Residential Aged Care Accommodation Pricing Review

Queensland Health Submission to the Consultation Questions

Accommodation Supplement for Supported Residents

Queensland Health supports the objectives for accommodation pricing set out in the Residential Aged Care Accommodation Pricing Review Consultation Paper, namely that policy and funding settings should:

- provide equity of contribution and outcomes regardless of how a particular individual's aged care accommodation costs are met or where they are located;
- ensure that low means residents have access to high quality accommodation within residential aged care;
- support the capacity of providers to invest in and deliver places in high quality residential aged care homes that will meet the needs of Australia's ageing population; and
- foster a sector able to innovate, sustain growth and attract investment.

The successful operation of the aged care services market, including for concessional consumers, is vital to achieving one of Queensland Health's key strategic objectives of delivering a sustainable model of healthcare to ensure an efficient, equitable, safe and quality service for patients.

1. **Outline how you think the Accommodation Supplement could be reformed to ensure quality accommodation for residents of low means.**

Equitable access requires equivalent funding

Queensland Health notes the analysis by Stewart Brown (2025, 30) that indicates that the maximum Accommodation Supplement of $70.94 would equate to an accommodation price of $323,664, assuming a Maximum Permissible Interest Rate (MPIR) of 8%. This figure is well below the average agreed accommodation price of just over $500,000 (based on average fully refundable accommodation deposit (RAD) taken). The equivalent daily accommodation payment (DAP) for a $500,000 RAD would be $109.59 per day, which is significantly higher than the maximum Accommodation Supplement.

Stewart Brown's assessment of the average full RAD taken is comparable to the average agreed accommodation price of $451,000 published in the *Financial Report on the Australian Aged Care Sector 2023-24.* Applying this lower agreed price and using the ten-year average MPIR of just over 6% (based on MPIR data in Figure 1 of the Consultation Paper which includes historical lows), yields an equivalent DAP of $75.17 which is still a significant shortfall over an average length of stay.

This funding gap creates a substantial opportunity cost for providers accepting concessional residents, particularly in higher-priced homes. The gap will widen as the $750,000 price cap and future increases further elevate market prices. Neutral or positive incentives are required to encourage providers to admit supported residents.

Queensland Health suggests the Accommodation Supplement should be reformed to ensure Commonwealth Government funding for supported residents is commensurate with fee paying residents for the same standard of accommodation. This approach would minimise current inequity where supported residents are less favourable to residential aged care providers than fee paying residents and directly align incentives to maintain access and quality for supported residents.

There is also an opportunity to make the methodology used to determine the current level of Accommodation Supplement more transparent, making it easier to assess its relative merits. The review should incorporate an assessment of the methodology and how it may be improved to support more equitable access for low means residents, consistent with the objectives of the new *Aged Care Act 2024 (Cth).*

Aged care funding and market failures have significant impacts on public hospitals

Queensland Health acknowledges the fiscal implications of increasing the Accommodation Supplement. However, without more closely aligning to average accommodation prices, supported residents will face limited choice and delayed discharge from hospital. This drives up costs in the public hospital system as patients typically deteriorate in public hospitals when they experience delayed discharge and require more intensive resourcing in subacute settings. The identification of suitable accommodation for these patients also requires intensive effort from clinicians and clinical assistants which has a fiscal and opportunity cost for public hospitals. Given that most Australians (62%) pay their aged care fees in full, the supplement for supported residents remains a targeted and fiscally contained measure.

There has been a sharp rise in the number of beds occupied by older people waiting for a residential aged care home (RACH) placement across all jurisdictions. In Queensland, delayed discharge patient numbers have been increasing year-on-year since 2020, despite significant investment from Queensland Health. As at August 2025, Queensland's Hospital and Health Services (HHSs) reported 629 patients awaiting residential aged care placement, with a further 447 patients in interim care beds awaiting a permanent residential aged care placement.

