Catholic Health Australia – Submission on the Pricing Framework for Residential Care 2026-27

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Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Executive summary

Catholic Health Australia (CHA) is the nation's largest non-government grouping of health, community, and aged care services. CHA members operate approximately 12 per cent of residential aged care facilities and deliver 20 per cent of home care across Australia. Catholic aged care providers have a vital interest in working with the Australian Government to ensure aged care and support services are sustainable, meet community expectations, and consistently deliver safe, high-quality care.

CHA welcomes the opportunity to contribute to the Independent Health and Aged Care Pricing Authority (IHACPA)'s consultation on the Pricing Framework for Australian Residential Aged Care Services 2026–27. We look forward to working with IHACPA to ensure the Framework achieves its intended outcomes and supports a high-quality, equitable, and sustainable aged care system for all Australians, regardless of their financial means or location.

This submission highlights priority issues raised in the Consultation Paper that CHA believes warrant further investigation. It is not intended as an exhaustive response to every issue.

Key observations and issues related to the Pricing Framework articulated in our submission include:

1. **Supporting provider participation in cost collection:** Accurate pricing advice relies on provider participation in IHACPA's Residential Aged Care Cost Collection, yet the process remains burdensome. CHA recommends targeted incentives for providers in regional and diverse communities, financial support to offset participation costs, and the deployment of data specialists. A standardised data template and centralised portal would also streamline submissions and improve data quality.
2. **Funding for dementia and cognitive complexity:** The AN-ACC model does not adequately capture the resource intensity of caring for independently mobile residents with dementia. These residents require frequent monitoring, behavioural support, and tailored care strategies. CHA recommends establishing a dedicated dementia classification and commissioning a study into targeted funding for Memory Support Units.
3. **Recognition of spiritual and emotional care:** Pastoral and spiritual care are central to holistic aged care but are not recognised under Care Minutes targets. They should be formally included and Pastoral Care Practitioners acknowledged as qualified providers of emotional and spiritual support. A sector-wide review of Care Minutes should reflect the importance of these dimensions of wellbeing.
4. **Support for transitional care at the health–aged care interface:** Transitions from hospital to residential aged care are often undermined by fragmented systems, limited rehabilitation services, and inadequate funding. AN-ACC pricing must reflect the real costs of discharge coordination, interim care, and appropriate staffing to help providers ensure safe and timely transitions for older people.
5. **Review of the accommodation supplement:** The current 40% threshold for supported residents remains an essential safety net, but delays in reviewing the supplement and its misalignment with actual costs threaten provider sustainability. CHA calls for an accelerated review and an interim increase by 1 December 2025, with outcomes integrated into AN-ACC pricing to safeguard equitable access and infrastructure investment.
6. **Funding for palliative care:** The current classification process for palliative care is resource-intensive and misaligned with actual costs. The assessment process should be streamlined and Class 1 – Admit for Palliative Care – adjusted to reflect the true

cost of care - regardless of admission status - ensuring equitable access across all settings.

7. **Hotel services and cost variations:** Providers are required to deliver mandated hotel services while accommodating resident preferences, yet inconsistencies in definitions and delivery models create confusion and cost pressures. CHA supports a review of the hotel supplement to account for structural differences, regional challenges, and the need for flexible, person-centred service delivery.

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Section 1: Cost Collections

CHA understands that the Residential Aged Care Pricing Advice 2026–27 will be informed by data collected through the 2025 Residential Aged Care Cost Collection. This section outlines key considerations for future cost collections.

Q1: What could IHACPA do to support improved provider participation and increased representation in our cost collections?

CHA agrees it is critical for residential aged care providers to contribute to IHACPA's cost collection process to ensure Government receives accurate pricing advice. CHA actively encourages its members to participate in the Residential Aged Care Cost Collection.

However, participation can be time-consuming, resource-intensive, and costly for providers—particularly as the benefits are not immediately visible. In some cases, staff involvement in data collection, especially from frontline roles such as nurses and personal care workers, reduces the time available for direct resident care.

To support broader and more representative participation, IHACPA should:

- **Introduce targeted incentives** for providers serving regional, rural, remote, and diverse communities. These incentives would help address resource constraints and enable a more diverse range of providers to contribute.
- **Deploy data extraction specialists** to work directly with nominated providers, particularly those serving priority populations. This approach has been effective in hospital cost collections such as the Australian Non-Admitted Patient Classification Project. The approach could be adapted to the aged care context, while recognising the sector's diversity of operating environments.
- **Provide financial support** to providers that participate in cost collections, ensuring they are not required to absorb the full cost of supplying essential data for pricing development.
- **Develop a standardised data collection template** aligned with reporting requirements and key cost indicators. A centralised IHACPA portal should allow providers to upload data efficiently, reducing inconsistencies, minimising misinterpretation of definitions, and streamlining the process overall.

