.

access and avoid chronic capacity-tightness across the sector.

If operational supply continues to grow at only +800 to +1,500 places per year, effective capacity, after offline beds adjustment, risks falling below the target ratio-implied requirements by the early–mid 2030s, as the 70+ cohort expands. The planning-ratio projections are sensitive to the chosen ratio and, crucially, to the underlying 70+ population projections.

In Figure 6 operational supply is estimated from the latest five years of sector data. The plots show national operational supply paths versus the required places band. Operational places at 30 June 2024 were 223,691, and net additions were approximately +2,200 in 2023/24 and +800 in 2024/25 (five-year average ≈+1,500/year). Starting from June 2025, the Figure 6 projects three supply paths for operational places: (i) *Low* at +800/year (reflecting 2024/25 outcomes), (ii) *Base* at +1,500/year (the trailing five-year average), and (iii) *High* at +1,700 in 2025/26, +3,000 in 2026/27, then +2,500/year thereafter to reflect an optimistic level. Resident demand is benchmarked to AIHW/GEN levels (around 190,000 in 2023/24) and recent growth of about +5,000 residents per year, yielding 195,000 in 2024/25 and +5,000/year thereafter. Residents are translated to required places at an occupancy band of 92–94% (mid-point 93%), consistent with sector occupancy measured on available beds. Figure 6 shows that under the Base path supply tracks demand until the late 2020s, after which a shortfall emerges, whereas the Low path falls behind more quickly. Only the High path roughly maintains balance over the full projection horizon, illustrating the sensitivity of system adequacy to relatively small differences in annual net additions.

4.5 Home and Community Care: Support at Home Transition and Pricing

The Support at Home (SAH) program (effective 1 November 2025) unifies in-home care streams under a single assessment and budget model, with means-tested consumer co-contributions for non-clinical supports and full public funding for clinical services. Price caps have been deferred to 1 July 2026; during the transition year, providers set prices but face enhanced consumer protections and monitoring.

Early "indicative pricing" guides stress transparent price-setting, updated Support at Home

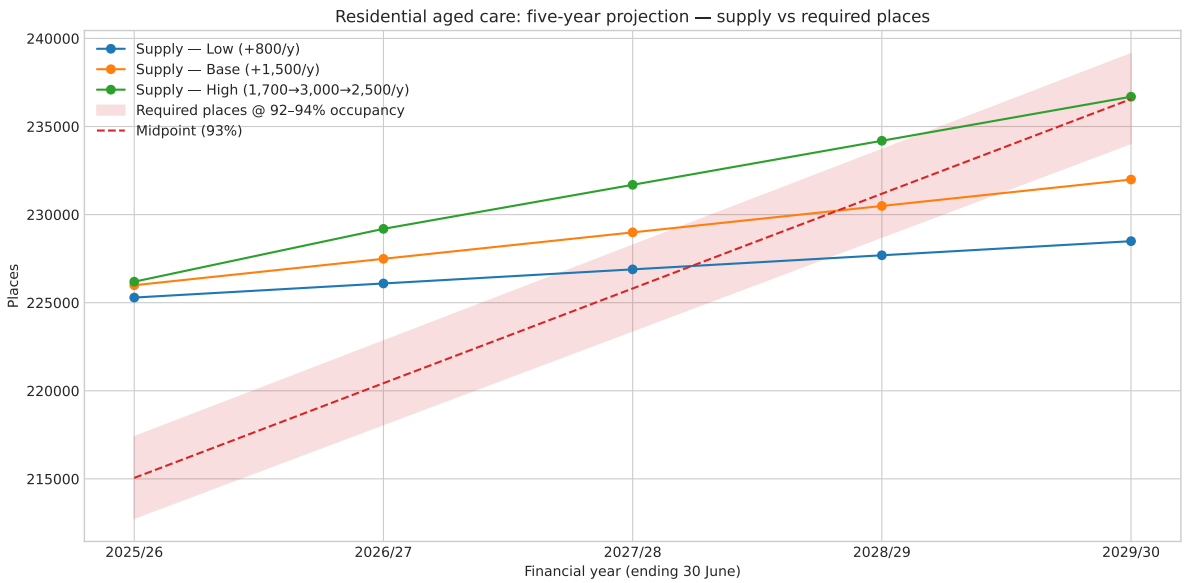

Figure 6: Residential aged care (Australia): five-year projection of supply versus required places under 92–94% occupancy. Supply paths start from June 2025 operational places and show three net-additions scenarios: Low (+800/year), Base (+1,500/year), and High (+1,700; +3,000; then +2,500/year). The red band shows required places if occupancy is held at 92–94%, with the dashed line at 93%.

(SAH) agreements, prohibition of entry/exit fees, and the "no worse off" principle for transitioning HCP consumers, with operational details around re-classification.

Home-care provider margins remain highly sensitive to fee regulation settings, particularly the proposed caps on care-management fees and the introduction of budget pooling rules under Support at Home (SAH). Recent financial reporting indicates that while home-care operating results rebounded in late 2024, with average earnings rising to $3.36 per client per day and margins improving to 4.0% in the September 2024 quarter, incoming reforms will materially impact surpluses.

