



Centre for Population Ageing Research (CEPAR)

Policy Paper*

**Residential Aged Care Accommodation:
Projected Shortfalls and Policy Responses**

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*This CEPAR Policy Paper was prepared by Bei Lu, John Piggott and Michael Sherris, drawing on previous work by several CEPAR investigators. It is informed by a CEPAR Roundtable held at UNSW on 10 June 2026, with presentations by Michael Sherris, Jessica Evans, Tim Hicks, Shane Keating and Bei Lu. We received many comments from Roundtable participants and others, on previous drafts. We would especially like to thank Marc de Cure, Jenny Gordon, Nick Hartland, David Kaunitz, Kate Lynch, and James Mantis for valuable comments. AI was used in the preparation of the paper.

Executive Summary

Australia had about 225,000 operational mainstream residential aged care (RAC) places at June 2025. The Department of Health, Disability and Ageing projects that the number of people using residential care will rise from about 198,300 in 2024 to about 409,700 in 2044. The Independent Review of Residential Aged Care Accommodation Pricing estimates that net capacity may need to increase by approximately 10,600 places a year over the next two decades (Ray and Sutton 2026). Recent supply growth is far below that requirement. Net operational places increased by an average of 3,212 a year over the decade to 2025, but by only 1,470 a year from 2020 to 2025; the net increase in 2024-25 was 802 places.

The supply shortfall reflects the interaction of accommodation under-funding, rising operating and construction costs, long development timeframes, changing prudential requirements, workforce constraints, demand uncertainty, and policy uncertainty. These pressures affect for-profit and not-for-profit providers differently and are especially acute in thin regional and remote markets, but the investment challenge is sector-wide.

The Independent Review and the 2026-27 Budget propose substantial accommodation payments, construction finance and targeted capital support. This paper examines complementary reforms that could improve investment conditions, regulatory fit and resource use, largely within the funding envelope created by recently announced reforms. Targeted public capital or risk sharing may nevertheless remain necessary in thin and underserved markets.

The paper advances five proposals for policy consideration, summarised below. The full recommendations are at Section 6.

- 1. Increase flexibility in care-minute compliance.** Trial longer averaging periods and multi-site arrangements, subject to a specified minimum.
- 2. Amend the new Minimum Liquidity Amount (MLA) regime for Refundable Accommodation Deposits (RADs) to improve risk sensitivity.** The MLA regime should be refined so that liquidity requirements better reflect provider-specific risk. A more risk-sensitive formula would provide a better measure of liquidity needs under stress, improve the allocation of capital across the sector and maintain strong protection for residents and taxpayers.
- 3. Recognise residential aged care as essential social and health infrastructure.** Such recognition has the potential to reduce development approval delays, especially in thin markets. Commonwealth leadership should focus on intergovernmental coordination. Recognition must not remove design, environmental, heritage, accessibility or community safeguards.
- 4. Review building, planning and regulatory pathways for avoidable delay and duplication.** Reform should reduce avoidable process costs without weakening safety or quality.
- 5. Investigate the feasibility of Modern Methods of Construction in developing RAC facilities.**

The paper treats workforce availability as a constraint on effective capacity but does not examine workforce policy, informal care or assistive technologies in detail; each requires separate analysis.

1. Introduction

This paper examines projected shortfalls in residential aged care accommodation in Australia, the causes of slowing supply growth and policy options to improve the sector's capacity to respond.

For more than two decades, Australian aged care policy has pursued a broadly shared objective: enabling older people to remain in their homes and communities for as long as possible. The expansion of Home Care Packages and the transition to Support at Home have changed patterns of use. People now tend to enter residential care later and with greater frailty, dementia, functional impairment or clinical complexity.

Home-based services can delay or avoid some admissions, but demographic growth will continue to increase underlying demand. The Australian Bureau of Statistics projects that the population aged 80 and over will rise from just over 1 million to approximately 3.77 million by 2071 under the medium series (Australian Bureau of Statistics 2024). The leading edge of the baby boom generation turns 80 in 2026, strengthening the near-term demand pipeline.

At the same time, the supply response has weakened. Net additions to operational places have fallen well below both the average of the previous decade and the growth implied by current demand projections. New capacity is also unevenly distributed, while some existing places are offline because of staffing, refurbishment or redevelopment. The result is a national investment problem with distinct regional manifestations.

The challenge is not simply demographic ageing. It reflects the interaction of longevity and health uncertainty, changing resident characteristics, funding design, provider balance sheets, workforce availability, prudential regulation, construction costs, planning systems and policy sequencing (Sherris 2021, 2026). Ownership matters: for-profit, not-for-profit and government providers have different capital structures, service footprints and financial results. Policy should therefore avoid assuming that a single constraint or remedy applies uniformly across the sector.

The emerging accommodation gap must also be considered in the context of wider fiscal pressures. Population ageing is increasing demand for residential care, home support, health care, disability services, including for participants ageing within the National Disability Insurance Scheme (NDIS), and income support. Governments face difficult trade-offs among access, quality, resident protection and long-term fiscal sustainability (Australian Government 2023).

The Independent Review of Residential Aged Care Accommodation Pricing (hereafter the Independent Review) has proposed accommodation payments, zero-interest finance and targeted grants, while the 2026–27 Budget provides \$1.7 billion to support additional residential aged care construction and equity of access. (Australian Government 2026; Ray and Sutton 2026). This paper focuses on complementary reforms to financial regulation, investment certainty, planning and delivery. It does not argue that these measures remove the need for public funding. It is informed by CEPAR research, and the academic literature more generally; available government, government-sponsored, and industry reports; and a Roundtable held by CEPAR in June 2026. Participants in the Roundtable are listed in Appendix 1.

Workforce availability is an important constraint on effective residential aged care capacity, and the paper acknowledges it at several points. However, a full examination of workforce policy—including training, migration, retention, occupational design and regional labour supply—is outside the scope of a paper focused on accommodation investment, financing, planning and construction. This scope limitation is stated in the Executive Summary.

