

National Aboriginal and Torres Strait Islander Ageing and Aged Care Council

Submission

Independent Health and Aged
Care Pricing Authority (IHACPA)
Pricing Framework for Australian
Support at Home Aged Care
Services 2027-2028

April 2026



NATSIAACC



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Acknowledgement of Country

NATSIAACC acknowledges the Traditional Owners of the lands and waters on which we work, live and gather, as well as Country throughout Australia, and their enduring connections to land, sea and community. NATSIAACC acknowledges that these lands and waters were never ceded, and we acknowledge the sovereignty and self-determination of the Traditional Owners.

NATSIAACC pays its deepest respects to Elders past and present and recognise the continued cultural and spiritual connection to Country and/or Island Home, community, culture and knowledge.

NATSIAACC thanks them for their wisdom and courage, and for sharing their ways of knowing, being and doing – teachings that guide us to cherish and protect our Elders and Older People.

This always was, and always will be Aboriginal Land.



National Aboriginal and Torres Strait Islander Ageing and Aged Care Council

About

The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) is the national peak body for Aboriginal and Torres Strait Islander Ageing and Aged Care. NATSIAACC works to ensure that Aboriginal and Torres Strait Islander Elders and Older People can access support and care that is culturally safe, trauma-aware and healing-informed, and recognises the importance of their personal connections to community, Country and/or Island Home.

NATSIAACC is building a membership base of:

- Aboriginal and Torres Strait Islander community-controlled providers of Ageing and Aged Care, and
- Entities with an interest in culturally appropriate ageing and aged care services.

NATSIAACC's founding Directors are all leaders in Aboriginal and Torres Strait Islander ageing and aged care provision.

Terminology Note: For the purposes of this submission, the term Aboriginal Community Controlled Organisation (ACCO) is used to refer to Aboriginal and Torres Strait Islander Community Controlled Service Providers, including Aboriginal Community Controlled Health Organisations (ACCHOs).

Our Vision

All Aboriginal and Torres Strait Islander people are thriving, healthy, strong, with ongoing cultural connections in their older years.

Our Purpose

NATSIAACC supports Aboriginal and Torres Strait Islander older peoples, their families, and communities to identify, engage in, advocate for, and lead systemic reform to embed culturally safe practices across the Aged Care and Ageing sector.

With thanks

NATSIAACC thanks its members, stakeholders, and other peak bodies for their valuable contributions to this submission and for generously giving their time to support older Aboriginal and Torres Strait Islander people.

Funding

NATSIAACC is funded by the Commonwealth Government and works closely with the Department of Health, Disability and Ageing (the Department) in the context of current Ageing and Aged Care reforms. The organisation has been in operation since 2022.



NATSIAACC Recommendations

The following recommendations are provided to support the Independent Health and Aged Care Pricing Authority (IHACPA) in developing clear, practical and implementable pricing advice to the Minister for Health and Ageing.

NATSIAACC makes these recommendations to ensure that Support at Home pricing accurately reflects the true cost of delivering culturally safe, trauma-aware and healing-informed care through Aboriginal Community Controlled Aged Care Providers for Aboriginal and Torres Strait Islander Elders and Older People.

NATSIAACC strongly recommends the following:

1. Simplifying Cost Collections

IHACPA should simplify cost collection methodologies by co-designing tools with Aboriginal and Torres Strait Islander Aged Care Providers, aligning requirements with existing reporting frameworks and introducing flexible submission pathways that reflect varying levels of provider capability.

2. Improving Participation in Cost Collections

IHACPA should adopt a more proactive and place-based engagement approach to cost collections, including direct, face-to-face engagement with Aboriginal Community Controlled Organisations (ACCOs) and targeted support for underrepresented Providers, to improve participation and strengthen the representativeness of the evidence base.

3. CHSP to Support at Home Cost Pressures

IHACPA should ensure that the pricing approach for the transition from CHSP to Support at Home reflects the full cost of delivering culturally safe, community-controlled care, including the explicit recognition and funding of relational and community-based service functions, workforce requirements and structural cost pressures, to avoid disruption to service continuity and access for Aboriginal and Torres Strait Islander communities.