Egan (2025) warns that with the 10% care-management fee cap and removal of package management fees, providers would need to increase service-delivery margins to over 32% to maintain current surplus levels, a shift that is unlikely without significant productivity gains. Pooled care-management budgets (10% of quarterly funds) began with Support at Home (SAH) from 1 July 2025, further affecting revenue flexibility.

In the 2025–26 transition, providers will need to focus on: defensible, transparent price books; cost-to-serve analytics by service line; workforce productivity (routing, rostering, skill-mix); digital intake and care-plan optimisation to meet quarterly budget dynamics; and consumer experience to mitigate churn when caps start in 2026.

4.6 Workforce, Wages and Compliance

The Aged Care Work Value Case (Fair Work Ombudsman (2024)) has delivered staged award wage increases for direct-care workers and nurses, effective from the first full pay period on or after 1 January 2025, and additional increases applying from 1 October 2025. These changes affect the Aged Care Award, SCHADS Award, and Nurses Award, including new definitions of direct-care employees, updated classification structures, and the reclassification of nursing assistants into the Aged Care Award. The Government is providing funding to support pass-through of these increases in both residential and in-home care, with further nurse-specific increases (Department of Health, Disability and Ageing (2025c)).

The cumulative wage effects, intersecting with annual wage case adjustments, will intensify payroll and compliance pressure and lift the break-even threshold for providers, especially in home care. Staffing models will need to incorporate higher base rates, revised classifications, and mandated care minutes in residential settings. Providers will need to ensure productivity improvements through skill-mix, supervision, and technology, ensure retention through career pathways, and accurate funding acquittals to demonstrate that Government wage funding is fully passed through.

4.7 Margin Pressures and Financial Performance Signals

StewartBrown (2025) shows tight or negative margins for many residential providers, with home-care profitability volatile and sensitive to fee rule-changes and administration cost caps. Home care results improved in late 2024, but are expected to come under pressure when management fee caps and structural changes under the Support at Home (SAH) program are fully implemented, reinforcing the need for lean operating models and pricing discipline.

The debate over "persistently thin margins" in aged care needs to be understood in the context of the sector's underlying risk profile and funding architecture. Residential aged care is generally characterised by low vacancy risk, highly regulated pricing, and a majority of revenue sourced from government subsidies, which together limit providers' exposure to demand or price volatility. In this environment, the central question is not whether providers face existential financial risk, but rather what level of operating margin is appropriate to sustain service quality, maintain workforce capability, and fund ongoing capital renewal. Although financial outcomes are highly variable across providers, with more efficient operators consistently generating positive margins even under current settings, for many not-for-profit providers, the challenge is less about short-term solvency and more about how to generate sufficient surpluses to invest in innovation, infrastructure, and service transformation, given the fixed nature of care funding and limited scope for price differentiation. Without access to retained earnings, RAD-based capital, or government grants and guarantees, these providers face structural constraints on their ability to modernise. This raises a broader policy question: how should a predominantly government-funded, low-risk sector generate the capital required for long-term sustainability and innovation without compromising equity or quality?

4.8 Strategic Responses: Capital, Technology and Service Mix

Providers will need to develop their capital and liquidity strategy using stress-testing to assess redevelopment and debt capacity against new liquidity floors and RAD retention flows. They will need to consider alternative funding such as long-dated debt, sale-and-leaseback, and joint-venture models, while maintaining compliance.

With margins compressed and wages rising, digital transformation for workflow automation (intake, rostering, documentation), AI-assisted scheduling, acuity-linked staffing, and analytics will be necessary to sustain quality and compliance at lower unit cost under the new pricing and prudential rules. Operational expectations and consumer-protection under the Support at Home program increase the value of transparent data and real-time reporting.

Demand growth is expected to be strongest for in-home care, but residential care remains essential for high-care cohorts. Providers will need to re-balance their product portfolios, enhancing home-care reach while upgrading residential assets to meet consumer expectations and leverage accommodation pricing (KPMG Australia (2025)).

4.9 Risks and Mitigations

Providers face a range of challenges and risks including higher wage floors, stricter prudential liquidity and investment rules, evolving accommodation funding with RAD retention, and sig-

nificant changes to in-home care pricing and consumer contributions. They will need to fortify balance sheets, improve efficiency of core operations with data and automation, and re-evaluate their product and service portfolios toward sustainable demand, while meeting heightened transparency and rights-based expectations.

There are a range of risks and mitigation that providers will need to increasingly focus on. Liquidity and refund risk under prudential standards and RAD retention risks require providers to maintain diversified liquidity (cash, commercial paper, committed bank lines), to implement early-warning systems and ensure board-level treasury oversight. Pricing and revenue risk during the Support at Home (SAH) transition will require providers to adopt transparent price governance, margin-by-service dashboards, and focus on consumer-communication protocols to minimise churn. Wage and workforce risk from award changes will require providers to model award translation scenarios, redesign roles/skill-mix, and ensure they can provide evidence of pass-through of Government wage funding. Regulatory and reputational risk from enhanced reporting and complaints oversight will require providers to strengthen quality systems, incident response, and public-facing disclosures aligned to Aged Care Quality and Safety Commission reporting.