Hospitals are designed for short-term acute healthcare services and are not suitable environments for long-term aged care. Prolonged hospital stays can lead to poorer health outcomes, increased pressures on hospital capacity and workforce, and higher healthcare costs.

Delayed discharge of older patients is often caused by limited capacity and capability within community and aged care services (particularly in relation to patients with complex needs and concessional patients), insufficient availability of appropriate post-hospital care, and inadequate coordination between health and aged care providers. Queensland Health collects qualitative data from HHSs on discharge barriers, which shows that a significant proportion of people experiencing discharge delays relate to difficulty accessing a concessional place in residential aged care. This indicates that RACHs may be preferencing consumers with an ability to pay, to enhance their financial viability.

Funding reform should be supported by measures to improve supply and complementary initiatives

The Accommodation Supplement provides a safety net for supported residents and an important market signal. Currently, residential aged care providers are required to meet the supported resident ratio of the region they are located in. Compliance reporting with supported bed ratios is not publicly available. The Aged Care Quality and Safety Commission monitors compliance and may apply sanctions to residential aged care providers that do not meet their regional ratio. Queensland Health notes that the Commonwealth is removing these mandatory ratios.

The Commonwealth's new Places to People Policy is expected to positively impact competition with flow on benefits to consumers. The reforms should include an equivalent mechanism to maintain these ratios and publish compliance data to enhance accountability and transparency to uphold access for supported residents.

Building supply and competition in the market is also an important lever to support equitable access. The aged care market should cater for a range of consumer needs, preferences and budgets from entry-level accommodation (that meets all standards) to premium accommodation for those willing to pay higher accommodation costs. The Accommodation Supplement should support access to the broadest range of residential accommodation possible to cater to the diverse needs of concessional consumers.

In the UTS Ageing Research Collaborative's 2022 discussion paper, *Sustainability of the Aged Care Sector,* it is argued that enhanced targeted funding support, transparent incentives, and regulatory mandates could collectively improve the acceptance rates of concessional residents, aligning operational practices more closely with the social equity objectives of the new *Aged Care Act 2024 (Cth)*. Queensland Health suggests that this independent review also explores levers that might complement reforms to the Accommodation Supplement.

Proposal for interim action

Noting this review will not be completed until July 2026, Queensland Health suggests that a time-limited uplift to the Accommodation Supplement is needed while the review is completed. Queensland Health suggests this be benchmarked to the daily accommodation payment equivalent for the average or median agreed room price for 2024-25. Increasing the Accommodation Supplement to reflect parity with residents that can pay would ensure that residents with low means are not excluded from accessing quality accommodation. It would improve the financial viability of the sector, and in turn create confidence for capital investment and refurbishment.

2. Should the value of the Accommodation Supplement be universal or tiered such as by location or proportion of residents or other basis?

Queensland Health is licensed to deliver 992 residential aged care beds within 16 Residential Aged Care Homes (RACHs), across seven Health and Hospital Services. There are also 300 aged care beds within Multi-Purpose Health Services in rural and remote locations, however, these are subject to different funding arrangements and are not considered here.

Queensland Health's RACHs service a range of geographic areas, as follows.

- 446 beds, or 45%, are within Modified Monash Model (MMM) categories 4-7: medium rural towns to very remote communities;
- 290 beds, or 29%, are within regional centres (MMM 2); and
- 256 beds, or 26%, are located within metropolitan areas (MMM 1).

The additional cost of fixed overheads experienced within rural and remote locations in Queensland (such as building maintenance, utilities, and servicing equipment such as air-conditioning units) impacts on the financial viability of providing services. Queensland Health supports tiered Accommodation Supplements by location, to improve the financial viability of providers in thin markets.

While tiered values may be an important incentive for non-government providers, they are not a key determinant within public RACH settings. The ability to pay a RAD is not a high consideration for admission to a public setting. Instead, residents are accepted based on the needs of the health system: over 90 per cent of residents are referred directly from hospital in the majority of public RACHs. Other factors include staffing capability and skill mix and balancing the needs of the existing resident cohort.