Section 2 examines projected demand; Section 3 considers current and regional supply; Section 4 analyses financial sustainability, operating costs, liquidity and policy certainty; Section 5 addresses

construction, refurbishment and development constraints; Section 6 presents proposals for policy consideration; and Section 7 concludes.

2. Demand for Residential Aged Care

Future demand depends on interacting demographic, health and service-system factors. Population ageing, dementia prevalence, disability, hospital discharge practices, the availability of informal care, the scale and effectiveness of home support, and community expectations will all shape the role of residential care. Long-term projections should therefore be treated as planning ranges rather than precise forecasts.

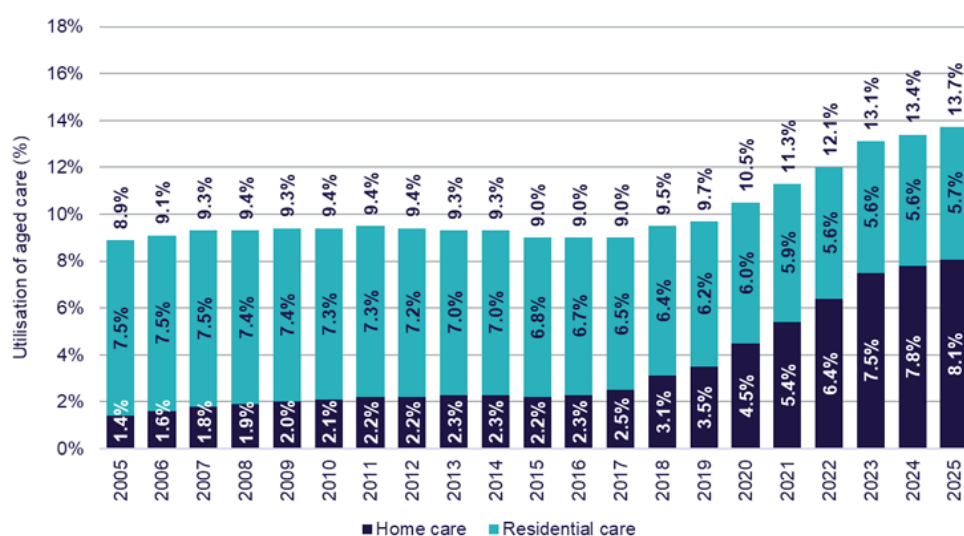
2.1 Demand Projections Based on Population Growth and Ageing

The Department of Health, Disability and Ageing projects that residential care use will more than double from 198,302 people in 2024 to 409,677 in 2044. The Independent Review reports an average requirement for approximately 10,600 additional operational places each year over two decades. This figure should be treated as an indicative planning benchmark rather than a precise construction target. It is derived from an aggregate projected utilisation path; the planning benchmark would move (up or down) if there were unanticipated changes in Support at Home, utilisation or length of stay, the required mix of specialist places, or the capacity margin needed to preserve choice and timely access. Planning should therefore test a range of demand and supply scenarios rather than rely on a single point estimate.

Residential care use is concentrated among the oldest age groups. Even if age-specific utilisation continues to decline, growth in the population aged 80 and over will eventually dominate. The timing and composition of demand are nevertheless uncertain because future cohorts may experience different patterns of disability, dementia, personal and housing wealth, family support and service preference.

Australia has expanded community-based aged care substantially. Home Care Packages, transition care, restorative care and other flexible programs have enabled many older people to remain at home longer. Published data also show a long decline in age-standardised residential care utilisation associated with a long-term rise in age-standardised in-home care utilisation. This trend is consistent with de-institutionalisation, consumer preference and government policy, but it should not be read as evidence that home support can replace residential care at every level of need.

Chart 1. Use of aged care services for people aged 70 to 99 years, aged care and home care, 2005 to 2025

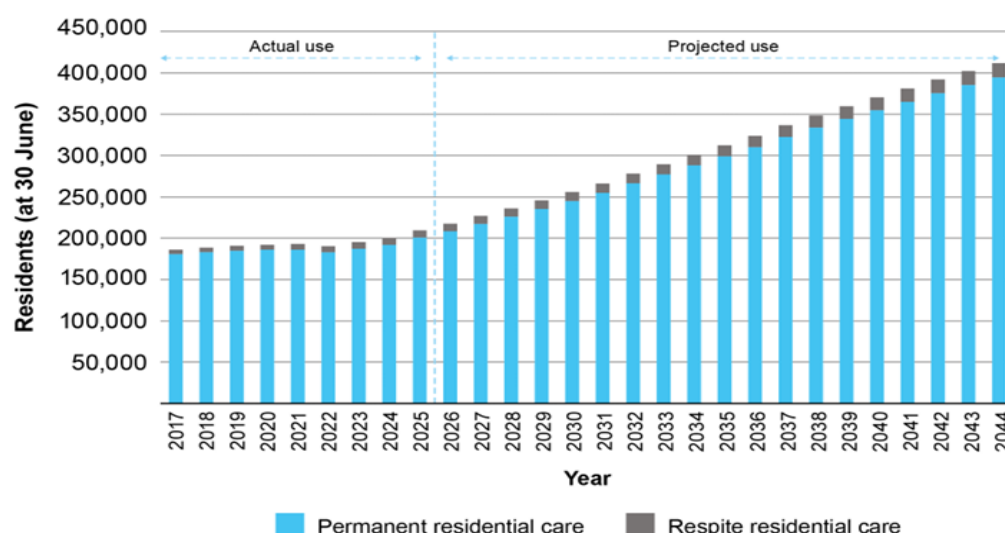


Source: Department of Health, Disability and Ageing (2026a), p. 90

Chart 1 illustrates the broad divergence between Home Care Package recipients and permanent residential aged care recipients over 2005-2025. Home-care utilisation increased substantially over this period, while residential-care utilisation declined until 2022 and has since been broadly stable.

Chart 2 reports the departmental projection reproduced in the Independent Review. It allows for declining age-specific utilisation while showing a pronounced increase in total use as the older population grows.

