



IHACPA

Pricing Framework for Australian Residential Aged Care Services 2026–27

Consultation Report

March 2026



Pricing Framework for Australian Residential Aged Care Services 2026–27 Consultation Report – March 2026

© Independent Health and Aged Care Pricing Authority 2026

This publication is available for your use under a [Creative Commons Attribution 4.0 International licence](https://creativecommons.org/licenses/by/4.0/), with the exception of the Independent Health and Aged Care Pricing Authority logo, photographs, images, signatures and where otherwise stated. The full licence terms are available from the Creative Commons website.



Use of Independent Health and Aged Care Pricing Authority material under a Creative Commons Attribution 4.0 International licence requires you to attribute the work (but not in any way that suggests that the Independent Health and Aged Care Pricing Authority endorses you or your use of the work).

Independent Health and Aged Care Pricing Authority material used ‘as supplied’.

Provided you have not modified or transformed Independent Health and Aged Care Pricing Authority material in any way including, for example, by changing Independent Health and Aged Care Pricing Authority text – then the Independent Health and Aged Care Pricing Authority prefers the following attribution:

Source: The Independent Health and Aged Care Pricing Authority



Acknowledgement of Country

We respect and acknowledge the Traditional Owners and Custodians throughout Australia and recognise their continuing connection to land, sky, waters and culture. We pay our respect to people, communities and Elders today and those who walk in spirit.

Artwork by Chern'ee Sutton

Contents

Abbreviations	5
Consultation questions	6
1. Introduction	7
2. Pricing principles	9
3. The Australian National Aged Care Classification funding model	11
4. Activity and cost data	15
5. Developing pricing advice	18
6. Funding model reviews	20
7. Supplements and grants	27
8. Priorities for future pricing advice	32
Appendix A: List of stakeholders	34

Abbreviations

Abbreviations	Full term
ACCO	Aboriginal Community Controlled Organisation
Aged Care Act	<i>Aged Care Act 2024</i>
AN-ACC	Australian National Aged Care Classification
BCT	Base care tariff
Consultation paper	Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27
Consultation report	Pricing Framework for Australian Residential Aged Care Services 2026–27 Consultation Report
Department	Department of Health, Disability and Ageing
Government	Australian Government
HELF	Higher everyday living fee
IHACPA	Independent Health and Aged Care Pricing Authority
MM	Modified Monash category
MMM	Modified Monash Model
MPS	Multi-purpose service
MPSP	Multi-Purpose Service Program
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
Pricing framework	Pricing Framework for Australian Residential Aged Care Services 2026–27

Consultation questions

Number	Question	Chapter
1	What could IHACPA do to support improved provider participation and increased representation in our cost collections?	Chapter 4 Activity and cost data
2	<p>A. For the Multi-Purpose Services Program, what activity and cost data points should be considered when developing recommendations for any new future funding model?</p> <p>B. For the Multi-Purpose Services Program, what methods of data collection should IHACPA consider when developing recommendations for any new future funding model?</p> <p>Please provide examples or supporting evidence.</p>	Chapter 6 Funding model reviews
3	<p>A. For the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, what activity and cost data points should be considered when developing recommendations for any new funding model?</p> <p>B. For the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, what methods of data collection should IHACPA consider when developing recommendations for any new future funding model?</p> <p>Please provide examples or supporting evidence.</p>	Chapter 6 Funding model reviews
4	<p>For approved providers receiving supplements to fund subsidised aged care, are there any cost variations associated with resident complexity or meeting specific resident care needs that need to be accounted for in the Australian National Aged Care Classification funding model?</p> <p>Please provide examples or supporting evidence.</p>	Chapter 7 Supplements and grants
5	<p>What factors, if any, contribute to variations in the cost of providing everyday living services (previously required hotel services) to residents?</p> <p>Please provide examples or supporting evidence.</p>	Chapter 7 Supplements and grants

1. Introduction

1.1 About IHACPA

The Independent Health and Aged Care Pricing Authority (IHACPA) was established as an independent government agency under the [National Health Reform Act 2011](#) (NHR Act). IHACPA assists the Australian Government by providing evidence-based pricing and costing advice to inform government policy and funding decisions in aged care and provides annual determinations of the national efficient price and national efficient cost for public hospitals.

Under the NHR Act and the [Aged Care Act 2024](#) (Aged Care Act), our aged care functions include:

- providing advice about aged care pricing and costing matters to government
- assessing applications from registered providers to charge higher maximum accommodation payment amounts.

Our vision is for all Australians to have fair access to transparent, sustainable and high quality health and aged care services. We use a consultative and data-driven approach to advise on and set fair pricing in the Australian health and aged care sectors, driving better outcomes.

As part of our work, we are guided by the Minister for Health and Ageing's [Expectations Setting Paper](#) and our [Statement of Intent](#). These outline IHACPA's aged care pricing and costing functions, including responsibilities and scope when developing our aged care pricing advice.

Aged Care Act

On 1 November 2025 the Aged Care Act commenced, replacing the *Aged Care Act 1997*, *Aged Care (Transitional Provisions) Act 1997* and *Aged Care Quality and Safety Commission Act 2018*. The Aged Care Act provides a regulatory model for government funded aged care services, including the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and the Multi-Purpose Services Program.

Following the introduction of the Aged Care Act, the [Higher Everyday Living Fee](#) (HELFF) replaced extra service fees and additional service fees. From 1 November 2025, IHACPA is not responsible for approving increases to extra service fees.

1.2 About this consultation report

IHACPA conducted a public consultation on key issues to be included in the Pricing Framework for Australian Residential Aged Care Services 2026–27 through the [Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27](#). The public consultation ran from Thursday 10 July 2025 to Friday 22 August 2025 and invited stakeholders to provide input into the development of the pricing framework.

The pricing framework is the key policy document for IHACPA related to residential aged care and residential respite care. It underpins IHACPA's approach to developing residential aged care pricing and costing advice to the government.

Key themes arising from the consultation feedback are summarised in this Pricing Framework for Australian Residential Aged Care Services 2026–27 Consultation Report. Where relevant, this stakeholder feedback has informed the development of the pricing framework.