3. **Should the Higher Accommodation Supplement be staggered over time, so that as the accommodation facilities age the Residential Aged Care Accommodation supplement is reduced (with the full value payable again after a new renovation)?**

The Higher Accommodation Supplement (HAS) refers to buildings built or significantly refurbished after April 2012. However, all of Queensland Health's building stock was built prior to this date, with many in need of significant refurbishment.

For older facilities or lower cost homes with a higher proportion of concessional consumers, an increase in the HAS may incentivise capital investment or refurbishment.

Reducing the HAS could impact the viability of providers that service markets with limited providers and high demand (e.g., Queensland Health providers, not-for-profit providers in rural and remote areas).

The Consultation Paper indicates that the HAS is no longer effective in encouraging the development of additional capacity in the residential care sector (page 9). An alternative suggestion to ensure aged care building assets remain aligned with contemporary standards is to introduce capital grants, linked to the National Aged Care Design Principles and Guidelines.

This could be supplemented by a subsidy linked to the age of the building or the time passed since significant refurbishment, rather than a fixed point in time (such as 2012) to support investment.

4. **How suitable is the current incentive structure to encourage providers to accept low means residents (a discount on the Accommodation Supplement based on a single threshold of 40% supported residents)? How could those incentives be preserved or enhanced?**

Queensland Health supports an incentive structure that encourages providers to house concessional residents. This is an important mechanism to ensure that low means residents can remain in and connected to their communities after entering care and alleviates pressure on the public health system and public RACHs.

Anecdotally, hospital staff report that concessional older patients experiencing discharge delay may be refused a permanent aged care bed in the private sector due to providers "cherry-picking" residents based on their ability to pay for services (RADs). This indicates that the current incentive structure is insufficient. A specific example of this is within the Gold Coast HHS area where there are no public RACHs. An independent aged care broker reported that there is an extreme shortage of beds for concessional/supported residents as RACHs predominantly accept RAD payers only.

Additionally, HHSs report that residents with lower means can correlate with poorer health outcomes and higher care needs, which may increase the cost of caring for this cohort. This is consistent with the international literature which suggests health and illness follow a social gradient: the lower the socioeconomic position, the worse the health (World Health Organisation, 2023). The current Accommodation Supplement is insufficient to accommodate some of the higher needs of this cohort, particularly where building infrastructure may be ageing. As an example, some of Queensland's public RACHs are over 30 years old, making them eligible for only the lower tiers of Accommodation Supplement. This limits the ability to invest in refurbishments or environmental improvements to meet contemporary design standards. Some of the older public RACHs are also unable to house high-care residents, such as bariatric or those with complex dementia due to the physical limitations of the building. The resident cohort is typically low means, with reduced capacity to pay fees and limited assets.

A rationale should be provided on why 40% has been chosen as the appropriate threshold for low means residents across all providers. 62% of providers are receiving the highest accommodation supplement, which could suggest that either the incentive structure is working well or that those who receive the HAS have a strong organisational mission to house low means residents, regardless of which tier of supplement they receive (Note that the highest supplement is for significantly refurbished or newly built on or after 20 April 2012.)

An alternative for consideration is a graduated incentive model, with a tiered system adjusting incentives based on local socioeconomic data, for example:

- 20–39% supported residents: small discount;
- 40–59%: moderate discount; and
- 60%+: higher discount.

This approach could encourage providers to increase supported resident numbers, and reward those who take higher proportions.

5. How can the Accommodation Supplement be reformed to support an uplift in the quality of accommodation?

Queensland Health suggests an additional quality-linked supplement payment. This could be performance-based, linked to the uptake of the National Aged Care Design Principles and Guidelines to ensure that accommodation fits with contemporary standards and best practice, particularly regarding dementia friendly design.

Accommodation could be incentivised to reward both providers who accept higher proportions of supported residents and maintain high accommodation standards. This would promote social inclusion and continuous improvement in the sector.