Chart 2. Actual and projected use of residential aged care places, 2017-2044



Source: Department of Health, Disability and Ageing

Source: Ray and Sutton (2026), Figure 1.1, based on Department of Health, Disability and Ageing projections. Permanent and respite residential care are shown separately.

2.2 Limits of Home Care Substitution

A central policy question is how far home-based care can substitute for residential care. Expansion of higher-level Home Care Packages has delayed entry for many people, but the incremental effect on permanent residential demand is difficult to identify because program growth, assessment practices, population health and consumer preferences changed at the same time.

Table 1 shows permanent residential aged care and Level 3-4 Home Care Package recipients per 1,000 people aged 65 and over. The rise in high-level home care coincided with a decline in the residential rate. This descriptive association is consistent with substitution at the margin, but it does not establish how many residential admissions were prevented or delayed.

Table 1. Permanent residential aged care and Level 3-4 Home Care Package recipients per 1,000 people aged 65 and over, 2018-2024

Year	Permanent residential care	HCP Levels 3-4
2018	58.1	11.6
2019	56.0	20.2
2020	54.4	25.0
2021	53.6	32.2
2022	53.3	39.1
2023	51.7	39.2
2024	51.5	43.0

Source: Productivity Commission, Report on Government Services, 2026. HCP = Home Care Package. Rates use the population aged 65 and over and should be interpreted descriptively.

The Financial Report on the Australian Aged Care Sector 2024-25 produced by the Department of Health, Disability and Ageing (hereafter FRAACS) reports that permanent residential care utilisation was broadly stable at 5.6-5.7 per cent from 2022, while home care utilisation among people aged 70-99 increased from 6.4 to 8.1 per cent. The Independent Review also reports that approximately 90 per cent of new entrants to residential care have high-level care needs. For many people with advanced frailty, dementia or complex clinical needs, a Home Care Package (or the new packages available under Support at Home) alone cannot provide safe and sustainable around-the-clock support (FRAACS; Ray and Sutton 2026).

Further expansion of Support at Home remains important for access, carer support and waiting-list reduction. On balance, despite significant improvements in home care availability, particularly for people with higher needs, RAC demand is likely to increase. The effect of further Support at Home expansion on residential demand is likely to be largest among people whose needs can be met safely at home and smaller among those requiring continuous supervision, specialised dementia support, extensive assistance with daily living or rapid clinical response.

Medium- and long-term demand also depend on future health and disability. The 2023 Intergenerational Report notes that recent longevity gains have not translated uniformly into additional years in good health. More years lived with disability or chronic illness may increase both health-care use and demand for formal aged care, while improvements in prevention, housing design and assistive technology could work in the opposite direction (Australian Government 2023).

The analysis now turns to the paper's central concern: whether accommodation supply can respond at the required scale and in the locations where demand will arise.

3. Supply of Residential Aged Care

At June 2025, Australia had 224,493 operational mainstream residential aged care places. Net additions averaged 3,212 places a year over the decade from 2015 to 2025, but only 1,470 a year from 2020 to 2025. The net increase in 2024-25 was 802 places, with 21 homes opening and 20 closing (Ray and Sutton 2026). If recent growth persists, it will be far below the approximately 10,600 net places a year (Ray and Sutton 2026).

3.1 System Pressure and Capacity Utilisation

Occupancy is an important indicator of pressure, but its interpretation depends on the denominator and sample. FRAACS reports an average occupancy rate of 89.9 per cent in 2024-25, calculated from government-subsidised care days divided by the days that mainstream government-funded places were available and operational. It excludes allocated places that were not operational because of factors such as workforce shortages or redevelopment. The latest StewartBrown survey reports 95.2 per cent occupancy of beds actually available to residents among mature participating homes for the nine months to March 2026, while the Independent Review cites a departmental estimate of approximately 95 per cent in January 2026. Differences in coverage, timing and treatment of new, closed, sanctioned or ramp-up homes explain why the estimates should not be combined into a single point figure (Department of Health, Disability and Ageing 2026a, pp. 19-20; Ray and Sutton 2026, p. 8; StewartBrown 2026).

Even a correctly measured national occupancy rate can overstate available choice. Vacancies may be temporary, unsuitable for a person's needs or located far from family and community. Resident turnover, infection-control arrangements, refurbishment, staffing shortfalls and temporary closures create frictional or unusable vacancies. A home with nominal spare capacity may therefore be at effective full capacity.

Hospital discharge delays provide a further signal of local pressure. Residential care is not the only cause of delayed discharge, but a shortage of suitable placements can keep older patients in acute or subacute beds after hospital treatment is complete. Accommodation planning therefore has consequences for health-system flow as well as aged care access.

3.2 Regional Variation and Localised Shortages

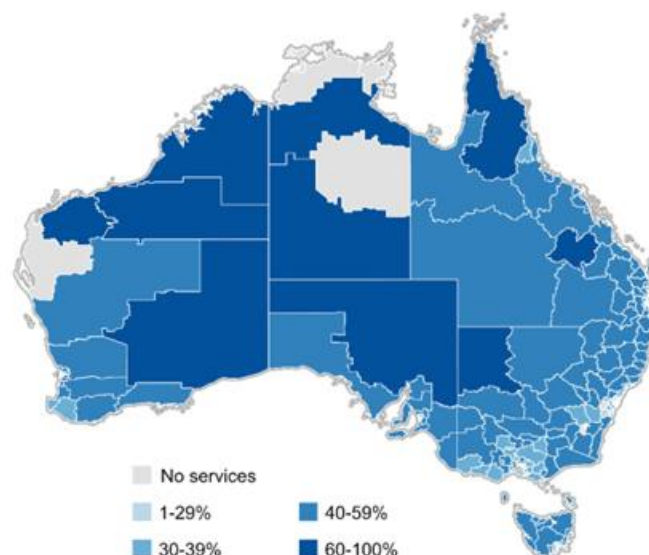
Residential aged care supply is unevenly distributed. Rural and remote areas face small resident pools, limited economies of scale, workforce shortages, long travel distances and higher construction and operating costs. A small number of vacancies can coexist with financial fragility, while the closure of one home can remove the only service within a large catchment.