While providers face genuine financial pressures, it is important to recognise that the intent of Commonwealth policy is to finance the cost of aged care—either directly through subsidies or indirectly through regulated consumer contributions—meaning that provider exposure is primarily related to timing mismatches, local cost variation, and adequacy of funding, rather than bearing the full cost of care. Evidence from StewartBrown (2025) shows that provider financial outcomes are highly variable, with substantial dispersion in operating margins, liquidity, and sustainability indicators. This variability reflects organisational and regional factors rather than an expectation that providers absorb system-level financing risk. Even so, from a policy perspective, the government's role should be to ensure appropriate funding levels and to manage transitions, not necessarily to guarantee individual provider profitability.

5 Intersections Between Individual, Government and Provider Perspectives

Australia's aged care financing system functions as an interconnected ecosystem. Individuals, government, and providers each face distinct financial exposures and behavioural incentives, but changes affecting one group inevitably reverberate across the others. Understanding these linkages is essential to designing sustainable, equitable aged care policy and ensuring sector stability. The reforms introduced through the Aged Care Act 2024, the Support at Home (SAH) program, and new Financial and Prudential Standards underscore the need for coordinated, system-wide thinking.

5.1 How Individual Behaviour Shapes Government Expenditure

Individuals' make decisions about when and how to access care—driven by health changes, liquidity constraints, cost sensitivity, and knowledge barriers. These decisions directly influence government outlays.

With the shift toward in-home care use, many older Australians prefer to remain at home longer, a behaviour reinforced by the Support at Home (SAH) program's service model. This tends to delay or reduce residential care entry, altering the cost profile borne by the Government and the timing of subsidy payments.

New means-tested co-contributions for non-clinical supports may encourage some individuals to limit service uptake, potentially reducing short-term government subsidies but increasing long-term government costs if delayed support accelerates health deterioration or precipitates

hospitalisation or earlier residential entry. The 2025 progress report (Inspector-General of Aged Care (2025)) warned that co-contributions may undermine policy aims of ageing in place.

Individuals who do not plan to incorporate home equity and draw down of retirement income in a sustainable retirement income plan will face the risk of having a higher reliance on government-funded services later in life. This interlinks personal financial planning with public fiscal sustainability.

Overall, government policy design—especially co-contribution structures, means-testing rules, and classification systems, interacts deeply with individual choices, making behavioural modelling crucial to long-term cost planning.

5.2 How Provider Financial Viability Influences Consumer Access and Government Objectives

Providers' ability to remain financially solvent underpins system capacity. Recent reforms impose significant operating and capital constraints. Tighter liquidity and investment standards require providers to maintain minimum liquidity and comply with governance and investment rules, which can constrain capital deployment and reduce risk-taking capacity. These measures are intended to safeguard continuity of care but may reduce providers' ability to expand services or innovate.

Workforce wage increases under the Aged Care Work Value Case elevate baseline operating costs for both residential and home care providers. Although government funding supports the increases, compliance requires accurate payroll classification and full pass-through, intensifying administrative burden. These rules strengthen workforce retention but challenge margins.

Home care pricing rules and future price caps mean that from 1 July 2026, providers face regulated price ceilings. This protects consumers but limits providers' ability to set prices that reflect rising costs or regional variability. During the transition year (2025–26), enhanced monitoring requires providers to justify pricing.

If providers cannot achieve sustainable margins, they may reduce service availability, exit thin markets, or reduce quality, outcomes that ultimately increase government expenditure through market-stabilisation measures, higher hospital system utilisation, or emergency interventions. The Government's fiscal strategy is therefore tightly coupled to maintaining a viable provider market.

5.3 How Government Reforms Reshape Individual and Provider Incentives

The new aged care legislative and funding framework introduces several feedback mechanisms. The Aged Care Act 2024 strengthens consumer protections and accountability mechanisms, requiring providers to meet higher standards of reporting, complaints handling, and transparency. While this protects consumers, the added compliance cost to providers is often passed through (to the extent possible) via service pricing—bringing consumers into tighter engagement with cost structures.

As individuals face new or expanded co-contributions under Support at Home (SAH), service uptake patterns shift. Reduced utilisation of personal support services due to cost create downstream effects: poorer functional independence, increased hospital presentations, and higher future government expenditure. The Inspector-General of Aged Care (2025) noted significant risks in assuming older people "easily adapt" to co-contributions.

Higher mandated liquidity levels help ensure providers can meet obligations—aligning with government's priority to protect RADs and continuity of care. But these requirements can stall development pipelines and reduce investment appetite, limiting system capacity and undermining government goals to expand supply.

Thus, policies aimed at financial safety and consumer rights must be balanced against the risk of constraining provider viability in the medium term.

5.4 System-Wide Sustainability: Aligning Incentives Across the Three Stakeholders

A sustainable aged care system requires incentive coherence. Misaligned incentives can trigger inefficiencies or higher costs across the system. Individuals may under-invest in personal care if co-contributions feel burdensome, increasing demand for more expensive later-stage services. Providers may under-invest in capacity and innovation if liquidity rules, price caps, or wage costs make returns uncertain. As government increases compliance and oversight, without sufficient supply-side flexibility, reforms may fail to deliver intended outcomes.