All submissions to the consultation paper will be published on the IHACPA website, except where respondents have requested their submission be kept confidential due to commercial or other reasons.

This document should be read in conjunction with the consultation paper and the pricing framework.

The pricing framework and consultation report will inform the development of the Residential Aged Care Pricing Advice 2026–27.

Stakeholder submissions

IHACPA received 47 submissions to the consultation paper from a diverse range of stakeholders, including:

- residents and their carers, families and representatives
- residential aged care providers and industry suppliers
- the aged care workforce
- governments and government departments and agencies
- peak bodies
- members of the public with an interest in aged care.

We also conducted 45 interviews with providers of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and the Multi-Purpose Services Program.

Appendix A outlines the full list of stakeholders that provided a response to the consultation paper or participated in interviews, except where respondents have requested their submission be kept confidential due to commercial or other reasons.

2. Pricing principles

IHACPA balances a range of Australian Government policy objectives when developing our pricing and costing advice. These objectives include, but are not limited to, promoting person-centred, high-quality care expected by the community and required by government policy and legislation. This also includes supporting improvements in the sustainability and efficiency of the aged care system over time.

Our residential aged care pricing principles support our commitment to government policy objectives, while providing transparency and accountability when making decisions on the development of pricing and costing advice.

In response to stakeholder feedback from public consultations over the last 3 years, we have refined the pricing principles annually. Due to these previous updates and general support from the sector for the existing pricing principles, the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 did not include a separate consultation question about the pricing principles.

This chapter sets out the stakeholder feedback received in response to the consultation paper in relation to the existing residential aged care pricing principles and considerations for future refinement.

2.1 Updates to existing pricing principles

Overall, in response to the consultation paper stakeholders remained broadly supportive of the existing pricing principles. Some stakeholders proposed changes to better reflect the specific and nuanced service and care needs of culturally and economically thin markets.

Stakeholder feedback recommended further refinement of the principles to incorporate a reference to culturally appropriate and trauma-informed care services. One national peak body recommended that the principles should include an explicit commitment to identifying, and pricing for, structural, historical and political disadvantages faced by Aboriginal and Torres Strait Islander peoples and older people, not just geographic remoteness and thin market analysis.

Stakeholders suggested updating the **Access to care principle** to include reference to funding that supports timely and equitable access to *culturally* appropriate aged care services. Similarly, stakeholders recommended that the **Fairness principle** be amended to highlight the need for fair and equitable pricing that accounts for variations in delivering care and services in economically and culturally thin markets.

Stakeholders also advocated for broadening of the **Administrative efficiency principle** to include data collection efficiency, highlighting that funding arrangements should promote effective and efficient processes and should not unduly increase the administrative burden on aged care providers.

2.2 Suggested new pricing principles

In response to the consultation paper, stakeholders recommended development of additional principles to:

- address reablement and commitment to multidisciplinary team care
- align pricing signals across the aged care, health and disability sectors for similar services
- include a 'Closing the Gap' principle to align pricing for Australian Residential Aged Care Services with the National Agreement and its 4 Priority Reform Areas.

3. The Australian National Aged Care Classification funding model

The Australian National Aged Care Classification (AN-ACC) funding model provides a meaningful way to relate care needs, residential care home location and service specialisations with the cost to deliver care to residents.

AN-ACC funding is provided for clinical care and some non-clinical care services, consistent with Australian Government policy, and is not intended to support everyday living services and accommodation expenditure. More detailed information about the AN-ACC funding model can be found on the [Department of Health, Disability and Ageing](#) website.

The Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 did not include a separate consultation question about the AN-ACC branching structure and classes due to the extensive and in-depth responses received from stakeholders to related questions in previous public consultations.

This chapter sets out the stakeholder feedback received in response to the consultation paper in relation to the AN-ACC funding model including where feedback is outside the scope of our remit.

3.1 AN-ACC branching structure and classes

Stakeholders suggested refinements to the AN-ACC classification system including:

- introduction of a new AN-ACC class with higher levels of funding to incentivise admission of higher-acuity residents to residential aged care and encourage faster discharge from hospitals
- pricing of AN-ACC classes at the same price per minute across all classes to eliminate price signals that favour some resident classes over others.

Stakeholders also identified a range of instances where the current AN-ACC branching structure and classes do not adequately account for differences in the costs of providing care to specific resident cohorts. Stakeholder suggestions for refinements to address this are outlined below.

Cognitive impairment

Several stakeholders emphasised that the cost of providing care to residents who are independently mobile with a cognitive impairment is not adequately recognised by the existing AN-ACC classes. Stakeholders noted that higher compliance and regulatory costs are often associated with providing care to this cohort as ambulatory residents with a cognitive impairment represent a high number of serious incidents under the 'unreasonable use of force' Serious Incident Response Scheme reporting category.

Stakeholders suggested several refinements to the AN-ACC funding model and the branching structure to include:

- consideration of compounding factors such as frailty, behavioural symptoms, cognition and technical nursing requirements for residents who are independently mobile
- recognition of behavioural and cognitive complexity and other compounding factors through dedicated loadings, supplements, pricing bands, creation of a sub-class, classification changes or weighting towards behavioural needs
- funding for Memory Support Units or retrofitting facilities to provide care to residents with dementia
- expansion of cost collection tools to include a dementia indicator, as well as specific behavioural care activities.

Resident complexity

Many stakeholders emphasised the need for AN-ACC funding to better reflect the costs of providing care to residents with complex clinical and personal care needs as well as those with complex social histories. Stakeholders identified specific resident cohorts that lead to cost differences within classes including residents:

- with mental health conditions or psycho-social needs
- cognitive or neurodegenerative disorders
- who have had bariatric surgery
- who require enteral feeding and complex nursing care, for example catheterisation
- who are under guardianship orders.

Several stakeholders recommended that the costs of providing culturally safe aged care should be considered through the use of equity weightings to reflect the social-cultural complexity of certain groups and expansion of the definition of complexity to include language, migration status and cultural disconnection.

One stakeholder called for greater financial incentives to admit residents with complex care needs through more granular classification and pricing within the AN-ACC funding model.