Cooper-Stanbury (2025) uses 60.1 places per 1,000 people aged 70 and over as a benchmark and estimates that around 32 per cent of SA3 areas did not reach this threshold in 2023. If national supply reaches 256,700 places by 2033, the projected share below the benchmark rises to about 54 per cent; using the population aged 80 and over as the denominator, it exceeds 75 per cent. The exercise is sensitive to the benchmark and does not predict actual waiting lists, but it demonstrates how national growth can still leave large regional gaps.

3.3 Thin Markets and Lower-Wealth Areas

Thin markets and lower-wealth regions often have smaller homes, more government-supported residents and less access to resident-funded accommodation capital. They also tend to offer lower expected returns while facing higher workforce and construction risk. Market-led expansion may therefore be weakest where the social need for capacity is greatest. For example, the 2024-25 agreed value for RADs was \$504,000 for metropolitan, \$386,000 for regional and \$319,000 for remote areas.¹

Chart 3. Proportion of supported residents by SA3, 2024-25



Source: Ray and Sutton (2026), p. 44. Supported-resident shares are shown by SA3.

The Aged Care Capital Assistance Program (ACCAP) supports construction, expansion, refurbishment and safety improvements, with priority for regional, remote, Indigenous and other thin-market services. The Independent Review recommends a substantial expansion of ACCAP and concessional finance for homes that are unlikely to qualify for commercial lending (Department of Health, Disability and Ageing 2026d; Ray and Sutton 2026).

¹ FRAACS 2024-25, page 61-62

The previous Aged Care Approval Round system allocated places to providers and sought to align regional supply with assessed need. It offered some investment certainty, but also created barriers to entry and the risk that allocated places would be held without development. Under the places-to-people arrangements that commenced on 1 November 2025, residential places are allocated to eligible older people rather than providers, and registered providers are no longer restricted by a provider allocation (Department of Health, Disability and Ageing 2026c).

The places-to-people arrangements commenced only recently, and their impacts on investment incentives, accommodation supply and regional access are not yet clear. Continued monitoring and evaluation will be important to ensure that the new framework delivers its intended objectives.

3.4 Alternatives to traditional residential aged care and intermediate care

The supply of traditional residential aged care may be constrained by high construction costs and substantial workforce requirements. However, expanding intermediate care models could provide medium to lower-level support for older people within their communities, particularly if more flexible funding arrangements are made available. This would assist people who have a temporary need for the level of support currently provided in RAC, but who do not need to enter permanently (for example, people with a short-term increase in need, and people who are ready to exit hospital but need temporary high levels of support). This support would delay or reduce entry to RAC, thereby driving efficiency in the use of the existing stock.

An example of this approach would be to use capacity in respite centres funded through the Commonwealth Home Support Program (CHSP). Another example would be to use capacity in the retirement living sector, particularly where a complex has independent living units (ILUs) that could provide residents, or temporary visitors, with an intermediate care option. It may be possible to deploy modular or prefabricated construction to enable facilities to be delivered more rapidly and at lower cost where conventional RAC development is financially or operationally difficult. This approach could be particularly valuable in thin markets and remote areas, where constructing a full-scale RAC facility may not be financially viable. Locating respite and transitional care facilities alongside independent living units (ILUs) could provide residents with an intermediate care option when their care needs temporarily increase, rather than requiring an immediate transition to permanent residential aged care.

The next two sections examine the constraints on supply growth. Section 4 focuses on financial sustainability, operating costs, prudential liquidity and policy certainty; Section 5 considers construction, planning and development.

4. Financial Sustainability, Operating Costs and Liquidity Constraints

Residential aged care is investment-intensive. Providers commit capital over long horizons to land, buildings, equipment, workforce development, maintenance and refurbishment. The willingness of providers, lenders and investors to make those commitments depends on expected operating performance, accommodation returns, balance-sheet resilience and confidence in the regulatory environment. Providers need to comply with three standards for capital adequacy and supervision: Financial and Prudential Management standards; liquidity standards; and investment standards (Aged Care Quality and Safety Commission (2025c))

Reforms following the Royal Commission have strengthened care quality, safety, governance, staffing and accountability. They responded to serious and legitimate quality concerns.

They have also changed cost structures and increased reporting, assurance, governance and compliance obligations. While these reforms were introduced to strengthen quality, safety and accountability, they have imposed additional administrative and regulatory costs on providers. While

some increase in administration costs was inevitable following the Royal Commission, there is a question as to whether changes to settings for quality protections could be considered to reduce those costs over time. Reducing administration costs, and providing long-term regulatory certainty, could significantly improve the attractiveness of new investment, especially in smaller and regional markets. The policy question is not whether quality protections should be weakened, but whether funding and regulatory settings achieve an appropriate balance between accountability, quality and the sector's capacity to invest in additional accommodation.

The analysis distinguishes ownership types because their financial structures differ materially. Not-for-profit providers hold most sector equity and investment property, while for-profit providers make greater use of leases and related-party financing and have much lower reported aggregate equity. Government providers often operate in markets or service configurations that are commercially difficult. Aggregate results therefore conceal substantial variation within each group.

4.1 Financial Position of the Sector

Residential care accounts are commonly divided into care, everyday living, accommodation and administration. Care is funded mainly through the Australian National Aged Care Classification; everyday living through resident contributions and government supplements; and accommodation through resident payments and subsidies for supported and partially supported residents. Corporate and administrative costs must then be allocated across these components, so component margins are sensitive to accounting methods.

Table 2 reports selected component results before administration by provider ownership type, together with total administration expense, the recurrent result and net profit before tax. The sector as a whole recorded a net profit before tax (NPBT) of \$12.21 PRPD, with for-profit and not-for-profit providers profitable, and government providers close to break-even. A separate FRAACS 2024-25 analysis, after allocating administration expenses, reports a sector-wide positive result for care and losses in everyday living and accommodation (pp. 10-11).