These measures would help strengthen participation, improve the quality of data, and ensure the funding model is built on robust, representative evidence.

Section 2: Funding model reviews

CHA understands that IHACPA will be undertaking a range of funding model reviews in the lead-up to the finalisation of the Pricing Framework. This section outlines key considerations for those reviews.

Q4: 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?

A range of supplements and grants are available to approved providers to deliver aged care services, including:

- Respite supplement for respite care recipients
- Oxygen supplement
- Enteral feeding supplement
- Veterans supplement
- 24/7 Nursing supplement
- Accommodation supplement
- Transitional accommodation supplement
- Pensioner supplement
- Hardship supplement
- Hotelling supplement
- Outbreak management support supplement

Dementia and cognitive complexity

Current AN-ACC funding does not adequately reflect the resource intensity of caring for residents with dementia and cognitive impairment—particularly those who retain independent mobility. Providers consistently report that the classification of dementia care is overly simplified and insufficient for this cohort. CHA recommends introducing a **dedicated dementia classification** for independently mobile residents.

These residents often require:

- Frequent checks or observations (e.g. every 15 minutes) to manage risks such as wandering or absconding.
- Regular redirection and diversional therapies to support safety and wellbeing.
- Ongoing behavioural monitoring, especially in cases of early-onset dementia or severe short-term memory loss.
- Staff support in external environments, tailored to individual needs.

Although mobile, this group is often highly resource-intensive. Providers must implement person-centred care strategies supported by staff training, consistent policy implementation, and operational coordination. Memory Support Units can provide specialised environments, but not all providers can invest in such infrastructure. Costs for staffing, clinical strategies, and training remain significant and are not adequately covered under current funding arrangements.

Moreover, many residents enter care with mild cognitive decline that can progress rapidly after admission, placing additional strain on staff and care systems. Delays in AN-ACC

reassessments compound this challenge, leaving providers under-resourced to meet evolving care needs.

CHA recommends commissioning a **study into the resource requirements of independently mobile residents with dementia** and the feasibility of introducing targeted funding for Memory Support Units. Consideration should also be given to Government funding for retrofitting or incorporating these units into existing facilities.

Finally, the current assessment of cognitive impairment – particularly for those with medium impairment - is often subjective and inconsistent, undermining funding accuracy and reliability.

Pastoral and/or spiritual care

Consistent with CHA's position on Care Minutes, spiritual and pastoral care should be formally recognised as an eligible emotional support service within the AN-ACC framework. Pastoral Care Practitioners play an essential role in supporting the emotional and spiritual wellbeing of residents, yet their contribution is currently excluded from Care Minutes targets.

CHA recommends a **sector-wide review of Care Minutes** with a view to identifying ways to recognise the contributions of a range of non-clinical practitioners in providing personal care such as Pastoral Care Practitioners who are qualified providers of emotional support. Aligning funding and policy with holistic, person-centred models of care will help ensure the sustainability and integration of spiritual and emotional support within aged care services. The review should also investigate the feasibility of the explicit inclusion of spiritual care in care minutes. Catholic providers, who already provide spiritual care in residential aged care settings, can participate in a pilot program as part of the review.

Caring for older people at interface of health and aged care systems

The interface between health and aged care remains fragmented, creating barriers for older people transitioning from hospital to residential aged care. Key challenges include:

- Limited availability of rehabilitation services within the health system
- Communication breakdowns between hospital and aged care providers
- Inadequate access to specialist dementia care for individuals with severe behavioural and psychological symptoms
- Insufficient funding within mainstream aged care to support complex health and behavioural needs
- Workforce shortages and limited dementia-specific training in aged care settings

AN-ACC pricing should be adjusted to reflect the real costs of hospital discharge, care coordination, interim care, and additional staffing. Funding must align with the realities of transitional care to ensure safe, timely, and person-centred support. Assessment delays and waitlists for acute care should also be factored into funding models, given their impact on discharge planning.

Ensuring adequate safety nets for older people

The accommodation supplement is a critical safeguard ensuring access for residents who cannot contribute to accommodation costs. The current 40% threshold has supported provider participation, but delays in review and misalignment with actual costs are creating financial risks.