Respite and palliative care

Several stakeholders reported increasing demand for residential respite care services and highlighted the added administrative burden and increased costs of admitting respite residents to aged care. Stakeholders recommended changes to the AN-ACC respite funding model to address growing concerns about the adequacy of current funding including:

- introduction of an initial one-off entry adjustment payment for respite care
- review of how often residential respite is used instead of AN-ACC class 1 (admit for palliative care) to provide end-of-life care
- consideration of an alternative funding model that does not rely on activity-based inputs to minimise standardisation, promote flexibility and improve resident choice.

Further, several stakeholders highlighted that quality palliative and end-of-life care delivers cost savings to the health system through fewer hospital admissions and reduced length of stay in acute care settings. Stakeholders advocated for greater inclusion of palliative care services in pricing and costing studies to ensure that IHACPA's pricing advice accurately reflects the cost of delivering end-of-life care.

A number of stakeholders also emphasised the importance of ensuring timely re-assessment of residents receiving palliative care to minimise the risk of providers delivering higher levels of end-of-life support than they are funded for.

3.2 AN-ACC basic daily subsidy

Stakeholders proposed that future refinement of the AN-ACC funding model should consider:

- provision of bespoke pricing advice for each state and territory to the Australian Government that accounts for variations in payroll tax and workers compensation costs
- elevation of priority Local Government Areas to higher Modified Monash categories or application of an additional base care tariff loading where costs in priority areas are determined to exceed funding
- AN-ACC and Base Care Tariff (BCT) price weights that are responsive to the expanded scope of compliance requirements and care obligations under the *Aged Care Act 2024* including enhanced clinical oversight, increased direct care time, increased data reporting, training and auditing and strengthened providers of culturally safe and appropriate care
- pricing adjustments for providers meeting the specialised needs of culturally and linguistically diverse communities.

3.3 Other AN-ACC funding model considerations

Care minute targets

While not within the scope of IHACPA's remit for pricing advice, some stakeholders noted that workforce shortages, particularly for registered nurses, can make it challenging to meet mandatory care minute targets. Some stakeholders indicated that providers must over-roster to account for unpredictable factors, such as staff absences and changes in resident numbers, and ensure that care minute targets can still be met. A number of providers recommended that revised registered nurse minute requirements be introduced to encourage flexibility and innovation and that reflect workforce capacity across the whole system.

Other stakeholder feedback noted that lifestyle, leisure and companionship services are not adequately covered by AN-ACC funding and suggested an overemphasis on direct care minutes. Several stakeholders requested that pastoral care practitioners should be included in care minutes requirements, with a suggestion to conduct a pilot program to explicitly include spiritual and emotional care in funding models.

Allied health

In response to the consultation paper several stakeholders, including national allied health peak bodies raised concerns that funding for allied health services is not based on the assessed needs of individual residents under the AN-ACC funding model. Stakeholders proposed that this is compounded by the absence of nationally consistent assessment and care planning tools and a lack of robust allied health data collection.

Stakeholders also highlighted that post fall or post hospitalisation reablement funding is not considered in the AN-ACC price.

Several stakeholders suggested that dedicated allied health funding to support the retention of allied health professionals in the sector would benefit residents. Several allied health providers suggested a proportion of the mandated care minutes should be allocated to the provision of allied health services. Other stakeholders recommended that cost collections should include allied health inputs, including consumables.

4. Activity and cost data

IHACPA uses activity and cost data in the development of residential aged care pricing and costing advice, including data from existing collections, such as the Aged Care Financial Report (ACFR) and Quarterly Financial Report (QFR), as well as data from our annual cost collections.

Annual cost collections allow our pricing advice to reflect contemporary cost structures and changes in costs and care delivery models over time, in accordance with the Australian Government's program and policy setting for residential aged care.

IHACPA continues to refine our cost collection methodology as more data is collected each year. This improves our understanding of targeted areas such as care related administration costs, allied health, indirect care time and respite services.

This chapter sets out the stakeholder feedback to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 in relation to future considerations for the representativeness, participation and associated methodology for IHACPA's cost collections.



Consultation question

What could IHACPA do to support improved provider participation and increased representation in our cost collections?

4.1 IHACPA's cost collections

Representativeness

In response to the consultation paper, several stakeholders advocated for strengthening culturally appropriate engagement methods with First Nations-led organisations and culturally and linguistically diverse (CALD) communities. Stakeholders suggested IHACPA continue to work with First Nations peak bodies to build trust, ensure cultural governance is upheld and co-designed data collection methods.

Stakeholders highlighted the need to ensure that engagement with First Nations-led organisations and CALD communities is culturally safe and relational, ideally involving face-to-face interactions and sustained support rather than one-off data requests.

National allied health bodies noted that some allied health professions are not captured in the data collected through the QFR contributing to the exclusion of allied health services from costing studies and policy planning. Allied health providers emphasised the importance of discipline specific inputs in cost collections to ensure that services remain sustainable and that alternative models of care are considered, particularly in thin markets and rural and remote contexts.

Stakeholders also recommended that a funded pilot data project should be undertaken to examine the true cost of allied health care provision by AN-ACC class to inform accurate pricing advice.

Methodology

Several stakeholders recommended tailored approaches to cost collections to better understand the costs of providing care to Aboriginal and Torres Strait Islander peoples, people from CALD communities, residents who have experienced or are at risk of experiencing homelessness and residents who have had bariatric surgery.

Stakeholders advocated for the sampling methodology to be expanded to include consumer perspectives, noting that the use of representative samples of residents would reduce the administrative load on providers.

Stakeholders suggested the use of stratified sampling in cost collections to ensure greater representativeness across provider type, governance and Modified Monash Model categories. Stakeholders also recommended that the sample sizes should be increased, and the scope of data collection expanded to ensure capture of detailed cost data for priority cohorts and under-represented AN-ACC classes.

Stakeholders recommended that IHACPA's pricing methodology should be more responsive to shifts in program design, workforce and fiscal decision-making, and include mechanisms for feedback and mid-cycle review to ensure responsiveness to cost pressures.