Table 2. Selected residential care financial results by provider ownership, 2024-25 (\$ per resident per day)

Measure	All providers	For-profit	Not-for-profit	LST government
Care result before administration	\$41.70	\$46.76	\$36.87	\$72.18
Everyday living result before administration	\$10.74	\$18.06	\$8.06	(\$24.68)
Accommodation and finance result before administration	\$7.18	\$3.70	\$10.77	(\$18.55)
Administration expense	(\$54.03)	(\$51.12)	(\$55.16)	(\$66.95)
Recurrent result	\$5.60	\$17.40	\$0.54	(\$38.01)
Net profit before tax	\$12.21	\$22.44	\$6.35	\$1.69

Source: Department of Health, Disability and Ageing (2026a), Tables 1.8 and 1.9; component results are income less directly attributed expenses before administration. LST = local, state and territory. Net profit before tax includes non-recurrent income and expenses.

The UTS Ageing Research Collaborative and StewartBrown use different samples and overhead and capital-cost allocation methods, and likewise report continuing accommodation deficits. For the nine months to March 2026, StewartBrown estimated an accommodation-margin deficit of \$13.11 per bed day and reported that 62 per cent of mature participating homes operated at a loss. These results are not directly comparable with the FRAACS accommodation result (Department of Health, Disability and Ageing 2026a; Ma et al. 2025; StewartBrown 2026).

Financial sustainability must be assessed at the whole-of-provider level. Although care, everyday living and accommodation are reported separately, providers and investors assess total cash flow and balance-sheet capacity. A surplus in AN-ACC-funded care may be absorbed by deficits in everyday living, accommodation or administration, reducing funds available for debt service, asset renewal and expansion. These are being addressed by government policy. The net result of the Independent Health and Aged Care Pricing Authority (IHACPA) costing should be that care and everyday living end up, on average, approximately break-even. Therefore, in this context, providers across all segments need to ensure that the funding stream over which they have the greatest control—accommodation—is sufficient to cover capital maintenance and future investment costs.

Financial sustainability should also be interpreted differently across ownership types. For-profit providers require a risk-adjusted return on equity sufficient to attract and retain private capital. Not-for-profit providers do not have shareholders and should not be assessed against an objective of maximising distributable profit. Nevertheless, break-even is not an adequate long-run objective. StewartBrown (2026) indicates that financial investability requires a minimum return of \$20,000 - \$22,000 per bed, or at least a 4 per cent annual return on a \$550,000 build. This is substantially above the return² over of \$4,835 per bed per annum recorded for the 9 months from July 2025 to March 2026 (p.8). This indicates that overall, financial sustainability is very weak for new investment.

4.2 Recent Reforms and Developments

Provider performance now reflects the combined effects of wage decisions, care requirements, service expectations, accommodation reform and government funding. Several important changes commenced after the 2024-25 reporting year, so their full effects are not yet visible in Table 2.

4.2.1 Care and Everyday Living

During 2024-25, residents received an average of 213.74 direct care minutes per day, including 43.10 registered-nurse minutes. Because the sector benchmark increased to 215 minutes, including 44 registered-nurse minutes, from 1 October 2024, the weighted annual target for the year was 212.95 and 43.10 minutes, respectively (Department of Health, Disability and Ageing 2026a, pp. 20-22). Home-level targets are adjusted for resident mix and are not a flat 215-minute requirement for every home.

Government funding has increased substantially to support staged Fair Work Commission wage decisions and higher care requirements. The Care component recorded a positive direct component result in FRAACS, including after an allocation for administration, assurance and corporate costs. More recent StewartBrown survey data to March 2026 report a direct-care margin, including administration, of \$5.91 per occupied bed day while total care minutes rose to 220.7. Because the sample and accounting methods differ from FRAACS, the figures are directional rather than directly comparable. The near-zero recurrent result for not-for-profit providers in Table 2 illustrates why a component surplus should not be treated as freely available capital (StewartBrown 2026).

Everyday living recorded a positive direct component result in 2024-25, but alternative overhead allocations can move it into deficit. The hotelling supplement increased to \$22.15 PRPD from 20 September 2025 and is indexed annually. This should improve future results for catering, cleaning and laundry, although the effect will depend on food, utilities, labour and compliance costs. This increase is not yet reflected in the 2024-25 accounts (Department of Health, Disability and Ageing 2026e).

4.2.2 Accommodation

Accommodation has consistently recorded losses after allocating administration expenses. Recent reforms seek to improve accommodation finance. They include capital grants through ACCAP; a

² The return is defined as Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA)

maximum annual RAD retention amount of 2 per cent for up to five years for residents entering under the post-1 November 2025 arrangements; indexation of Daily Accommodation Payments; and the increase in the room price that can be charged without Independent Health and Aged Care Pricing Authority approval from \$550,000 to \$750,000 from 1 January 2025, with indexation thereafter.

The Independent Review recommends zero-interest take-out finance for the supported-resident share of qualifying new builds and significant refurbishments, a new-home payment of \$30 per supported resident per day for up to 25 years, a significant-improvement payment of \$15 per supported resident per day for up to 15 years, expanded ACCAP support and changes to the conversion mechanism between refundable and daily payments. The \$15 payment proposed by the Review would cover qualifying extensions or refurbishments that materially add beds, bring offline beds back into use or preserve stock at risk of permanent closure (Ray and Sutton 2026).

The Government's initial response adopts part of this package but changes some design details. It provides \$348.4 million over four years for targeted capital subsidies: \$30 per supported resident per day for eligible new homes and \$15 per supported resident per day for eligible expansions that increase bed numbers by at least 40 per cent, with payments commencing from 1 January 2027. It also provides \$1.1 billion over four years for accommodation-supplement changes and \$33.8 million for greater room-pricing flexibility (Department of Health, Disability and Ageing 2026f). In total, the 2026–27 Budget provides \$1.7 billion to support additional residential aged care construction and equity of access.