CHA recommends that the **review of the accommodation supplement be accelerated and completed by 1 December 2025**, with an interim increase introduced immediately to preserve incentives and enable continued investment in residential infrastructure.

Without timely action, the following risks may compromise access to care for supported residents:

- Not-for-profit providers, such as CHA member organisations, will be disproportionately affected as they support a greater volume of supported residents;
- Uncertainty around providers' capacity to re-invest in upgrading or expanding residential infrastructure, which may hinder their capacity to meet complex care needs; and
- Potential for providers to shift their case-mix by reducing bed capacity for supported residents in favour of increasing availability for non-supported residents (where there is increased funding for accommodation costs under the new Act), which reduces access to care for supported residents.

Review outcomes must directly inform AN-ACC pricing adjustments and be integrated into the Pricing Framework to ensure alignment with actual accommodation costs.

Palliative care

CHA members identify two key issues with current palliative care classification:

1. **Assessment burden** – The requirement for a Palliative Care Status Form, including independent medical or nurse practitioner assessment, is resource-intensive and consumes valuable clinical time. This is particularly challenging in rural and remote areas, where access to medical practitioners is limited.

2. **Funding misalignment** – Funding is tied to a resident's classification status rather than the actual cost of care. This disconnect leaves providers underfunded when existing residents require palliative care.

CHA recommends a **streamlined assessment process** and an adjustment to *Class 1 – Admit for Palliative Care* so that it reflects the true cost of care, regardless of admission status. Addressing these issues is critical to ensuring timely, equitable, and sustainable access to palliative care across all settings.

Q5: What factors, if any, contribute to variations in the cost of providing required hotel services to residents?

CHA understands that residential aged care providers are required to deliver hotel services to residents, funded through the Basic Daily Fee (BDF) and the hotelling supplement ($12.55, as outlined in the draft *Aged Care Rules 2025*).

CHA believes providers must retain flexibility to tailor hotel services to residents' individual needs and preferences. While many of these services are mandated - such as those outlined in *Schedule 1 of the Quality of Care Principles 2014* - they should be delivered in a way that is person-centred and responsive to local circumstances. However, CHA notes overlap and potential confusion between the required hotel services in Schedule 1 and the services listed in Section 8-145 of the Residential Care Rules.

Schedule 1 defines "general laundry" to include heavy laundry and machine-washable personal laundry, excluding dry cleaning and laundry done independently by residents. In contrast, the Residential Everyday Living Services list expands this to include "ironing of machine-washed clothes (other than underwear and socks)," introducing ambiguity around what is considered standard practice versus an additional service.
Schedule 1 defines "Meals and refreshments" are to be "served each day at times generally acceptable to both care recipients and management". In contrast, the Residential Everyday Living Services list describes that meals and refreshments are to have "reasonable flexibility in mealtimes, if requested, so the individual can exercise choice" introducing ambiguity around what flexibility is required.

This inconsistency underscores the importance of IHACPA's review of hotel service costs to address both the **scope of services** and their **interpretation in practice**. CHA supports the proposed approach to calculating the hotel cost gap (i.e. required hotel service costs minus the BDF and hotelling supplement) but stresses that pricing must reflect the **true cost of personalised service delivery across diverse settings**.

There are many contributing factors to cost variations. These include:

- Ambiguity in service definitions - A clear and consistent definition of service expectations, aligned with existing practices, is essential to avoid confusion, ensure fair funding, and support sustainable service delivery given the cost of providing required hotel services.
- Structural differences in service delivery - Some providers rely on agency staff or contractors to deliver hotel services, which raises costs and affects service continuity.
- Regional, rural, and remote challenges - Limited access to trades and essential services (e.g. appliance repairs) increases costs; capital and operational constraints also limit facility upgrades.
- Delays in AN-ACC reassessment - Particularly in remote areas, slow access to assessors means resident needs may not be fully reflected in funding allocations, despite higher operational pressures.
- Resident independence and choice - Residents' preferences (e.g. managing their own laundry, declining certain services) require flexible policies and investment in staff training and systems to ensure consistency and quality across multiple sites.

To support sustainability and account for legitimate and unavoidable cost variations, IHACPA should:

1. **Establish clear, consistent definitions** of hotel service requirements, aligned with existing practice and intended applicability of legislation under the new Act.
2. **Ensure recognition of structural and regional differences** in delivery models when determining funding levels.
3. **Use pricing mechanisms that reflect the costs of flexibility**, enabling providers to meet resident preferences while ensuring service quality and equity across all settings.