Many stakeholders emphasised the need to maintain data confidentiality and transparency about how data will be used, noting that a data governance framework for cost collections should be developed and published by IHACPA to build trust across the sector.

Participation

A number of stakeholders recommended that IHACPA provide clear communication about the purpose and intent of cost collections including more detailed information about collection methodologies and provider requirements to improve participation.

Stakeholder suggestions to improve sector participation in cost collection activities included:

- provision of regular updates about how data has informed pricing model changes and the impacts to providers
- dissemination of information across various aged care platforms and provision of role-specific training, webinars, step-by-step instructions, frequently asked questions and national roadshows reflecting IHACPA's current pricing framework
- provision of live chat, phone support or helpdesk functions for real-time assistance during cost collection periods

- facilitating access to peer learning opportunities or collegiate costing support networks to support other small or low-capacity providers
- providing targeted resourcing and culturally appropriate support staff from IHACPA to assist providers of Aboriginal and Torres Strait Islander aged care services
- deploying data extraction specialists to work directly with nominated providers, particularly those serving priority populations.

Many stakeholders emphasised the significant time and resource burden of data collection, noting that this is a potential barrier to participation impacting representativeness in the costing data set. Stakeholders recommended IHACPA communicate clear timeframes for costing periods, avoid major consultation periods during key operational peaks, share advanced notice of upcoming consultations and offer staggered or flexible training, data collection and submission options to accommodate diversity of resourcing within the sector.

Many stakeholders noted that staff participation in cost collection processes often detracted from time available for direct care, and the immediate benefits of contributing to cost collections are not always clear. Several stakeholders provided feedback on ways to improve data collection efficiency to minimise the time and resource burden of participation on providers, including:

- leveraging existing data collected for reporting and compliance purposes
- enhancing cost collection workbooks and templates to support data mapping, granularity and alignment with reporting requirements
- using collection methods compatible with systems in use across the sector.

Stakeholders provided varied feedback on the use of global positioning system tracking methods for data collection. Many stakeholders raised privacy considerations and highlighted these as a potential deterrent to their participation in cost collection activities. Alternative methods to obtain real-time data were proposed, including the use of swipe card systems.

A number of stakeholders recommended that data collection tools should support tiered participation in cost collections and be adaptable to different contexts while maintaining national consistency in reporting standards. Two stakeholders suggested that IHACPA explore artificial intelligence-driven platforms to assist providers to identify cost trends, anomalies and generate predictive insights.

Stakeholders noted that participation in cost collections places an unfunded burden on aged care providers and advocated for the use of financial incentives to boost participation and increase representativeness. Providers also highlighted that investment in technology and training is critical for efficient and accurate data collection.

Several stakeholders advocated for the establishment of clear feedback loops to demonstrate the value of participation in cost collections and provide tangible outcomes for participants. Stakeholders suggested IHACPA provide sector-level insights alongside confidential benchmarking data to enable providers to reflect on their comparative operational efficiency, care models and cost structures.

5. Developing pricing advice

IHACPA's development of residential aged care pricing and costing advice is independent, transparent, evidence-based and consultative. It is based on services meeting the standards of care required by Australian Government policy and legislation.

We provide residential aged care pricing advice to support government decisions on the Australian National Aged Care Classification (AN-ACC) funding model.

Our pricing advice includes:

- the AN-ACC price for residential aged care and residential respite care, based on funding the cost of care
- any recommended adjustments to the AN-ACC funding model, such as national weighted activity unit price weights, base care tariff categories and AN-ACC classes.

In addition, our pricing advice includes an estimation of the gap between the costs of delivering everyday living services and related revenue received by residential care homes.

The Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 did not include a separate consultation question about the development of pricing advice due to extensive feedback received in previous consultations. Despite this, several stakeholders provided feedback on the development of our pricing advice for broader consideration. This chapter sets out the stakeholder feedback received, including where feedback is outside the scope of our remit.

5.1 AN-ACC pricing model development

Indexation and adjustments

Stakeholders provided feedback that the current approach to indexation may not adequately account for the premium cost of labour required to ensure continuity of service in remote regions.

Feedback to the consultation paper recommended that consideration be given to AN-ACC funding model adjustments that reflect the real costs of providing transitional care to residents including staffing and coordination for hospital discharge and rehabilitation. Stakeholders also suggested the use of outcomes-based funding or quality-based pricing adjustments to incentivise improved outcomes for recipients of residential aged care services.

Pricing advice cycle

While not within the scope of our remit for pricing advice, some stakeholders provided feedback that late announcement of the AN-ACC price impacts providers' ability to implement effective budgeting measures across their organisations. Stakeholders requested that indexation amounts and the AN-ACC price be published prior to 1 July each year to support annual budgeting processes.

6. Funding model reviews

The Australian Government currently provides block grant and subsidy funding to a range of aged care programs, including the [Multi-Purpose Services Program](#) (MPSP) and the [National Aboriginal and Torres Strait Islander Flexible Aged Care Program](#) (NATSIFACP).

As part of broader funding and regulatory reforms to the aged care sector, government has requested we undertake an assessment of the funding models for these 2 programs over the coming years. Our analysis will evaluate the most effective future funding arrangements for the MPSP and NATSIFACP services designed to operate in rural and remote areas, often referred to as thin markets.

Informed by our analysis and advice, government will make a policy decision as to the implementation of any proposed new funding arrangements for the MPSP and the NATSIFACP.

This chapter sets out the stakeholder feedback received in response to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 and the supplemental targeted interviews conducted with MPSP and NATSIFACP providers. Through this process, we sought to understand:

- costs of staffing and resources to deliver services in rural and remote settings
- types of services delivered to older people accessing services
- administrative information about service users and service providers
- any other cost drivers.



Consultation question

- A. For the Multi-Purpose Services Program, what activity and cost data points should be considered when developing recommendations for any new future funding models?
-
- B. For the Multi-Purpose Services Program, what methods of data collections should IHACPA consider when developing recommendations for any new future funding model?
-

Please provide examples or supporting evidence.