The most effective policy settings therefore align stakeholder incentives through fair and predictable co-contribution rules, financially secure yet flexible prudential frameworks, evidence-based pricing and workforce sustainability. To avoid distortions, co-contribution formulas must maintain equity, affordability, and clarity. This supports consumer willingness to engage with early, preventative services. Liquidity and investment rules should protect consumers while avoiding undue constraints on capital flow for growth and modernisation. Price caps in Support at Home (SAH) must reflect real costs to prevent provider withdrawal and maintain service quality. Wage increases must be matched by productivity improvements, training support, and appropriate funding flows, recognising that workforce shortages directly limit both access and quality.

5.5 Focus on Provider Implications

The transition to the Aged Care Act 2024, combined with demographic ageing and accelerating workforce cost pressures, has material implications for aged care providers. While policy reform has emphasised higher transparency, strengthened prudential oversight, and greater consumer co-contribution, providers now face a structurally different operating environment in which financial capability, liquidity management, and consumer affordability become core strategic concerns rather than peripheral considerations.

A central insight is that the financial behaviour of older Australians is increasingly shaped by liquidity constraints rather than by total wealth. Households with moderate assets, particularly couples, tend to delay residential care entry until a liquidity shock occurs, resulting in abrupt utilisation patterns and greater volatility in facility demand. Models of retirement consumption and aged care entry show that modest asset changes can trigger disproportionately large shifts in means-tested contributions, reflecting the non-linear incentives embedded in the current fee structure.

Another recurring theme is the under-utilisation of home equity as a funding source for aged care. Despite the fact that most middle-wealth households cannot sustain long-run care expenditure without drawing on housing wealth, take-up of equity release remains low due to behavioural barriers such as bequest framing, emotional attachment to the family home, and perceived product complexity. This creates an affordability bottleneck: consumers increasingly ask how to pay for services, yet lack confidence engaging with financial products.

The strategic opportunity for providers lies not in becoming financial product issuers but in serving as trusted intermediaries who help consumers navigate equity release pathways, including the Home Equity Access Scheme, simplified reverse-mortgage channels, and emerging hybrid care-financing products.

These financial dynamics intersect directly with the new prudential and investment standards. Tighter liquidity and governance requirements restrict how much of the RAD pool can be used for long-duration investment, shifting providers toward more liquid asset portfolios and placing downward pressure on traditional development funding models. Facility construction becomes more capital-intensive, with slower payback periods and reduced flexibility. Larger providers will need to develop long-horizon capital strategies that accommodate both rising acuity among future residents and heightened prudential oversight.

On the demand side, providers must prepare for a client base that is older, frailer, and more clinically complex at entry. Support at Home (SAH) is expected to prolong community living, which will compress the clinical profile of those eventually entering residential care. At the same time, Support at Home's service-based co-contribution model introduces additional unpredictability in home care utilisation for middle-wealth households, particularly if budgets tighten or price caps bind. Providers operating across home care and residential care will therefore need to anticipate new patterns of substitution and complementarity between these services.

Finally, the sector is likely to see increasing innovation in care–finance integration. Long-term care insurance (LTCI) or hybrid annuity–care products can be particularly valuable for mid wealth retirees, provided they are cost effective, bundled, tax-favoured, and integrated with means testing. Providers may ultimately form partnerships, not vertically integrate, to participate in emerging ecosystems where clinical services, financing tools, and decision-support systems are offered in integrated consumer-facing pathways. This is especially relevant as cost pressures rising faster than pension incomes create widening affordability gaps for consumers, and as providers who support financial navigation are more likely to secure trust, continuity of care, and stable occupancy.

Overall, the new aged care financing environment requires providers to adapt to a simultaneous set of pressures: rising labour and compliance costs, increasing care-intensity, capital constraints, and greater consumer heterogeneity. The providers best positioned to succeed will be those that embed financial capability, liquidity management, and affordability facilitation alongside traditional clinical and operational excellence.

6 Aged Care Financing Policy Issues

6.1 Funding adequacy and the case for an aged care levy

The Royal Commission into Aged Care Quality and Safety framed aged care as an entitlement based on need, and identified inadequate, unstable funding as a foundational cause of system failure, recommending a sustainable financing base for universal access, including consideration of levy-based funding to underpin rights-based access. Subsequent government processes have not adopted a levy: the 2024 Aged Care Taskforce explicitly rejected a tax or levy and instead endorsed higher co-contributions from those with means, a position echoed by the Minister at the time. In contrast, the Inspector-General of Aged Care (IGAC) has warned that expanding co-contributions, especially for "non-clinical" supports essential to independence, risks undermining ageing-in-place and diverges from the Royal Commission's rights-based vision, suggesting the current trajectory leaves a structural funding gap that a broad-based levy could better fund. A hypothecated aged care levy merits renewed consideration to stabilise revenues, reduce reliance on means-tested co-contributions for basic daily living supports, and align financing with the Royal Commission's entitlement framing and the IGAC's calls for system-wide coherence. Combining government tax based funding with individual pre-funding through an aged care levy, or through the superannuation system, along with a lower level of co-contributions should be considered for its potential for a more sustainable and equitable funding basis.