4. Applying Rural and Remote Cost Adjustments Across Service Types

IHACPA should incorporate structural cost pressures associated with rural and remote service delivery into its pricing framework, including travel time, workforce constraints, safety considerations, infrastructure limitations and service delivery complexity.

5. Rural and Remote Cost Pressures

IHACPA should ensure that pricing methodologies account for rural and remote cost pressures across both clinical and non-clinical services, including through service-level analysis that captures how these costs manifest differently across service types.



6. Applying Culturally Safe Pricing Across Service Types

IHACPA should develop and implement Aboriginal and Torres Strait Islander-specific pricing adjustments that reflect the full cost of delivering culturally safe, trauma-aware and healing-informed care, supported by stronger data collection and direct engagement with Aboriginal and Torres Strait Islander Providers.

7. Diverse Backgrounds and Life Experiences Cost Pressures

IHACPA should ensure that pricing adjustments for services delivered to people with diverse backgrounds and life experiences reflect the full cost of delivering context-responsive and culturally safe care, including the explicit recognition and funding of relational service functions, workforce capability requirements and additional coordination and engagement activities, supported by improved data collection and targeted engagement with underrepresented Providers and communities.

8. Applying Aboriginal and Torres Strait Islander Cost Pressures

IHACPA should embed culturally safe care as a system-wide pricing consideration across both clinical and non-clinical services, ensuring that pricing reflects the delivery model required for Aboriginal and Torres Strait Islander communities.

As a next step, NATSIAACC recommends that IHACPA progress co-designed cost collection pilots with ACCOs, alongside targeted engagement and interim testing of pricing adjustments to strengthen the evidence base and inform future pricing advice.

Executive Summary

NATSIAACC welcomes the opportunity to provide input into the Independent Health and Aged Care Pricing Authority's (IHACPA) Consultation Paper on the Pricing Framework for Australian Support at Home Aged Care Services 2027–2028. NATSIAACC acknowledges IHACPA's ongoing work to refine its pricing framework and improve the quality and representativeness of cost data across the In-Home Aged Care sector. This submission is directed to IHACPA's role in pricing methodology, cost collection and evidence development within the Support at Home program.

In particular, we recognise IHACPA's commitment to culturally safe, trauma-aware and healing-informed care within its pricing principles. However, the current pricing framework remains constrained by incomplete and structurally unrepresentative data, particularly in relation to Aboriginal and Torres Strait Islander Aged Care Providers and communities. This limitation is explicitly identified within IHACPA's own consultation paper, which acknowledges that while stakeholders have consistently highlighted higher care needs and additional costs associated with delivering culturally safe, trauma-aware and healing informed care, there is currently insufficient data to support the application of national pricing adjustments. This underscores that the absence of Aboriginal and Torres Strait Islander-specific pricing adjustments is driven by limitations in the available evidence base.



This submission makes a central observation in that the absence of Aboriginal and Torres Strait Islander-specific pricing adjustments reflects limitations in both the current evidence base and IHACPA's engagement approach.

Preliminary analysis of pricing data from NATSIAACC member organisations delivering Support at Home services indicates that the cost of providing these services is consistently higher than national median prices across a broad range of service types. While this dataset is indicative and not exhaustive, it reflects a robust cross-section of Provider experience within NATSIAACC's membership. It also does not capture the full extent of cost variation across all Aboriginal and Torres Strait Islander Providers, many of whom operate at or above these indicative levels. Notwithstanding these considerations, the data demonstrates a clear and consistent pattern of higher costs across both clinical and non-clinical services.

Aboriginal and Torres Strait Islander Aged Care Providers operate in service environments that differ fundamentally from mainstream delivery models. These differences are structural and include higher workforce costs, increased time required to deliver culturally safe and relationship-based care, ongoing community engagement and governance responsibilities, service delivery in thin markets, and significant travel and infrastructure challenges.