Because most of these measures are recent, their effects on total provider cash flow, resident payment choices, investment commitments and completed operational capacity will take time to emerge. Their operation should be monitored as evidence accumulates before further system-wide intervention is designed, without delaying targeted action in markets where under-provision is already evident.

4.3 Non-budgetary Reforms: An Integrated Approach

The following measures seek to improve the fit of regulation and strengthen investment capacity with limited direct recurrent budgetary cost. They are complements to, not substitutes for, adequate funding. Targeted intervention in thin markets will still require public capital or risk sharing.

4.3.1 Direct Care Minutes: Testing Flexibility without Weakening Safeguards

Mandatory direct care minutes are intended to protect residents against inadequate staffing and to ensure a minimum contribution from registered nurses and other direct-care workers. From April 1st 2026, the financial consequences of failing to meet care minutes targets could be up to \$33.41 per resident per day, according to the AN-ACC base tariff, for Modified Monash Model MM1 metropolitan providers (Department of Health, Disability and Ageing 2026g). The relevant evidence needs to be separated into three questions: whether staffing is associated with quality; whether a binding mandate changes staffing; and whether a particular numerical threshold improves outcomes. The literature is strongest on the first question, reasonably persuasive on the second for homes below a binding floor, and weakest on the third.

Systematic reviews generally find that adequate staffing - especially registered-nurse input - is associated with some better clinical outcomes, but the evidence is heterogeneous and largely observational. Armijo-Olivo et al. (2020) found that studies of minimum-hour cut-offs were few and generally low quality. Later reviews report a favourable overall tendency for registered-nurse staffing, pressure-injury prevention and some infection and pain outcomes, while results for total staffing and other outcome categories remain mixed (Jutkowitz et al. 2023; Blatter et al. 2024).

Observational studies face serious case-mix and reverse-causation problems: homes with residents who have greater needs may employ more staff and still record poorer outcomes. Facility averages

also conceal how staff are distributed across shifts, units and residents. Measured direct-care hours do not capture continuity, leadership, allied health, activities, housekeeping, food quality or the time staff spend on indirect but necessary tasks. These limitations make it difficult to infer a universal optimal threshold from correlations alone.

Natural experiments from United States staffing laws generally find that a binding floor raises measured staffing in homes that begin below or close to the requirement. Park and Stearns (2009), Bowblis (2011) and Werner et al. (2026) report increases concentrated among lower-staffed facilities. Estimated outcome effects are mixed: some studies find improvements in selected deficiencies, restraints or mortality, while Matsudaira (2014) found increased nursing-assistant hours without a discernible improvement in the measured resident outcomes. Different policy designs, enforcement regimes and staff definitions preclude a single dose-response conclusion.

The literature also identifies substitution risk. When staff categories are treated as interchangeable, providers may shift toward lower-cost workers or reduce housekeeping, food-service, activities or other indirect-care staff (Bowblis and Hyer 2013; Chen and Grabowski 2015). This does not negate the case for a staffing floor; it shows why the separate registered-nurse component, shift coverage and monitoring of allied-health and support services matter.

Australia's framework is more nuanced than a uniform national ratio. The sector-wide benchmark is 215 direct-care minutes, including 44 registered-nurse minutes, but each home's target is calculated from its resident mix and assessed over a quarter. The framework also includes 24/7 registered-nurse coverage, public reporting and an audited Care Minutes Performance Statement, and has recently been strengthened by the creation of the Care Minutes supplement. These arrangements improve accountability, but the audit and funding changes are too recent for a mature causal evaluation (Department of Health, Disability and Ageing 2026b).

The principal Australian study analysed 2,292 facilities over five quarters from January 2023 to March 2024. The proportion reaching the total-minute target increased, but no statistically significant association was found between care-minute levels and the available facility-level resident-experience or quality measures (Harrison et al. 2025).

International systems use a mix of approaches. Ontario legislates a province-wide average, England relies on a general duty to deploy sufficient qualified staff, and Scotland requires staffing appropriate to needs, skills and real-time conditions rather than a fixed universal ratio. Cross-country comparison is difficult because definitions, funding, case-mix adjustment and enforcement differ (Government of Ontario 2021; Care Quality Commission 2025; Scottish Government 2025).

The defensible conclusion from the available academic literature is that a binding floor can protect against very low staffing and raise staffing at the lower end of the distribution. Its effect on resident outcomes depends on skill mix, shift and unit coverage, workforce availability, funding and management quality.

Changes in resident case mix can alter a home's care-minute target more quickly than staffing can be adjusted. A rise in assessed need may therefore produce a temporary shortfall despite reasonable recruitment efforts, while a fall in assessed need may leave a provider with committed staffing costs. This timing mismatch provides a rationale for testing longer averaging periods, subject to a non-waivable home-level floor, transparent reporting and pre-specified resident safeguards.

Greater flexibility in the administration of care-minute requirements may enable providers to manage workforce variability and resident needs more effectively while maintaining care quality and resident safeguards. A trial of six-month, rather than three-month, averaging and limited multi-site averaging within a single provider organisation could be undertaken, consistent with the evidence reviewed above.

See Proposal 1.

4.3.2 Liquidity, Balance-Sheet Resilience and the Role of RAD Capital

RADs and contributions transfer part of a resident's housing wealth into residential accommodation. They remain a central source of sector capital and support investment in buildings and infrastructure. Sherris (2026) estimates that refundable accommodation funding finances roughly two-thirds of sector assets. Because the amounts are repayable when a resident leaves or an estate becomes entitled to repayment, the funding model creates a structural maturity mismatch between demandable liabilities and illiquid assets.

Prudential safeguards are therefore essential. Residents and families must be confident that refundable balances will be returned, and the Australian Government bears residual loss through the Accommodation Payment Guarantee Scheme. At 30 June 2025, the Scheme had been activated 17 times since 2006 and had refunded approximately \$180.2 million, including interest, to 541 residents. It was not activated during 2024-25. Low historical losses are reassuring but do not eliminate future risk if margins deteriorate, leverage increases, or refund outflows coincide with operating or property-market stress (Department of Health, Disability and Ageing 2025).