There are sustainability considerations which support a level of non clinical care co-contributions introduced in the new Aged Care Act 2024. If these are to continue as a component of the financing of aged care, then individuals should be able to pre-fund and insure these potential costs. A sustainable approach to aged-care financing could be achieved through a voluntary contribution levy of up to 3% of earnings paid into an individual's superannuation fund from age 50, earmarked specifically to pre-fund long-term care needs. Under this framework, superannuation funds would offer non-guaranteed long-term care insurance, ideally structured as a hybrid "combo" pooled lifetime pension incorporating long-term care protection. To maintain purchasing power in retirement, the lifetime pension could include an inflation-linked es-

calation—potentially implemented as a fixed 3% annual increase embedded in the pricing of the long-term care component. Benefits would be designed to respond directly to aged-care needs, with income payments doubling upon assessment of functional disability or eligibility for aged-care services, providing meaningful support at the point of need. Alternatively, benefits could be delivered as capped lump-sum payments aligned with existing aged-care non-clinical cost caps, currently around $135,000. This model allows individuals to pre-fund future care, leverages existing superannuation infrastructure, and uses risk-pooling principles to provide scalable, flexible protection against rising long-term care costs.

6.2 Integrating aged care co-contributions with superannuation and LTC insurance

Australia's retirement income policy is moving toward "lifetime income" within superannuation with trustees guiding members to lifetime income products as part of retirement solutions, but integration with aged-care co-contributions has not been considered. Innovative income streams under current SIS regulations supports product designs that pool longevity risk and could be combined, contractually or by advice pathways, with long-term care (LTC) cover or riders to pre-finance non-clinical care contributions. International experience shows hybrid life/LTC and annuity-LTC combinations can convert retirement savings into contingent care benefits, suggesting a feasible architecture for super funds to integrate LTC coverage with lifetime pensions. Treasury and APRA should consider facilitating superannuation-delivered lifetime income products that embed optional LTC cover or drawdown pathways for aged-care fees to reduce liquidity shocks from means-tested co-contributions.

6.3 The role of RADs and issues with phasing out RADs, DAPs and proposed DAFs

RADs (refundable accommodation deposits) function as interest-free loans from residents to providers, financing a large share of sector assets, and their prudential risks have long concerned regulators and the Royal Commission. The Government's accommodation reform pathway raises the ceiling for advertised prices, introduces RAD retention (2% p.a. up to five years) for new entrants, indexes DAPs (daily accommodation payments), and a process for considering the phasing out of RADs, reflecting a shift toward more transparent, diversified capital funding while seeking to stabilise provider revenues. The policy debate remains unsettled. RADs finance two-thirds of sector assets and their rapid withdrawal could impair capital investment without a ready replacement; conversely, over-reliance on RADs creates consumer equity and prudential concerns. The notion of daily accommodation fees (DAFs) or similar instruments to replace RADs requires precise determination methods including indexation, regional pricing, and risk-adjusted supplements to avoid affordability issues and ensure investor confidence in residential financing. Any RAD phase-down must be paced with clear, provider viable formula-based DAF pricing, accommodation supplements, and prudential transition arrangements to maintain capital flow, protect consumers, and avoid destabilising provider liquidity.

6.4 Inconsistent and complex means testing across Support at Home (SAH) and residential care

Means testing remains complex and inconsistent across programs, complicating personal financial planning and advice. Under the new Act and Support at Home (SAH) reforms, co-contributions for non-clinical supports sit alongside residential means tests for accommodation and care, with multiple thresholds, caps, and status rules for "low means" and the treatment of the home, that are hard for consumers to navigate. The Inspector General of Aged Care has cautioned that the

structure of home-care co-contributions has the potential to produce perverse incentives, including deferral or forgone essential supports, potentially accelerating entry to residential care. The multiplicity of fees, basic daily fee, hotelling/non-clinical contributions, means-tested care fees, and accommodation payments also adds to the administrative burden of assessments and ongoing reporting. A unified, transparent contribution schedule across Support at Home (SAH) and residential care, with common definitions, streamlined assessments via Services Australia/DVA, and harmonised caps, would reduce behavioural distortions and improve planning.

6.5 Forecasting demand by functional disability and cognition

Funding and capacity planning are still largely population-based rather than calibrated to functional disability and cognitive-impairment trajectories. Contemporary evidence shows dementia prevalence and dependence-related care needs will rise markedly to the mid-2030s, with regional heterogeneity and a falling worker-to-dementia ratio that will strain residential and home-based services. AIHW's national dementia reporting and the 2024–2034 National Dementia Action Plan reinforce the need to embed cognition and function metrics in planning, monitoring, and investment decisions. Government reporting frameworks acknowledge the importance of better system data, yet targets and funding are not consistently tied to functional-severity distributions across regions. This gap is also evident in the Intergenerational Report, which projects aged-care expenditure primarily from demographic ageing rather than from severity-adjusted need; as a result, it understates the fiscal and workforce pressures associated with rising dementia prevalence and high-acuity care. Population projections used for aged-care planning should incorporate severity-by-age profiles of functional limitation and cognition, and IGR modelling should be updated to reflect these trajectories to provide a more realistic basis for long-term financing and capacity planning.