6. Outline how the Accommodation Supplement pricing impacts on incentives for capital investment in residential aged care.

As noted previously, the Accommodation Supplement provides a strong signal to the market. For providers that accept a high proportion of concessional consumers, the income derived from concessional consumers must be comparative to part-fee and full-fee paying consumers to not hinder the ability of the provider to fund capital improvements.

Queensland Health considers that broader consumer preferences and willingness and capacity to pay for higher quality accommodation will also be influential at driving quality, given the smaller proportion of concessional consumers.

7. In what ways could the Accommodation Supplement be reformed to better incentivise capital investment in residential aged care?

To better incentivise capital investment in RACHs, consideration should be given to alternative ways the Accommodation Supplement could be delivered, for example an upfront payment model emulating a RAD, shared equity arrangements, or access to low interest loans through the Commonwealth Government.

Reform should consider long-term funding certainty. For example, the provision of multi-year funding guarantees for providers investing in high-quality accommodation for supported residents.

The Grattan Institute (2020, 5) proposed a new capital financing model that recognises that residential aged care is a social benefit that requires the Commonwealth Government to support its capital financing. This involves establishing a Commonwealth Government financing facility to fund capital investment in residential aged care through concessional loans, where the RACH funds are raised through government bonds. While the purpose of the Grattan Institute proposal is to gradually replace RADs, this would decrease the disparity between providers and enable smaller providers and providers admitting a higher proportion of concessional consumers the financial security to fund capital expenditure.

8. To what extent is the current rates of the Accommodation Supplement sufficient to cover providers' capital and operational costs relating to accommodation?

Queensland Health's RACH have high operational costs (Queensland Treasury Corporation, 2024, 11). HHSs have provided advice that there is a higher cost base experienced in the public sector driven by comparably high-cost labour when compared to the industry average.

Unlike non-government aged care providers, Queensland Health has responsibility for the public hospital and health system, allowing insight into and management of the issues at the interface between health and aged care. Queensland Health's public RACHs are often co-located with hospitals and share staffing and other resources.

Admission practices for Queensland Health RACHs are driven primarily by risk factors associated with the delayed discharge of older patients from hospital who may have low means and/or complex care needs. To provide quality care to the diverse and complex care needs of residents in public RACHs, Queensland Health recruits staff with a mix of skillsets to ensure residents receive high specialist care to minimise inappropriate hospital re-admissions. This has resulted in public RACHs operating at a deficit compared to the industry average.

Public RACHs in Queensland have limited opportunity for financial optimisation due to the financial capacity of consumers and limits on the ability to independently fund capital expenditure. Additionally, Queensland Health RACHs often provide the only option for older people to stay in and connected to their community in rural and remote settings, which make up 45 per cent of the public RACH footprint.

Therefore, public RACH services may require an additional funding supplement to cater for:

- higher cost inputs;
- limited ability to decline residents, such as those that are ineligible for Medicare and create sometimes hundreds of thousands of dollars in foregone revenue;
- remoteness; and
- providing services where there are no other, or limited, care options.

Anecdotally, Queensland Health's RACHs report that the Accommodation Supplement is one of many income sources that fluctuate according to the resident cohort at the time.

The Accommodation Supplement is indexed in line with the pension twice yearly. This has not kept pace with broader macroeconomic trends impacting provider operations such as increases in construction prices and the cost of capital. This is especially pertinent for providers operating in rural and remote areas, where construction, labour and transport related costs are higher than metropolitan and major regional hubs.

9. How does the costs of providing accommodation vary across different operating environments, such as differences in location?

Public residential aged care is expensive to deliver in rural and remote environments. As mentioned above, construction, labour and transport cost inputs are higher. Queensland Health's rural and remote RACHs are particularly constrained by staffing shortages, which affects service delivery and bed availability. Infrastructure uplift may assist with attracting workers to these locations. In remote and rural locations, Queensland Health has historically provided incentives to attract staffing, such as staff accommodation. This expense is borne by Queensland Health, however, is necessary to ensure continuity of service provision. As at October 2025, there are two rural public RACHs with reduced operational beds due to workforce constraints.