Current cost collection methodologies do not adequately capture these realities. They continue to rely on assumptions of scale, administrative capacity and standardised service delivery, which do not reflect the operating context of many Aboriginal and Torres Strait Islander Providers. As a result, the pricing framework risks systematically underestimating the true cost of delivering culturally safe care.

Improving pricing outcomes cannot be achieved through data refinement alone. It requires a fundamental shift in how IHACPA engages with community-controlled Providers and collects evidence. In particular, IHACPA must move beyond sole reliance on written submissions and digital-only processes and instead test ways in which they might be able to undertake direct, place-based engagement with ACCOs. Cost collection methodologies must be co-designed with Providers to ensure they reflect community-controlled models of care.

NATSIAACC's position is that IHACPA should move toward the implementation of Aboriginal and Torres Strait Islander-specific pricing adjustments within the pricing framework, supported by improved data collection and strengthened engagement. Cultural safety must be recognised as a core and measurable cost driver and structural cost pressures associated with regional, rural and remote service delivery must be appropriately incorporated into pricing methodology.

A pricing framework that does not adequately account for these factors risks embedding structural inequity into the Support at Home program. Pricing is not neutral. It determines which models of care are viable and which are not. Without structural adjustment to pricing methodology, the Support at Home program will continue to reflect mainstream service assumptions and will not deliver equitable outcomes for Aboriginal and Torres Strait Islander communities.

NATSIAACC remains committed to working collaboratively with IHACPA to strengthen the evidence base and ensure pricing reflects the realities of service delivery for Aboriginal and Torres Strait Islander communities.

Reframing Pricing Through a First Nations Lens

NATSIAACC's position is that the current pricing framework is built on assumptions that do not hold for Aboriginal and Torres Strait Islander communities.

The framework is based on transactional, time-limited-service delivery models. In contrast, safe and effective care for Aboriginal and Torres Strait Islander Elders and Older People is relational, continuous and community connected. This requires a shift from a program-based lens to a function-based lens.

The core functions required to delivery culturally safe, trauma-aware and healing-informed care include:

- Trust-building and relationship continuity.
- Community engagement and outreach.
- Kinship and family connection.
- Cultural brokerage.
- Workforce cultural load and supervision.

These functions are not supplementary or discretionary. They are core service delivery requirements. However, under the current pricing framework, they remain unrecognised and unfunded.

As a result, the pricing model systemically underestimates the true cost of care and risks embedding structural inequity into the Support at Home program.

NATSIAACC's position is that:

- These functions must be explicitly recognised within the pricing framework.
- Pricing adjustments must be applied to reflect their cost.
- Delivery must be community-controlled and culturally safe.
- Outcomes must be visible and measurable.

Without this shift, pricing reform will continue to reflect mainstream service assumptions rather than the realities of service delivery for Aboriginal and Torres Strait Islander communities.



Response to Consultation Questions

Question 1: What further strategies or measures could IHACPA implement to simplify and help providers contribute to our cost collections?

IHACPA's current cost collection approach places a disproportionate administrative burden on Providers, particularly smaller organisations and ACCOs. Existing methodologies largely assume a level of digital maturity, administrative capacity and system standardisation that does not reflect the operational realities of many Providers delivering care in Aboriginal and Torres Strait Islander communities.

For many ACCOs, limited administrative resourcing means that available staff are prioritised toward frontline service delivery rather than complex, lengthy and time-consuming data reporting requirements. While the industry may want to be involved in this process to provide IHACPA with the advice it seeks to improve cost collection contribution rates and inform pricing adjustment decisions, IHACPA needs to recognise that if it continues to rely solely on online processes and written submissions, participation in cost collections for our communities will become increasingly difficult. This is regardless of the importance of that participation in informing equitable pricing outcomes. This creates a structural risk that the Providers most critical to delivering culturally safe care are underrepresented in the evidence base used to inform pricing.