Consultation question

- A. For the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, what activity and cost data should be considered when developing recommendations for any new future funding models?

- B. For the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, what methods of data collections should IHACPA consider when developing recommendations for any new future funding model?

Please provide examples or supporting evidence.

6.1 Multi-Purpose Services Program

Stakeholder feedback in response to the consultation paper and the targeted interviews with MPSP providers identified the limitations of the current funding model and included considerations and recommendations to inform any proposed new future funding arrangements. This stakeholder feedback is outlined below.

Program objectives and design

Stakeholders reported that many multi-purpose services (MPS) function as providers of last resort, where no other market or provider exists, particularly in rural and remote areas. MPSP providers noted that this issue is exacerbated by MPS experiencing demand over and above capacity resulting in long waiting lists and residents accessing care through the MPSP health care stream instead of the aged care stream.

Providers further noted challenges associated with cost allocation due to the splitting of shared resources and associated costs between the health and aged care settings.

Resident activity drivers and impacts on costs

Stakeholder feedback noted that MPS have limited capacity to support the increased care needs required by higher complexity residents, such as those with comorbidities, chronic conditions and cognitive and mental health conditions particularly as providers have anecdotally observed that resident complexity is increasing over time. Additionally, clinical complexity can be compounded by demographic factors. This may include people from Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities and other socioeconomic factors. Providers note that older people with these additional demographic factors are associated with different care delivery models and varying degrees of resource utilisation.

Stakeholders further noted lack of in-home aged care providers in thin markets meant that some residents enter MPS earlier with longer lengths of stay impacting ongoing costs of care.

Cost pressures

Stakeholders highlighted cost pressures as a key consideration for IHACPA's funding model assessment, including increased operational, workforce and location-specific costs.

Operational costs

Stakeholders identified the following operational costs as key considerations for the funding model assessment:

- increased costs associated with utilities, maintenance, food services and supply chain services
- the impact of the availability of non-health services on service delivery
- the impact of inflation on grant funding in comparison to actual costs
- increased costs associated with administrative, regulatory and compliance measures.

Workforce costs

Stakeholders advised that MPS incur workforce costs such as:

- agency staffing premiums
- outsourcing expenses
- incentives paid for rural and regional staff
- accommodation provision and security
- security, visa and cultural liaison support
- staff training.

Location-specific costs

With respect to location-specific costs, some stakeholders suggested that the Modified Monash Model (MMM) as a measure of geographic isolation for the MPSP may not adequately reflect the cost of service delivery in thin markets and that there is a need to consider service and location characteristics in IHACPA's funding model assessment. Further, that MPS in MMM areas of increasing geographical isolation have lower activity volume and higher unit costs.

Location-specific cost pressures for rural, remote and island MPS include:

- increased costs associated with accessing required goods such as fresh produce, water, fuel consumables and pharmaceuticals
- the need to purchase goods in smaller quantities due to limited storage capacity
- the extent to which workforce and equipment can be shared between health and aged care services due to colocation
- environmental conditions impacting the length of useful life and increased ongoing maintenance costs
- cost premiums paid on infrastructure upgrades and maintenance, including wait times for repairs and the availability of tradespersons.

Stakeholder recommendations to inform the funding model assessment

Stakeholders recommended a blended funding model approach that considers:

- base funding to ensure service continuity regardless of the number of occupied bed days
- an activity-based or scalable funding component that allows consideration of resident acuity and service needs to ensure equitable funding for providers
- the role of means testing to support MPS, as well as how these are waived in circumstances of financial hardship
- better integration of Australian Government and state and territory government funding with improved transparency.

With respect to recommendations for current and future data collections, stakeholders recommended the implementation of a co-designed data collection approach to integrate operational and financial service capability, including the development of specific MPSP costing guidelines to support current and future reporting activities.

Stakeholders noted that any proposed new funding arrangements should be informed by data collected on resident occupancy rates and length of stay, frequency and type of clinical interventions, cultural programs to support identity and connection to Country, and non-care activity and services such as lifestyle and leisure activities, transport and hotel services.

Stakeholders also provided recommendations for IHACPA's cost modelling approach with assessing any proposed new funding models. Stakeholders suggested various cost modelling approaches including a mixed methods approach with qualitative data, desktop and time-in-motion costing studies to collect consistent data to better understand direct service inputs and models of care, and consideration of shadow and activity-based funding pilots in sample sites. Some stakeholders recommended that data collection methods should be undertaken in a phased rollout with a group of diverse MPSP providers.

6.2 National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Stakeholder feedback in response to the consultation paper and the targeted interviews with NATSIFACP providers identified the challenges and limitations associated with the current funding model and included considerations and recommendations to inform any proposed new future funding arrangements. This stakeholder feedback is outlined below.

Program objectives and design

Stakeholders noted while the NATSIFACP funding permits service providers to charge consumer contributions, this can create barriers for Aboriginal and Torres Strait Islander peoples accessing care. Stakeholders further noted NATSIFACP client considerations that impact funding include:

- clients facing significant disadvantage and high care needs, as such, mandatory contributions risk disengagement from aged care services
- trust being critical and where services must act as debt collectors, this conflicts with Aboriginal Community Controlled Organisation (ACCO) models of service
- the impact of Elders' vulnerability to familial financial abuse
- some service's introducing a hardship policy offering fee reductions ensuring equitable access.

Several stakeholders acknowledged that the NATSIFACP is used to bridge aged care service gaps for Elders under Commonwealth Home Support Program and National Disability Insurance Scheme funding by offering flexible, culturally safe care where mainstream programs cannot meet this need.

Stakeholders expressed their concern regarding the impact of the transition to the *Aged Care Act 2024* (Aged Care Act) on the NATSIFACP noting:

- a lack of guidance hindering provider preparation
- stricter reporting requirements increasing the administrative burden on providers
- the new assessment process which includes automated consent recording, creating barriers to service use for Elders
- the need for culturally appropriate training and more Aboriginal and Torres Strait Islander assessors to facilitate culturally safe engagement with Elders
- the Aged Care Act being seen by providers as overly prescriptive and limiting flexibility in service delivery.