6.6 Prudential and liquidity requirements, and staffing mandates (care minutes and RNs)

The new Aged Care Financial and Prudential Standards (commencing with the new Act) consolidate governance, liquidity and investment standards, including a formula-based minimum liquidity requirement for residential providers and strengthened oversight of refundable deposits. While aimed at continuity of care and depositor protection, they raise balance-sheet and cash-flow compliance costs, for many providers especially those with thin margins. Concurrently, the mandatory staffing regime, 24/7 on-site registered nurse coverage and an average 215 care minutes per resident per day, including 44 RN minutes, has improved baseline quality expectations but adds substantial labour cost and rostering complexity amid workforce shortages. Government guidance and supplements partially offset costs. To avoid unintended exits and service contraction, prudential/liquidity settings and care-minutes enforcement should be coordinated with funding support through AN-ACC prices and class weight updates, rural loadings and targeted transition support.

6.7 Simplifying the system and reducing the regulatory cost burden

The Inspector General of Aged Care's progress reviews recognises significant reform activity but emphasises that system-wide coherence is lacking, with fragmented changes adding complexity and administrative cost to providers and consumers. The new Aged Care Act and regulatory model aim to improve quality, transparency and oversight; however, without simplification of financing rules, fees, means tests, prudential reports, and staffing obligations, compliance burdens will divert resources from care. There is a need for a whole-of-system simplification program, to rationalise reporting, align prudential/liquidity metrics with sector risk, standardise fee constructs, and publish a stable reform roadmap with adequate lead times to build sector confidence.

6.8 Summary of Targeted Policy Recommendations

Aged-care financing faces multiple structural pressures, and a sustainable long-term system requires a sequenced approach to reform. Financial sustainability should be reconsidered by revisiting levy options to stabilise funding and reduce reliance on co-contributions for essential non-clinical supports, consistent with rights-based access. A credible accommodation-funding transition is also essential, requiring reevaluation of DAF formulas, indexation rules, and accommodation supplements, with staged changes to avoid capital shocks if RADs are phased out. Over the medium term, superannuation retirement-income solutions should be integrated with aged-care contributions, enabling optional LTC benefits within lifetime income products. A unified means-testing framework across home and residential care—with common caps, definitions, and streamlined assessments—would improve equity and predictability. Planning and pricing frameworks should be tied to functional and cognitive-severity distributions within regions, embedding these metrics in projections, targets, and AN-ACC pricing reviews. Prudential and staffing mandates should be synchronised with AN-ACC price and weight updates, supported by transitional subsidies to prevent provider exits during workforce and liquidity tightening. Finally, regulatory burden should be reduced through a simplification taskforce, proportionate risk-based oversight, and a consolidated reporting regime to support provider viability and system efficiency.

7 A Role for Actuaries and the Actuarial Profession

Australia's aged care financing landscape is undergoing profound transformation. The interplay between individual financial preparedness, evolving government policy, and provider financial stability forms a tightly coupled system. Changes in any one domain inevitably cascade across the others. Sustainable policy must recognise and manage these interactions, ensuring that reforms aimed at rights, safety, or fiscal sustainability do not inadvertently undermine provider capacity or consumer access. With its strong analytical and systems-thinking capabilities, the actuarial profession is uniquely positioned to support this alignment.

The complexity and interconnectedness of Australia's aged care financing system create a strong and growing need for actuarial expertise. Actuaries bring a distinctive combination of long-term financial modelling, risk analysis, system-wide thinking, and evidence-based policy design that is directly aligned with the challenges in the aged care sector. As demographic change accelerates, costs rise, and regulatory reforms reshape funding structures, actuarial involvement can support sustainability, equity, and resilience across the system.

Actuaries can provide that broader system-wide thinking with a focus on modeling aged care costs and risks, designing and assessing sustainable long-term financing frameworks, and the integration of aged care risks and costs with retirement income models and insurance products.

The aged care system contains multiple feedback loops—behavioural, fiscal, and operational—that must be understood together rather than in isolation. Actuaries are uniquely equipped to model these cross-system interactions because of their deep expertise in stochastic modelling of care needs and lifetime costs. Actuaries have the expertise and training to develop and implement microsimulation of individual financial trajectories and scenario analysis for government expenditure and policy settings along with financial viability modelling for providers under regulatory and market constraints

By integrating these elements, actuaries can help develop policy and funding structures that avoid unintended consequences, such as under-utilisation of early-stage supports, provider exit in thin markets, or escalating long-term public expenditure.

7.1 Policy Design Issues for Actuarial Contribution

Actuaries can contribute to the development and assessment of government policy in several key areas. These include demand forecasting, scenario modelling, long run demographic and economic modelling; modelling population ageing, increasing longevity, and morbidity trends and long term demand projections and uncertainties across care types; stochastic modelling of utilisation patterns to understand the cost implications of demographic change, particularly under different pricing, co-contribution, and entitlement settings; sustainability modelling for public expenditure, and the interaction of aged care policy with superannuation, tax, and social security systems.

7.2 Prudential Policy and Provider Viability

Government policy is closely intertwined with provider financial sustainability. Actuaries have a long established background in prudential regulation. They can quantify and assess the liquidity and capital adequacy implications of shifting funding models, the impacts of regulatory changes on provider behaviour, and long-term viability of providers under new pricing and subsidy conditions.

Actuaries can develop integrated micro-simulation models linking individual financial behaviour, government subsidies, and provider cost structures across demographic scenarios. These models can use stress-testing and scenario analysis to assess prudential standards, RAD retention flows, wage increases, and Support at Home (SAH) price caps. Behavioural modelling can be used to predict responses to co-contribution changes and classification adjustments. System-level optimisation can be used to assess trade-offs between affordability, sustainability, and equity. Actuarial analysis can guide reforms that minimise unintended consequences and strengthen long-term system resilience.