The current Liquidity Standard, in force from 1 November 2025, is not simply a uniform minimum. Each quarter, a provider must calculate both a default Minimum Liquidity Amount (MLA) and an evaluated MLA based on its own financial circumstances, then decide which amount it will maintain with governing-body approval. The default formula adds 35 per cent of cash expenses, 10 per cent of residential refundable deposit liabilities and 2 per cent of specified retirement-living refundable amounts. The evaluated pathway provides room for provider-specific assessment, but its consistency, comparability and supervisory use will depend on guidance, data quality and implementation (Aged Care Quality and Safety Commission 2025a, 2025b).

Recent CEPAR research evaluates the default formula against simulated representative provider archetypes. It finds that the uniform default may over-constrain large, well-capitalised providers while under-buffering smaller, less-diversified providers. For one representative large provider, a stress-calibrated rule releases up to \$223 million, or 27 per cent, for investment while keeping the modelled probability of a liquidity shortfall below 1 per cent under severe stress (Lyu et al. 2026).

Lyu et al. (2026) also argue that aged care providers face a capital-liquidity trade-off similar to banking, because providers hold illiquid assets while having large deposit-like liabilities. They find that a uniform MLA may not accurately reflect differences in provider risk profiles and propose stress-based, risk-sensitive liquidity requirements. Providers with similar RAD obligations may have substantially different default risks depending on their equity buffers, profitability, and asset structures. FRAACS 2024-25 reported for-profit providers had a low net equity ratio of 3 per cent in June 2025, from minus 1 per cent in June 2023 (Department of Health, Disability and Ageing 2026a, p. 56), indicating some providers operate at very low or even negative net equity levels. A provider with near-zero net equity has limited capacity to absorb shocks and is therefore more vulnerable to RAD repayment stress than a better-capitalised provider, even if both satisfy the same MLA requirement.

The broader corporate-finance literature supports that conclusion. General corporate-finance studies consistently identify weak capitalisation and leverage as predictors of financial distress (Altman 1968; Ohlson 1980; Shumway 2001). Financial-guarantee literature also emphasises that public protection should be paired with prudential monitoring (Merton 1977; Demirguc-Kunt and Kane 2002).

See Proposal 2.

The next section considers the physical supply constraints created by construction costs, refurbishment, planning processes and development economics.

5. Construction, Refurbishment and Development Constraints

Financial sustainability is necessary but not sufficient for capacity expansion. A project must be designed, approved, financed, built, commissioned and staffed, and it must meet evolving standards for safety, accessibility, infection control, dementia design, environmental performance and resident amenity. The sector's ability to expand therefore depends partly on the broader construction and planning systems.

Over the past decade, construction costs have risen, development timeframes have lengthened, and building-sector workforce constraints have intensified. Residential aged care is especially exposed because facilities are specialised, capital-intensive and subject to operational requirements that continue after construction. Higher standards can improve resident outcomes and building quality, but they also increase the amount and timing of capital required.

5.1 Construction Costs and Project Viability

Sector submissions to the Independent Review commonly reported new-build construction costs of about \$500,000 per bed, with estimates of \$570,000-\$620,000 in parts of Western Australia. These are indicative project estimates rather than a national cost index and generally exclude land. They vary with location, site conditions, design, scale, building standard and procurement method (Advance Ageing WA 2025; Ray and Sutton 2026).

Construction is only part of total development cost. Land, consultants, approvals, statutory charges, finance, fit-out, technology, commissioning and the period required to reach mature occupancy can materially change project economics. Interest-rate and construction-price movements during a long approval and build period can turn an initially viable project into an unviable one.

Accommodation revenue is constrained by local housing wealth, the mix of supported residents and residents' capacity to pay. The mismatch is most acute in lower-income regions, where resident-funded capital is least available and supported-resident ratios are higher. Refurbishment may be cheaper than replacement but is not inexpensive. One reported 2025 project delivered a major renewal for less than \$250,000 per bed, approximately half the cited cost of a new build; it is a single case and should not be generalised without comparable project data (Egan 2025). Better national data on completed project costs, scope, delivery time and post-opening performance would improve policy calibration and lender confidence. In general, however, refurbishment does not add to aggregate supply. But in-fill development, where beds are added to an existing facility with adequate back-of-house capacity, could provide additional beds at lower cost.

5.2 Planning Delays and Development Timeframes

Site acquisition, planning approval, environmental and heritage assessment, community consultation, design, procurement, financing, construction and aged-care registration can add years to the development and approval process before a home opens. Participants at the June 2026 CEPAR Roundtable reported typical end-to-end timeframes of four to five years, with pre-construction stages often taking as long as the build itself. This estimate should be tested against a project-level dataset rather than treated as a national average.

Residential aged care sits at the intersection of housing, health and community services. Insufficient capacity can delay hospital discharge, separate older people from family and community, and increase pressure on acute and community systems. In that functional sense, it is part of the infrastructure required for population growth and ageing.

The legal and planning consequences of that proposition differ across jurisdictions. For example, South Australia now expressly includes qualifying aged care facilities in the definition of essential infrastructure under regulation 3DA; with appropriate state sponsorship, a proposal may use the

section 131 Crown development and essential-infrastructure pathway, although sponsorship does not guarantee approval or funding (PlanSA 2025, 2026). Queensland's Planning Regulation 2017, Schedule 5, lists residential care facilities among infrastructure eligible for designation, but eligibility is not an automatic designation or approval.

Other jurisdictions use sector-specific planning provisions rather than an essential-infrastructure label. Victoria has explicit statewide policy for residential aged care and dedicated development standards in Clause 53.17. New South Wales includes residential care facilities in the State Environmental Planning Policy (Housing) 2021 seniors-housing framework, although minimum capital investment values apply, and the timeframe for some approvals can be lengthy. Western Australia's 2024 position statement introduces aged-care and independent-living land-use categories and asks local governments to identify need early in strategies and schemes (New South Wales Government 2026; Victorian Government 2026; Western Australian Planning Commission 2024).