Cost pressures

Stakeholders identified several cost pressures as key considerations for IHACPA's funding model assessment, including increased operational, capital, workforce and location-specific costs.

Operational and capital costs

Stakeholders identified that operational costs posed significant challenges, specifically repair and maintenance costs in remote areas, given supplier scarcity and comparably high costs. Stakeholders also noted the impact of extreme weather conditions causing frequent breakdowns and infrastructure repairs, budget constraints forcing deferral of critical maintenance works and rigid NATSIFACP grant funding processes which constrain large-scale upgrades to service buildings and infrastructure.

Several stakeholders identified location-specific capital costs for remote services, including:

- security costs from break-ins and vandalism, increasing repair expenses
- installing security fences for staff and resident safety
- the need for secure staff housing, vehicle storage, and security measures during times of community unrest
- accommodation for staff, residents and families is limited, with on-site options insufficient and requiring additional leases and infrastructure upgrades.

Workforce costs

Stakeholders advised that location-specific workforce costs are the key cost driver for NATSIFACP providers with impacts including:

- housing shortages in remote areas, limiting staff attraction and retention and impacting service capacity
- high staff turnover limiting consistency in the provision of culturally safe and appropriate care
- wage pressures, driven by award increases and employment competition with local hospitals

- leadership and administrative burdens falling on limited numbers of senior staff
- high costs of agency staff
- recruitment challenges, particularly for registered nurses and clinical staff
- high cost of comprehensive cultural immersion programs during recruitment which is essential in supporting engagement with local communities.

Several stakeholders advocated for workforce development as a priority to support Aboriginal and Torres Strait Islander staff, noting that cultural competency remains critical, with investment in training and culturally appropriate aged care models essential to deliver high quality and culturally safe and appropriate care.

Stakeholders noted that training provision, delivery and funding is challenging in remote locations and that staff retention relies on trauma awareness and ongoing professional development. Some stakeholders also acknowledged that while aged care roles are valued for their connection to Elders and their community, these roles are sometimes avoided due to cultural considerations such as kinship obligations and responsibilities.

Location-specific costs

Stakeholders indicated that location-specific cost pressures impacting rural and remote NATSIFACP services include inadequate transportation costs to account for poor road conditions, remote terrain and adverse weather events that reduce accessibility to remote areas for extended periods.

Stakeholders further identified the impact of funding limitations on travel for cultural purposes (for example, Sorry Business or family responsibilities), risking Elders' disconnection from their communities.

Other location-specific costs identified by stakeholders as a major NATSIFACP cost consideration in rural and remote areas for Aboriginal and Torres Strait Islander Elders include nutrition, healthy meal options and food insecurity.

Stakeholder recommendations to inform the funding model assessment

Stakeholders noted NATSIFACP funding does not account for the true cost of providing culturally safe, culturally appropriate and trauma informed aged care services for Aboriginal and Torres Strait Islander Elders which include yarning circles, Sorry Business, on-Country respite, healing programs, interpreters, gender-specific carers, cultural-specific infrastructure (verandas) and cultural awareness training. Several stakeholders indicated that providers currently bear the cost of providing essentials for residents experiencing or at risk of experiencing homelessness or poverty.

Stakeholders further noted that the provision of these services are reliant on a mixed funding approach including provider self-funding in instances where these costs are not fully met under the current NATSIFACP funding model.

Stakeholders emphasised that data reporting requirements should consider the unique challenges of NATSIFACP providers, including an acknowledgement that internet connectivity is consistently unreliable in rural and remote areas.

Stakeholders noted that manual reporting with inconsistent templates creates inefficiencies and increased administrative burden, particularly when reporting is required within unrealistic timeframes. Stakeholders advocated for the use of streamlined automated systems and a focus on more meaningful metrics in reporting.

In the context of data reporting requirements, stakeholders emphasised that community involvement in data collection and survey design and the linking of data to Closing the Gap initiatives is critical.

Stakeholders expressed support for community-led, culturally safe data capture, including embedding Indigenous Cultural Intellectual Property principles and Free, Prior and Informed Consent. Stakeholders advised that data reporting, collection and management needs to reflect Indigenous Data Sovereignty to ensure data transparency.

7. Supplements and grants

Separately to Australian National Aged Care Classification (AN-ACC) funding, the Australian Government pays a range of supplements and grants to registered providers to deliver aged care services.

The government also pays supplements to registered providers on behalf of each person receiving government-subsidised aged care, to help with the cost of meeting specific care needs. IHACPA will continue to work with the Department of Health, Disability and Ageing to understand the diversity of the existing supplements and grants available to registered providers, and how these may be factored into future pricing advice.

This chapter sets out the stakeholder feedback received in response to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 on supplements to fund subsidised aged care.



Consultation question

For approved providers receiving supplements to fund subsidised aged care, are there any cost variations associated with resident complexity or meeting specific resident care needs that need to be accounted for in the Australian National Aged Care Classification funding model?

Please provide examples or supporting evidence.

7.1 Supplements for specific care needs

Stakeholder feedback in response to the consultation paper was varied with some stakeholders advocating for the establishment of new supplements to better support care delivery, while others supported retention of the current supplement structure with expanded pricing adjustments for specialised cohorts. Feedback on supplements and grants is outlined below.

Oxygen supplement and enteral feeding supplement

In response to the consultation paper, several stakeholders indicated that oxygen therapy and enteral feeding generate material cost variations that are not currently captured in IHACPA's cost collections.

While one stakeholder advocated for continuance of the current supplement funding structure specifically for oxygen, enteral feeding and veterans' care, another recommended that consideration be given to integrating oxygen therapy and other clinical supplements into AN-ACC pricing.

One stakeholder emphasised that inadequate supplement funding is a deterrent to supporting complex residents in residential care homes, potentially increasing pressure on the acute care health system.

Veterans' supplement

Two stakeholders highlighted the importance of maintaining a separate classification or supplement for veterans to ensure their unique care requirements are met and equitable access to appropriate services is provided.