Freight costs are a significant expense which leads to a higher reliance on storage and use of utilities (through refrigeration). Inflated costs have a direct and immense impact on the financial viability of service provision in remote locations.

Maximum Permissible Interest Rate

10. What factors should be considered in setting an equivalence mechanism and rationale for each?

Queensland Health supports approaches that create certainty for older people contributing to the cost of their care as well as more predictable revenue for providers. For example, it is important that the MPIR (or any alternative measure proposed) is fixed for the duration of a resident's accommodation agreement. Consumers should not be significantly financially disadvantaged by electing one payment type over the other.

Queensland Health suggests that the independent review explore alternative options to achieve equivalence, and publish further analysis to identify which option (including retaining the MPIR) will best achieve the Government's policy objective and ensure that transactions between consumers and providers are fair, transparent and economically efficient.

A mandated minimum accommodation payment may introduce unintended consequences relating to resident choice and market dynamics.

11. What is an appropriate rate of return on lump sum for providers? Is this an appropriate level for setting an MPIR?

The permitted uses of the refundable deposits set out in the *Aged Care Act 2024 (Cth)* provide guidance as to the opportunity cost to providers of receiving a daily accommodation payment instead of a lump sum payment.

Registered providers are limited to using refundable deposits for uses such as capital expenditure (of a kind prescribed by the Aged Care Rules), repaying debt associated with that capital expenditure or investment in a regulated financial product.

The MPIR should reflect commercial interest rates payable on debt, and/or the income that may have been received from investment in a regulated financial product at the time.

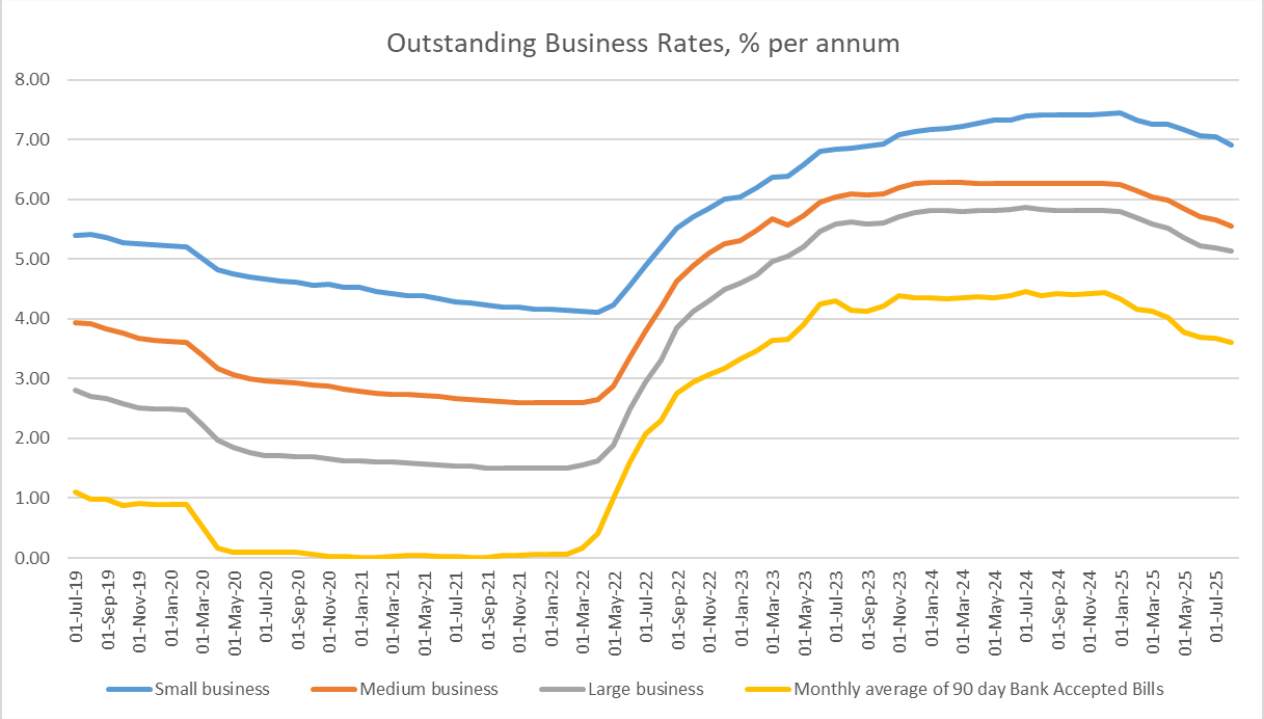
The interaction of the calculation methodology for the MPIR (set out in the *Aged Care Act 2024 (Cth)*) and the General Interest Charge (set out in the *Taxation Administration Act 1953 (Cth))* suggests that the MPIR is related to the 90-day Bank Accepted Bills published by the Reserve Bank of Australia in the following way:

MPIR = Monthly average yield of 90-day Bank Accepted Bills published by the Reserve Bank of Australia + 4%.

The review should consider whether an uplift of 4% on the 90-day bank bill rate reflects provider opportunity costs (of not being able to use a refundable deposit on permitted uses), and risks.

Comparing business lending rates with the 90-day bank bill rate suggests that a 4% margin is more aligned with the margin that lenders apply above the 90-day bank bill rate to small business borrowers which may not be the appropriate benchmark (Figure 1).

Figure 1 Outstanding Business Loan Rates, Large, Medium and Small compared to the 90-day Bank Bill.



Source: Reserve Bank of Australia Statistics, Business Lending Rates and Interest Rates and Yields – Money Market – Monthly

12. How does this change with economic conditions? Does the MPIR link to the General Interest Charge represent an appropriate way of adjusting equivalence in line with economic conditions?

As the MPIR is linked to the 90-day Bank Accepted Bill rate (via the General Interest Charge), underlying economic conditions contribute to movement in the MPIR. Queensland Health suggests that the margin (4%) applied to the base rate (the 90-day Bank Accepted Bill rate) is reviewed to ensure it remains appropriate and the results of the analysis made publicly available in review reports.

Queensland Health further suggests the review consider whether the methodology should incorporate any smoothing to constrain volatility in the DAP over time. While noting the MPIR is fixed for the duration of a resident's accommodation agreement, potential residents could still be adversely affected by movement in the MPIR (and DAP) during their search for accommodation, for example if they take 6 to 12 months to locate and secure appropriate residential aged care accommodation. They could also experience a change in DAP for equivalent rooms if they move residential aged care homes.

Volatility in daily accommodation payment rates over time also creates uncertainty for providers in relation to revenue forecasting.

Queensland Health notes analysis that shows, based on a RAD of $400,000, an equivalent DAP in July 2021 was $44.05, peaking to $91.84 in January 2024 and moderating to $83.40 in October 2025 (Simply Retirement, n.d.). This suggests that the timing of the point of entry matters to lifetime payments made for non-supported or partially supported residents. People have little control over when they need to enter residential care, and there appears to have been significant disparity in payments required by the DAP amongst the cohort entering care in the last 5 years.

13. Would a Weighted Average Cost of Capital be an appropriate equivalence mechanism? If so, how should this be derived

Queensland Health notes Frontier Economics (2020) set out a methodology for estimating a Weighted Average Cost of Capital (WACC) for the provision of accommodation in the residential aged care sector. However, Macquarie University (2021) argues that using a WACC, which is intended to determine the return required to cover the cost of capital, is distinctly different from the process of creating equivalence between a RAD and DAP. They point out that providers have different WACCs so an MPIR based on an average WACC would provide a competitive advantage to providers with a lower WACC.