7.3 Demand and Cost Modelling Across the Care Continuum

Accurate forecasting of aged care utilisation and costs is vital for system sustainability. Actuaries can estimate future care demand by age, cohort, health status, and functional impairment, develop long-term cost projections for in-home and residential care, quantify tail risks, such as high-severity dementia pathways, and model distributional impacts of co-contribution changes on different consumer groups. Such projections and forecasts can assist policymakers anticipate funding needs, ensure equitable cost-sharing, and prepare for demographic pressures such as longer life expectancy and increased prevalence of chronic conditions.

7.4 Designing Sustainable Funding and Co-Contribution Models

With the introduction of new co-contribution rules, a unified in-home care program, and revised provider funding structures, actuarial skills can contribute to a sustainable aged care sector through designing means-testing frameworks that balance fairness, simplicity, and revenue adequacy, co-contribution schedules that reflect service value without deterring necessary early-stage care, long-term financing models incorporating superannuation, retirement income streams, and home-equity use, and subsidy formulas and pricing principles aligned to risk, cost drivers, and consumer protections. Actuarial models can stress-test across economic, demographic, and behavioural scenarios.

7.5 Supporting Provider Financial Sustainability

The strengthened prudential regime raises new analytical requirements for providers. Actuaries can support providers and regulators by assessing liquidity requirements, capital adequacy, and investment strategies, modelling RAD/RAC retention flows and refund obligations, forecasting

operating margins under wage increases, price caps, or shifting consumer preferences, quantifying risk exposures across residential and home-care portfolios, and supporting strategic planning, including service-mix optimisation and capital investment decisions.

7.6 Enhancing Workforce and Productivity Planning

The aged care workforce is a critical constraint, especially in the context of the Work Value Case wage reforms. Actuaries can contribute by modelling workforce supply and demand under different policies, assessing the impact of wage reform on costs, staffing patterns, and service prices, identifying productivity levers that maintain quality without unsustainable margin compression and evaluating the financial impact of technology adoption, such as AI-enabled care coordination. Robust workforce modelling supports both providers and government to make informed decisions about funding, staffing, and service delivery.

7.7 Improving Transparency, Accountability, and System Monitoring

As sector reporting expands—with financial, prudential, quality, star-ratings, and cost data now routinely published—the need for rigorous interpretation increases. Actuaries can contribute through developing design metrics and dashboards for financial viability and quality outcomes, identifying leading indicators of provider stress to inform early intervention, analysing sector-wide trends, informing government oversight and market-stability strategies.

7.8 Informing Innovation and New Financing Mechanisms

There is clear scope for actuaries to lead in the development of innovative financing solutions, including hybrid aged-care insurance models, deferred-care funding products linked to retirement income streams, equity-release structures that integrate with means-testing and government subsidies, and outcome-based funding models for preventative care or reablement services.

7.9 Championing Equity and Intergenerational Fairness

Finally, actuarial analysis is uniquely positioned to address questions of equity—between individuals, between socioeconomic groups, and across generations. Actuaries can contribute through quantifying how costs and benefits are distributed under alternative funding models, whether contribution structures appropriately reflect ability to pay, and how intergenerational burdens are allocated under different financing pathways.

Actuaries have the potential to provide a vital, multifaceted role in shaping the future of aged care financing in Australia. Their blend of quantitative rigour, systems thinking, and policy insight enables them to bridge the perspectives of individuals, government, and providers. By applying these skills to demand forecasting, financing design, prudential modelling, provider strategy, and system-wide evaluation, the actuarial profession can help build a resilient, equitable, and financially sustainable aged care system for an ageing population.

8 Conclusion

8.1 Summary of challenges and opportunities

Australia's aged care financing system is undergoing a period of profound reshaping, driven by demographic ageing, rising care expectations, and major reforms to legislation, regulation, and funding structures. The introduction of the Aged Care Act 2024, the transition to the Support at Home program, and the new Financial and Prudential Standards, together represent the most substantial redefinition of aged care responsibilities and financial architecture in decades. These

reforms collectively shift the balance of cost between government and individuals, elevate regulatory and prudential expectations for providers, and aim to embed a rights-based, person-centred philosophy at the heart of the care system. In this context, the financial sustainability of aged care has become both more complex and more urgent.

From the individual perspective, the challenge lies in navigating uncertain care needs, rising longevity, and the interplay between superannuation, retirement income streams, home equity, and co-contribution obligations. For many older Australians, aged care remains an under-planned element of later-life finances. Ensuring that individuals have the information, incentives, and financial strategies to meet potential care needs is central to both personal well-being and broader system sustainability.

From the government's standpoint, the task is to manage fiscal pressures while upholding equity, ensuring access, and strengthening quality and accountability. The shift toward greater consumer co-contributions, the redesign of in-home care funding, and the intensification of regulatory oversight reflect the Government's balancing act between affordability, sustainability, and consumer empowerment. The contrast with entitlement-based systems such as the NDIS underscores the importance of designing mechanisms that are fair, targeted, and fiscally resilient.