Simplification of cost collection processes must therefore focus on reducing administrative burden while improving accessibility and relevance. This includes co-designing cost collection tools with Providers to ensure they reflect community-controlled service delivery models, aligning data requirements with existing reporting frameworks to avoid duplication, and introducing flexible submission pathways and Provider outreach that accommodate varying levels of Provider capability.

IHACPA should also consider providing tailored, hands-on support to Providers who face barriers to participation, including those operating in regional, rural and remote areas. Without this, simplified tools alone will not address the underlying structural challenges that limit engagement.

NATSIAACC also suggests that a key structural way IHACPA can support Aboriginal and Torres Strait Islander Providers in contributing to cost collections is by engaging directly with communities in person and facilitating cost collection in a culturally safe, relationship-based and respectful way. Simply applying the same lens of waiting on submissions from community Providers, who do not have the same capacity as mainstream or larger organisations, will not produce the expected level of participation. It will continue to result in the same outcomes despite ongoing effort.

In this context, simplification is not solely about technology or making consultation materials easier to understand. Cost collection must align with First Nations data sovereignty principles, including co-design, community control and appropriate governance of data.



It requires a shift toward methodologies that are proportionate, culturally appropriate and responsive to the realities of Aboriginal and Torres Strait Islander service delivery. Without this shift, the evidence base will continue to underrepresent the true cost of delivering culturally safe care.

Strengthening participation in cost collections will ultimately depend on IHACPA's ability to design internal processes that enable meaningful, place-based engagement with Aboriginal and Torres Strait Islander Providers and Communities.

In addition, the current pricing principles do not adequately recognise the functions required to delivery culturally safe care. Without explicitly incorporating these functions into pricing methodology, the framework will continue to underestimate costs and limit the viability of culturally appropriate service delivery. These functions must be explicitly recognised and funded within pricing methodology if cost collections are to reflect the true cost of care delivery.

NATSIAACC Recommends

IHACPA should simplify cost collection methodologies by co-designing tools with Aboriginal and Torres Strait Islander providers, aligning requirements with existing reporting frameworks and introducing flexible submission pathways that reflect varying levels of provider capability.

Question 2: How can IHACPA better support participation in our cost collections, particularly from:

- **Small Providers.**
- **Providers delivery services for people from Aboriginal and Torres Strait Islander communities.**
- **Aboriginal and Torres Strait Islander health practitioner and health worker services.**
- **Providers delivering services for people with diverse backgrounds and life experiences.**

IHACPA should prioritise cost collection from Provider groups whose service delivery models are not currently reflected in the evidence base, particularly ACCOs. This is critical to ensure that pricing reflects the full cost of delivering culturally safe care, including relational and community-based functions that are currently unmeasured.

As outlined in NATSIAACC's response to Question 1, the current barriers to contribution in IHACPA's cost collections are already well understood. They include disproportionate administrative burden, limited workforce and back-of-house capacity, overreliance on digital and submission-based processes and cost collection methodologies that do not reflect the operational realities of many Providers. Those same issues apply directly to Question 2.

For ACCO Providers, the challenge is rarely a lack of willingness to contribute. Rather, it is that the process itself has not been designed around their operating context. If IHACPA is seeking to better support participation from these Providers, it must accept that a standardised process will continue to produce standardised results, meaning stronger participation from larger, better-resourced mainstream Providers and weaker participation from those whose service delivery realities are most important to equitable pricing reform.



In practical terms, this means that the reforms proposed in response to Question 1 should be treated as directly applicable here. IHACPA should simplify its processes, provide more tailored and hands-on support, adopt flexible participation pathways and move toward more direct, place-based and face-to-face engagement where possible. It should also continue to work through trusted peak bodies and representative organisations that already hold established relationships with Providers and communities.

What Question 2 adds is a need for sharper targeting. IHACPA should not only improve participation generally but deliberately prioritise those Provider groups that have historically been underrepresented in the evidence base. Without that targeted effort, IHACPA risks continuing to develop pricing advice from datasets that are skewed toward the Providers most able to respond, rather than those delivering care in more complex, culturally specific or resource-constrained settings.