Queensland Health notes the Macquarie University advice that applying a WACC to the margin between the accommodation price and cost of the room may be seem unfair by consumers. With the maximum refundable accommodation deposit that can be charged without approval being lifted to $750,000 under the new *Aged Care Act 2024 (Cth)*, it is likely that the RAD set by providers will already incorporate an expected return on the initial investment in the residential aged care home infrastructure. The ability for providers to set a room price to reflect their individual required rate of return provides greatest flexibility for a diverse market. However, competition is important in ensuring those returns are not unreasonable.

For providers like Queensland Health who operate in regional, rural and remote areas, input costs for accommodation may be higher due to higher building and construction costs, more expensive utility costs and increased storage space requirements (for example, food and supplies are delivered less frequently to minimise freight costs but then require increased refrigeration and storage). The methodology for calculating a WACC includes many input parameters, and it may be difficult to determine an industry-wide WACC that does not inadvertently disadvantage some providers due to fixed characteristics of the accommodation location.

The WACC may have other applicability for the aged care sector, for example it may be an appropriate basis for calculating the Accommodation Supplement, including setting price tiers. It could also be used to set a daily room price from first principles, rather than as a tool to convert the RAD to an equivalent DAP.

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

If an equivalence range facilitates a smoother MPIR over time, for example by using a year-average base rate at each quarter, rather than the single quarterly figure, then Queensland Health considers it is worth further consideration and analysis.

The policy intent would be to achieve greater parity of DAPs across residents that enter residential aged care within similar time periods and to reduce volatility in DAPs while residents search for a care home, which can take several months.

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

Queensland Health is concerned that introducing a mandated minimum accommodation payment would not address the underlying issue that DAPs appear highly sensitive to changes in 90-day Bank Accepted Bill rate, contributing to consumer and provider uncertainty.

The MPIR calculation equation means that the MPIR can never fall below 4%. Even in 2020 when the 90-day Bank Accepted Bill rate reached historic lows (related to COVID-19 economic recovery efforts), the MPIR average was 4.02% as shown in Figure 1 of the Consultation Paper.

RAD vs DAP

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

Shifting the MPIR-related fluctuations from the DAP to the RAD may limit the volatility in accommodation pricing for those who chose the daily payment method. However, Queensland Health considers the risks associated with shifting the MPIR-related fluctuations in pricing to the RAD to be significant, particularly in relation to provider financial sustainability.

The degree of volatility in the current MPIR approach would see greater fluctuations than in housing markets, including times where the lump sum prices may decline. In these situations, there may be liquidity risks as a provider is required to refund a RAD where the new RAD does not cover the amount owing (Australian Government Department of Health, Disability and Ageing, 2025, 19).

A consequence of this change may be a reduction in the proportion on accommodation costs paid using a RAD, which may in turn undermine growth in capital investment in the sector. While RADs remain an important financial instrument for the aged care sector, this option would require significant oversight and ongoing monitoring for unintended consequences. For example, a potential consequence could be that providers hold rooms vacant while waiting for economic conditions to improve, and a higher RAD to be available.

If the option causes lower RAD uptake (in a supply constrained market, providers may use negotiating power to preference DAPs), there may be a disadvantage to fee paying residents who would benefit more from using a lump sum payment approach, such as those who expect to reside in a RACHs for a long period of time.

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

Queensland Health recognises that the choice between a RAD or DAP can be complex for consumers as the outcome of the choice can significantly impact the consumer's estate. A decision for payment choice for a RACH can be highly emotive, often occurring during a period of high stress, and may require an urgent decision due to a sudden health event or change in circumstances.

There are some advantages for consumers at RACH entry by setting the DAP as the default accommodation payment. These include:

- alleviating some of the stress arising from this significant financial decision; and
- permitting consumers and their families adequate time to seek and consider financial advice to support them in making the right decision to suit the consumer's financial circumstances and risk appetite.