For aged care providers, the environment is characterised by rising wage costs, tighter prudential and liquidity requirements, evolving pricing rules, and increasing expectations from regulators, consumers, and the workforce. Providers must navigate thin or volatile margins while modernising operations, investing in workforce capability, adopting digital and AI-enabled tools, and planning capital development in a more constrained liquidity environment. Financial strength and operational efficiency are essential not only for organisational survival but also for maintaining service quality and system capacity.

Across these three perspectives, a common theme emerges: the aged care system functions as an interconnected ecosystem, where changes affecting one group inevitably influence the others. Sustainable reform requires recognising and managing these interdependencies. Consumer affordability affects provider viability; provider capacity influences government expenditure and system performance; and government policy shapes both individual behaviour and provider strategies. Poor alignment among these elements risks escalating costs, reducing access, or compromising quality.

In this environment, actuaries are uniquely equipped to analyse long-term care needs, model financial risks, evaluate policy options, and quantify system-wide interactions. Through integrated modelling, scenario analysis, and evidence-based design, actuaries can help policymakers, providers, and individuals make informed decisions grounded in long-term sustainability rather than short-term pressures. Their expertise is essential in constructing co-contribution frameworks, designing prudential standards, optimising pricing models, and forecasting future demand and workforce needs. In doing so, actuaries can help to identify unintended consequences, ensure policies remain equitable, and support a system that works coherently for all stakeholders.

As Australia prepares for rapid growth in the population aged 80 and above, the need for a financially sustainable, consumer-centred, high-quality aged care system has never been greater. The reforms currently underway offer an opportunity to build such a system—but success will require ongoing collaboration, transparent evaluation, and rigorous financial and system-level analysis. Actuaries, with their capacity to bridge individual, provider and government perspectives, are well-placed to play a leadership role in guiding this transformation.

Aged care financing is a societal challenge that touches every Australian. By combining analytical clarity with a commitment to equity and long-term thinking, actuaries can contribute meaningfully to shaping a system that supports dignity, independence, and quality care for Australia's ageing population in the decades ahead.

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A A Summary of Related Research Contributions to Aged Care Financing

This Appendix provides a brief summary of selected aged-care previous and current research with my co-authors at UNSW. This research has focused on developing multiple state models of morbidity and mortality risks incorporating functional disability and mortality, the application of these models to the pricing and analysis of long term care insurance, and the incorporation of these models into the analysis of individual retirement financing including home equity and long term care insurance. More recent research considers policy issues in the aged care area.

The multiple state models feature trends and uncertainty in trends and have been calibrated to U.S. longitudinal data (Sherris and Wei (2021), Chinese longitudinal data (Fu et al. (2022)) as well as Australian cross sectional data (Park and Sherris (2025)). The models incorporate both chronic illness as well as functional disability. They provide an analytical foundation for integrating housing, retirement income, long-term care (LTC) risks, and government support into coherent financing frameworks. Park and Sherris (2025) develop an Australian functional disability and health-state model, providing estimates for transition intensities relevant for projecting aged care demand and funding needs in the Australian setting.

There is a significant potential for the development of a long term care insurance product, either through a stand-alone product or integrated with life time pension products offered through superannuation funds. Kabuche et al. (2024) develop a multi-state pooling framework that jointly models functional disability and mortality. This provides the theoretical foundation for designing mutual risk sharing care annuities and LTC insurance pools capable of managing correlated later-life risks.

Shen et al. (2025) consider an innovative combination product that embeds longevity protection and LTC insurance within a variable annuity structure. They demonstrate how integrated risk-sharing products can enhance financial resilience in later life by providing contingent payouts aligned with aged care risk states as well as incorporating investment flexibility. These hybrid or combo products have potential in the Australian market, where there is no stand-alone LTC insurance other than that provided through government Aged care support.

Although long term care insurance has an untested valuable role in financing aged care costs in Australia, home equity has a compelling role to play in financing aged care costs. The role of housing, bequests, and liquidity constraints in long-term care financing is explored by Xu et al. (2023), who show how household preferences and liquidity limitations shape optimal insurance and housing decisions in retirement planning.

In the Australian setting, home-equity–based financing models that explicitly incorporate Age Pension means testing and government aged care subsidies are important in capturing the interaction between government support and private retirement finances. Lyu et al. (2026) analyse the interaction between home equity release, public support, and care costs, evaluating how older Australians can fund aged care while retaining adequate retirement consumption. This illustrates the potential for home equity to supplement both public financing and personal retirement finances, under Australia's means-tested Age Pension and Aged Care system.

Finally, Sherris (2021) provides a broader policy perspective by examining sustainable aged care financing in Australia, emphasising the need for coherent funding models that balance public support, private contributions, and risk-sharing mechanisms. Sherris (2021) advocates for an integrated insurance based model for sustainable Australian aged care, blending public (tax-based, levy based social insurance) and private (insurance, individual contributions) funding, alongside innovations including life-care annuities and integration with retirement income. Actuarial reviews would ensure equitable and sustainable balancing of inter-generational equity with government tax-based financing from consolidated revenue, contributions from individuals during their working lives, and means-tested co-contributions with lifetime cap, integrated with the Age Pension, for care costs along with the design of insurance products that are affordable and meet individual needs, balancing risk and cost. This would support the transition to a demand-driven system with timely access to care, not just supply-based, and addressing long wait-lists for aged care.

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