Ultimately, if IHACPA wants participation from underrepresented Providers, it must design its collection methods around the realities of those Providers, rather than expecting those Providers to adapt to a process built for others. Without that shift, the evidence base will remain incomplete and pricing advice may continue to fall short of reflecting the true cost of care delivery across the full diversity of the Aged Care sector.

NATSIAACC Recommends

IHACPA should adopt a proactive, place-based engagement approach to cost collections, including direct, face-to-face engagement with ACCOs and targeted support for underrepresented Providers, to improve participation and strengthen the representativeness of the evidence base.

Question 3: What cost pressures and supporting data and evidence should IHACPA consider when developing the pricing approach for the transition of the Commonwealth Home Support Program (CHSP) to the Support at Home program?

The transition from CHSP to Support at Home introduces a significant structural shift in how care is funded, delivered and priced. For Aboriginal and Torres Strait Islander communities, this transition carries material risk if pricing assumptions continue to be based on standardised, transactional service delivery models that do not reflect the realities of community-controlled care. Pricing is not neutral. It determines which models of care are viable and which are not.

CHSP has enabled flexible, community-responsive delivery, particularly through Aboriginal Community Controlled Organisations (ACCOs). This flexibility supports relational care, continuity of workforce, and sustained engagement with Elders, Older People, families and communities. These elements are not ancillary to service delivery, they are fundamental to whether care is accessed, trusted and maintained over time.

Under CHSP, Providers have been able to respond to local need, adjust service delivery in real time, and invest in the relational and community-based functions required to deliver culturally safe care. These include trust-building, community engagement, kinship and family connection, cultural



brokerage, and workforce support. These functions are not optional; they are core components of safe and effective care delivery.

Support at Home introduces a more structured, activity-based pricing model. While this model aims to improve consistency and transparency, it also risks constraining service delivery if it does not adequately recognise and fund the full scope of work required to deliver culturally safe, trauma-aware and healing-informed care.

A key cost pressure in this transition is the risk that relational and community-based functions will be treated as indirect or unpriced activities, rather than as core components of service delivery. If these functions are not explicitly recognised within pricing methodology, Providers will be required to absorb these costs or reduce the level of relational care provided. This creates a direct risk to continuity of care, service accessibility and outcomes for Aboriginal and Torres Strait Islander Elders and Older People.

There are also workforce-related cost pressures associated with the transition. Maintaining continuity of care, supporting culturally capable staff, and ensuring safe service delivery in community settings often requires additional investment in workforce recruitment, retention, supervision and support. These costs are not consistently reflected in standard pricing assumptions but are critical to delivering safe and sustainable care.

In addition, many Aboriginal and Torres Strait Islander Providers operate in thin markets, where service viability is already constrained by geography, workforce availability and infrastructure limitations. The transition to a more structured pricing model may further increase these pressures if flexibility is reduced and funding does not reflect the true cost of delivery.

The evidence available to NATSIAACC, including indicative Provider pricing data from within our membership, demonstrates that the cost of delivering services under current conditions is already higher than national median pricing across a broad range of service types. This reinforces that pricing for Support at Home must be informed by the actual cost of delivery in community-controlled and culturally specific contexts, rather than by extrapolation from mainstream service models.

Without explicit recognition of these cost pressures, the transition to Support at Home risks shifting the system away from flexible, community-led care toward standardised service delivery that is not fit-for-purpose for Aboriginal and Torres Strait Islander communities.

IHACPA should ensure that:

- pricing supports flexible, community-based delivery models
- relational and community-based care functions are explicitly recognised and funded
- workforce and service delivery costs associated with culturally safe care are reflected in pricing methodology
- transition settings do not disadvantage Aboriginal Community Controlled Organisations
- continuity of care is maintained for Aboriginal and Torres Strait Islander Elders and Older People throughout the transition



NATSIAACC Recommends

IHACPA should ensure that the pricing approach for the transition from CHSP to Support at Home reflects the full cost of delivering culturally safe, community-controlled care, including the explicit recognition and funding of relational and community-based service functions, workforce requirements and structural cost pressures, to avoid disruption to service continuity and access for Aboriginal and Torres Strait Islander communities.