24/7 registered nurse supplement

Stakeholders highlighted that services located in Monash Model (MM) 6-7 persistently experience difficulty recruiting and retaining qualified registered nurses, incur higher costs for agency staff and face logistical barriers in the delivery of care due to their rural and remote location. To address these inherent inequities, stakeholders recommended that decreasing the supplement based on occupied bed days be removed for services in MM 6-7.

Stakeholders noted that smaller residential care homes experience difficulty meeting care minute requirements due to staffing limitations. Stakeholders suggested care minute allocations for smaller providers be adjusted to ensure that the 24/7 registered nurse supplement effectively supports safe and consistent staffing levels.

Accommodation supplement

In response to the consultation paper, stakeholders highlighted that the current accommodation supplement does not align with the true cost of building, maintaining, or modifying services, noting that without uplift, providers may shift toward higher-paying markets, impacting equity of access to residential aged care services.

A number of stakeholders suggested that current supplement settings disadvantage residents with higher or more specialised needs, noting that respite supplements do not cover the true cost of care. Stakeholders also highlighted that concessional and lower socioeconomic residents are under-served due to the high cost of construction required to accommodate them relative to supplement levels, potentially leading to system-wide impacts including the delayed discharge from hospital of this cohort.

Proposed new supplements

In response to the consultation paper, several stakeholders proposed new supplements to address gaps in the AN-ACC funding model including for:

- dementia care
- behavioural care
- palliative care
- psychological and emotional support
- allied health
- compliance and government
- medication management.

Other stakeholder suggestions included the introduction of loadings for innovation, culturally and linguistically diverse supplements and incentives for environmental modifications or assistive technology to support the delivery of complex care.

Other feedback on supplements

One stakeholder provided feedback that cost variations associated with resident complexity should be addressed through an expanded set of pricing adjustments for specialised cohorts with higher resource utilisation, rather than the use of supplements in the funding model.

7.2 Hotelling supplement

The government is seeking our advice on the differences in the cost to provide everyday living services based on location, service or resident-specific factors, as well as the potential impact of interactions between these factors over a multi-year project. The outcomes of the review will form the basis of any recommendations from IHACPA to government, which may include a proposed new structure, such as tiering, for the hotelling supplement. Informed by our analysis and advice, government will make any policy decisions regarding an alternative funding approach for the hotelling supplement.

Stakeholder feedback provided in response to the consultation paper highlighted that modified monash category, building age and design and service delivery models employed in a residential care home are all significant factors in determining cost differentials related to the delivery of everyday living services. This stakeholder feedback is outlined below.



Consultation question

What factors, if any, contribute to variations in the cost of providing everyday living services (previously required hotel services) to residents?

Please provide examples or supporting evidence.

Location-related factors

Several stakeholders advised that regional, rural and remote providers of residential aged care incur significantly higher costs per resident per bed day, noting the:

- higher wage, supply, transport, maintenance and utilities costs experienced in remote regions
- reliance on outsourcing, reduced economies of scale and potential for supply chain disruptions resulting from road closures due to seasonal weather events, particularly in Aboriginal and Torres Strait Islander communities
- elevated labour costs due to higher penalty rates, workforce shortages and a reliance on casual or agency staff, immigration-related staffing challenges and limited staff accommodation
- higher acuity of residents who are more likely to enter care with complex needs, due to higher disease burdens, greater social disadvantage, and limited access to primary health services.

Service-related factors

Several stakeholders highlighted a range of service specific factors that may impact the cost to provide everyday living services, including:

- higher unit costs for smaller providers compared to larger providers, due to reduced ability to negotiate competitive supplier contracts and leverage bulk purchasing
- for smaller homes or homes with lower occupancy, increased cost of everyday living expenses per-resident due to fixed costs, such as utilities, maintenance, and baseline staffing, that must be spread across fewer residents
- increased costs for government providers, potentially due to the use of health service operating models, which includes off-site laundry and catering systems
- variability in labour costs resulting from Fair Work Commission decisions, enterprise agreements, and sector competition
- limited ability to fund everyday living services for concessional residents within a residential care home, as the provider may be unable to subsidise costs with revenue from additional or extra service fees
- increased regulation and compliance obligations, including enhanced requirements for infection control, food safety, and workplace health and safety due to introduction of the *Aged Care Act 2024*
- increased labour costs for tasks such as cleaning, meal delivery, and laundry for residential care home design features due to long distances between resident rooms and service areas and increased costs for infection control, cleaning, linen and meal delivery due to higher proportions of private rooms within a home.

Resident-related factors

Several stakeholders provided feedback on the impact of resident care needs on the cost to provide everyday living services, including:

- increased frequency of laundry and cleaning services or requirement for special meals for residents with mobility issues, cognitive impairments, dementia or requiring palliative care
- condition-specific training that may increase workforce costs
- cost pressures due to specialised staff skills, ingredients, and preparation systems required to provide special dietary requirements, texture-modified meals, and culturally appropriate foods
- increased costs to account for resident-specific preferences, such as takeaway food, soft drinks and lollies, important for dignity and behavioural support not covered in current funding
- unique costs associated with culturally safe and community-based service delivery, in particular for Aboriginal and Torres Strait Islander Elders and people from culturally and linguistically diverse backgrounds
- additional engagement, interpreters, special events and community liaison roles to support connection to culture, traditional lands and community.

Higher everyday living services

A number of stakeholders highlighted that when enhanced hotel services are bundled together, residents may be charged for services they are unable to use. They noted that higher everyday living fees are unregulated by government and must be fully paid by the resident. Stakeholders suggested that there is a need for improved provider accountability, clear delineation between everyday living services and optional upgrades, and the alignment of charges with individual resident needs, independence and choice.

8. Priorities for future pricing advice

8.1 Safety and quality

Future adjustments for safety and quality through the Australian National Aged Care Classification (AN-ACC) funding model will be considered, where requested by the Australian Government.

Safety and quality adjustments in pricing are a long-term objective. This is due to their complexity within residential aged care and could be considered when the AN-ACC funding model is further established.

In response to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27, a range of peak bodies, providers and other stakeholders emphasised the need for future pricing models to reflect increased expectations around safety and quality. Specifically, stakeholders called for compliance costs associated with strengthened Aged Care Quality Standards under the *Aged Care Act 2024* (Aged Care Act) and growing workplace health and safety requirements to be accounted for in IHACPA's pricing advice to government.