The DAP as the default payment also provides consumer security in accommodation while consideration of alternative payment pathways is underway. This will decrease some disparity in the negotiating power between consumer and provider. As noted in the Consultation Paper, consumers are accustomed to understanding housing rents in terms of weekly or fortnightly amounts, so expressing accommodation costs in these terms may be more easily understood and allow comparison across homes, without the need for specialist financial advice.

While setting the DAP as the default payment may make it easier for prospective residents to understand costs, having both methods of payments available supports greater choice and flexibility for residents to select the method that best suits their individual circumstances.

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

Queensland Health acknowledges that the proposal for the DAP as default payment will influence consumer behaviour and perception, which in turn will affect providers.

Although preference in consumer payment varies across providers, RADs are often favoured by providers seeking to undertake capital expenditure (Gu et al., 2024, 396). Queensland Health is concerned that making the DAP the default payment may have unintended consequences. For example, dissuading providers from undertaking capital projects aimed to improve the quality of accommodation.

Providers may be more inclined to seek RADs and/or raise room prices, in light of the introduction of the two percent retention rate in order to fund capital investment in the short-term. Although there is a legislated obligation for aged care providers to remain neutral, the power imbalance and opportunity to influence consumer payment decisions will remain in room price negotiations.

Grant Thornton (2023, 3) argues that the uncertainty over the replacement of the RAD capital model is likely stifling investment in facilities, services and innovation. Queensland Health suggests that policy direction on this issue and a long-term plan for RADs is needed to support sector investment over the longer term.

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

Nil response. Queensland Health suggests further analysis should be taken as part of the review to guide stakeholder consideration of this issue.

References

Australian Government Department of Health, Disability and Ageing. 2025. *Residential Aged Care Accommodation Pricing Review Consultation Paper*. https://www.health.gov.au/resources/publications/accommodation-pricing-

Centre for Health Economy, Macquarie University. 2021. *The role of refundable accommodation deposits – prepared for Aged Care Financing Authority.* https://www.health.gov.au/sites/default/files/documents/2021/03/the-role-of-refundable-accommodation-deposits.pdf

Frontier Economics. 2020. *The required return for aged care service providers – report prepared for Aged Care Royal Commission*. https://apo.org.au/sites/default/files/resource-files/2020-09/apo-nid308247.pdf

Grant Thornton. 2023. *Key considerations for a capital model to support sustainability in the aged care sector.* https://www.grantthornton.com.au/globalassests/1.-member-firms/australian-website/industry/hac/pdfs/gtal_2023_aged_care_report_.pdf

Grattan Institute. 2020. *Australian needs a new approach to capital financing of residential aged care – Submission to the Royal Commission into Aged Care Quality and Safety.* https://grattan.edu.au/wp-content/uploads/2020/10/Grattan-Institute-submission-capital-financing.pdf

Gu, M., Cutler, H., Aghdaee, M., Gu, Y., & Bilgrami, A. (2024). The role of refundable accommodation deposits in financing aged care capital expenditure: Views from the sector. Australian Journal of Management, 50(2), 390-407. https://doi.org/10.1177/03128962241230665.

Queensland Treasury Corporation. 2024. *Aged Care Forecast Model Final Outputs.*

Simply Retirement. n.d. “What is the MPIR?”. Accessed October, 13 2025. https://simplyretirement.com.au/MPIR-aged-care-payments

Stewart Brown. 2025. *Aged Care Financial Performance Survey Report: Year Ending 30 June 2025*. https://www.stewartbrown.com.au/images/documents/StewartBrown%20-%20Aged%20Care%20Financial%20Performance%20Survey%20Report%20June%202025.pdf

UTS Ageing Research Collaboration. *Sustainability of the Aged Care Sector*. https://www.uts.edu.au/research/centres/uarc/research-themes-programs-and-projects/sustainability-aged-care-sector

World Health Organisation. 2023. “Social determinants of health”. Accessed October, 31 2025. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1