However, even if accelerated planning approval were given the highest priority across all jurisdictions, planning reform alone would not resolve the supply constraints facing residential aged care. Residential aged care facilities must satisfy the technical requirements of the National Construction Code, including requirements applying to Class 9c residential aged care buildings, while also meeting the operational, safety and quality requirements of the Commonwealth aged care regulatory framework. The strengthened Aged Care Quality Standards, which commenced on 1 November 2025, place particular emphasis on the individual, care and services, the physical environment, clinical care and the residential community. The combination of specialised building requirements, care standards, workforce requirements and financial viability, involving all levels of government, therefore makes residential aged care considerably more complex and costly to develop than conventional housing.

A possible approach to reducing the time and financial costs of these processes would be to designate RAC facilities as a permissible use of land in all but the most incompatible zones (for example, Industry Zones). If they were then made Code Assessable rather than Impact Assessable, this would lower development risk.

5.3 Innovation and Alternative Delivery Models

The scale and speed of projected demand raise questions about whether traditional, bespoke development models can deliver residential aged care capacity in a timely and cost-effective manner.

Modern methods of construction, including modular and prefabricated construction, may reduce on-site construction time, improve quality control and enable incremental expansion where designs can be standardised and site conditions are suitable, without compromising quality. Roundtable participants indicated that potential benefits are likely to be greatest where transport logistics, design standardisation, procurement and early design decisions are carefully coordinated (Shooshtarian et al. 2025; Parracho et al. 2025).

Application to residential aged care remains underdeveloped, in part because Class 9c and aged care-specific compliance requirements are complex. A design competition or pilot program could test standardised modular designs within the existing regulatory framework.

See Proposals 3-5.

The following section consolidates the proposals arising from the analysis.

6. Proposals for Policy Consideration

The Independent Review and the 2026-27 Budget emphasise accommodation funding and construction support. The proposals below are intended to complement those measures. Most of them have low direct recurrent fiscal cost.

6.1 Financial Sustainability and Investment Certainty

The first two proposals address policy certainty, operating flexibility and prudential targeting while preserving resident protection and quality.

- 1. Increase administrative flexibility in care-minute compliance.** Test six-month rather than three-month averaging and limited multi-site averaging. Retain a non-waivable home-level floor, home-specific acuity targets, the separate registered-nurse component, 24/7 registered-nurse obligations and public reporting. Evaluate resident-level safety, experience and quality-of-life outcomes against pre-specified stop criteria. Do not allow persistent shortfalls at a particular home, unit or shift.
- 2. Amend the Minimum Liquidity Amount (MLA) formula to improve risk sensitivity.** The recently introduced MLA regime should be refined so that liquidity requirements better reflect provider-specific risk. In particular, the weighting applied to RAD liabilities in the default formula should be reduced and supplemented by measures of liquidity, receivables, debt obligations, capital strength, and provider size. Larger and more diversified providers generally face lower liquidity risk from RAD outflows than smaller providers, while highly leveraged providers face greater risk. A more risk-sensitive formula would provide a better measure of liquidity needs under stress, improve the allocation of capital across the sector and maintain strong protection for residents and taxpayers.

6.2 Construction and Planning Reform

Proposals 3-5 address issues around planning, development and construction of residential aged care accommodation.

- 3. Recognise residential aged care as essential social and health infrastructure.** Such recognition has the potential to reduce development approval delays, especially in thin markets. Commonwealth leadership should focus on intergovernmental coordination. Recognition must not remove design, environmental, heritage, accessibility or community safeguards.
- 4. Review building, planning and regulatory pathways for avoidable delay and duplication.** Investigate the feasibility of streamlining these, especially through allowing RAC facilities to be designated as a permissible use in most zones, with Code Assessable rather than Impact-Assessable. Again, community safeguards must be respected.
- 5. Investigate the feasibility of Modern Methods of Construction in developing RAC facilities.** There is an opportunity for governments and industry to explore whether standardised, pre-approved modular designs could be developed within the existing regulatory framework for RAC facilities. Modern-construction pilots could include small-scale respite and transitional-care facilities.

7. Conclusion

Australia's emerging residential aged care accommodation gap is the product of a demand problem, a financial sustainability problem and a delivery problem. Home support will continue to delay or avoid some admissions, but demographic growth and the concentration of high care needs among new entrants mean that substantial additional residential capacity will still be required. The precise scale and composition of that requirement are uncertain. Public planning should therefore combine demographic baselines with regularly updated regional scenarios for health, disability, technology, home support and informal care.

Supply will not respond at the required scale unless both for-profit and not-for-profit providers can earn returns consistent with sustaining their capital base. For-profit providers must be able to attract risk-bearing capital. Not-for-profit providers must generate sufficient recurrent surpluses to renew

assets, absorb shocks and expand services in pursuit of their mission. Prudential settings must protect residents and taxpayers without tying up capital indiscriminately. The next stage of reforms should combine liquidity risk with capital efficiency and financial performance indicators.

Even a financially viable project faces a long and costly path from site identification to an operational service. Planning reform, infrastructure recognition and modern methods of construction should therefore be tested through an end-to-end delivery program involving a pipeline of real projects and publication of their outcomes. This would show which changes materially reduce time and cost while preserving safety, quality and legitimate community safeguards.

The reforms proposed in this paper complement, rather than replace, the funding measures arising from the Independent Review and the 2026–27 Budget. Targeted public capital or risk sharing will remain necessary where provision is socially required but commercially unviable. The paper does not examine the supply and organisation of the aged care workforce, or the role of robotics and artificial intelligence, in detail, although workforce availability remains an important constraint on effective capacity. The immediate task is to align demand planning, provider sustainability, prudential supervision and project delivery so that operational capacity is created where and when it is needed.

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Appendix 1: Participants in the CEPAR Roundtable on Residential Aged Care Supply, June 2026, UNSW

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