A number of stakeholders suggested that consideration be given to the correlation between funding and service quality, with long-term reforms to include quality-based pricing adjustments. Further, several stakeholders linked digital capability, artificially intelligent-powered monitoring systems and robotic assistance to safety improvements, noting that funding should support providers to adopt these technologies to ensure aged care services remain future-ready and responsive to evolving expectations.

8.2 Thin markets

For residential aged care and residential respite care, thin markets typically occur in areas with inadequate provision of care providers to drive efficiency within certain populations or regional, rural or remote locations. This means there may be inadequate services for people requiring residential care, as the services may not be sustainable under current market conditions.

The final report of the Aged Care Taskforce made several recommendations for the delivery of aged care services in thin markets. It also indicated that certain thin markets may require specialist funding arrangements.

In response to the consultation paper, stakeholders highlighted challenges experienced by providers of aged care services in thin markets and regional, rural and remote areas. These include but are not limited to:

- added costs of compliance, including providing staff education and training, and covering travel expenses arising from expanded regulatory requirements of the Aged Care Act
- significant financial pressure of 24/7 registered nurse and care minute responsibilities on residential care homes in isolated areas, where workforce shortages often require the use of agency staff at a higher cost and incentives to attract staff
- increasing need to rely on agency staff and overtime, and additional expenses related to overseas recruitment, including visa sponsorship and accommodation.

A number of stakeholders also highlighted the significant challenges in care access for people living with dementia in thin market areas. Stakeholders noted that aged care providers and workforce capacity is insufficient to meet demand, resulting in older people being forced to relocate away from their communities to access appropriate care.

Appendix A: List of stakeholders

The stakeholders who made submissions in response to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 are outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholders
Ageing Australia
Allied Health Professionals Australia
Anglicare Sydney
Australian Association of Gerontology
Australian Dental Association
Australian Independent Retirees
Australian Institute of Health and Welfare
Australian Multicultural Action Network Inc
Australian Nursing and Midwifery Federation
Australian Physiotherapy Association
Australian Podiatry Association
Australian, New Zealand and Asian Creative Arts Therapies Association
Barkly Regional Council
Bolton Clarke
Carers NSW
Catholic Health Australia
Community Industry Group
Dementia Australia
Department of Health Queensland
Department of Prime Minister and Cabinet
Dietitians Australia
HammondCare

Stakeholders

Harbison Memorial Retirement Village t/as Harbison
Minister for Aboriginal Affairs Western Australia
My CDC
National Aboriginal and Torres Strait Islander Ageing and Aged Care Council
National Aboriginal Community Controlled Health Organisation
National Rural Health Alliance
Ngaweeyan Maar-oo
Northern Territory Department of Health
NSW Health
Palliative Care Australia
Partners in Culturally Appropriate Care Alliance
Public Sector Residential Aged Care Leadership Committee
South Australia health
Speech Pathology Australia
St Andrews Community Aged Care
Uniting Care Queensland
WA Government

The Multi-Purpose Service Program providers that participated in interviews in response to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 are outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholder	Jurisdiction
Norfolk Island Health and Residential Aged Care Services	External territory
Far West Local Health District and The Ministry of Health	NSW
Hunter New England Local Health District and The Ministry of Health	NSW
Mid North Coast Local Health District and The Ministry of Health	NSW
Murrumbidgee Local Health District and The Ministry of Health	NSW
Nepean Blue Mountains Local Health Network	NSW
Southern NSW Local Health District and The Ministry of Health	NSW
Western NSW Local Health District and The Ministry of Health	NSW
Northern Territory Department of Health	NT
Queensland Health - ACPSD Policy Unit	QLD
Woorabinda Multi-Purpose Service, Central Queensland HHS	QLD
Barossa Hills Fleurieu Local Health Network	SA
Eyre and Far North Local Health Network	SA
Riverland Mallee Coorong Local Health Network	SA

Stakeholder	Jurisdiction
Yorke and Northern Local Health Network	SA
Huon Regional Care	TAS
Tasmanian Health Organisation - North and the Crown in the Right of Tasmania	TAS
Alpine Health and the State of Victoria	VIC
Great Ocean Road Health and the State of Victoria	VIC
Mallee Track Health and Community Services and the State of Victoria	VIC
Orbost Regional Health and the State of Victoria	VIC
Robinvale District Health Services and the State of Victoria	VIC
Timboon & District Health Care Service and the State of Victoria	VIC
WA Country Health Service	WA
NSW Ministry of Health	Government

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program providers that participated in targeted interviews in response to the Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 are outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholder	Jurisdiction
Canowindra Tweed-Byron Aged & Disabled Aboriginal Corporation	NSW
Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corp	NT
Central Desert Regional Council	NT
Calvary Community Care	NT
Kalano Community Association	NT
Thamarrurr Development Corporation	NT
Australian Regional and Remote Community Services Limited	NT
Victoria Daly Regional Council	NT
Ltyentye Apurte Arelhe Ingerrenyekekenhe Apmere Aboriginal Corporation	NT
Danila Dilba Biluru Butji Binnilutlum Health Service Limited	NT
Winnam Aboriginal and Torres Strait Islander Corporation	QLD
Selectability Limited	QLD
Yadu Health Aboriginal Corporation	SA
Umoona Aged Care Aboriginal Corporation	SA
Aboriginal Community Elders Service (ACES) Inc	VIC
Rumbalara Aboriginal Co-operative Limited	VIC
Ngaanyatjarra Health Service (Aboriginal Corporation)	WA
Yaandina Community Services	WA
South West Aboriginal Medical Service Ltd	WA
Office of the Interim First Nations Aged Care Commissioner	Government



IHACPA

Independent Health and Aged Care Pricing Authority

Eora Nation, Level 12, 1 Oxford Street, Sydney NSW 2000

Phone: 02 8215 1100

Email enquiries: enquiries.ihacpa@ihacpa.gov.au

ihacpa.gov.au