Question 4: Compared to services in metropolitan areas, what cost pressures and supporting data and evidence should IHACPA take into account when considering pricing adjustments for services provided in rural and remote locations?

NATSIAACC considers that IHACPA should take into account the fact that service delivery in rural and remote locations is not simply a more expensive version of metropolitan service delivery, but often a fundamentally different operating environment altogether. The consultation paper acknowledges a range of these pressures, including travel distances, vehicle operating costs, worker safety considerations, freight costs, workforce challenges, and the impacts of geographic isolation on service delivery.

In practice, Support at Home Providers operating in rural and remote locations are often delivering care across large geographic areas, with small and dispersed client bases, limited workforce availability and fewer opportunities to achieve economies of scale. This means that standard assumptions which may hold in metropolitan areas, such as route efficiency, workforce depth, ability to seek service substitution and administrative scale, do not apply in the same way.

IHACPA should also take into account the substantially higher workforce costs associated with rural and remote delivery. These include the cost of recruiting, retaining and supporting appropriately skilled and culturally capable staff, the use of travel subsidies and accommodation, the need for workforce flexibility where local labour markets are thin and the added burden of maintaining continuity of care in environments where turnover is often high. In remote settings, the absence of local workforce can result in even greater costs where providers are required to bring staff in from outside the community or region.

There are also significant infrastructure and service delivery challenges that should be properly factored into any pricing adjustment analysis. Providers in rural and remote areas may be working with unreliable internet and telecommunications, longer delays in access to equipment and consumables and reduced access to clinical supervision, allied health support and broader health system infrastructure. These constraints increase the cost of providing care and also make service coordination and compliance more difficult and resource intensive than in metropolitan settings.

NATSIAACC also emphasises that service delivery in these areas often requires a broader relational and community engagement function that is not easily visible in mainstream pricing assumptions. Particularly in Aboriginal and Torres Strait Islander communities, Providers may undertake additional liaison, cultural engagement, trust-building and informal coordination work in order to maintain safe



and effective access to care. These functions are often essential to service continuity and should not be excluded from consideration simply because they are harder to quantify through conventional metropolitan-based costing lenses. These relational and community engagement functions are core to service delivery and must be recognised within pricing adjustments.

In considering pricing adjustments for rural and remote services, NATSIAACC recommends that IHACPA move beyond narrow comparisons with metropolitan service delivery and recognise that the non-metropolitan underlying costing structure is materially different. Pricing adjustments must be informed by this reality if they are to support equitable access and sustainable service delivery across the full geography of the Aged Care system.

NATSIAACC Recommends

IHACPA should incorporate structural cost pressures associated with rural and remote service delivery into its pricing framework, including travel time, workforce constraints, safety considerations, infrastructure limitations and service delivery complexity.

Question 5: Do higher costs or different cost pressures associated with services provided in rural and remote locations apply to all service types, or only to specific services? For example, clinical services in comparison to non-clinical services.

As reflected in NATSIAACC's response to Question 4, the cost pressures associated with regional, rural and remote service delivery should not be understood as confined to one subset of services. They are structural pressures that apply across the Support at Home service system as a whole, although they do not present in identical ways across every service type. In that sense, the issue is not whether rural and remote cost pressures apply only to clinical or only to non-clinical services, but rather how those pressures manifest differently depending on the delivery requirements of the service in question.

For clinical services, cost pressures are often more immediate and visible. These services are more likely to depend on scarce, regulated and professionally qualified workers, which means Providers in regional, rural and remote areas frequently face higher recruitment costs, greater reliance on agency or travelling staff, increased accommodation and transport expenses, and added difficulty maintaining continuity of care. Providers may also face higher indirect costs associated with supervision, professional isolation, and reduced access to broader clinical infrastructure. In practical terms, the cost of delivering a clinical service in a rural or remote setting is often shaped not just by the time spent with the participant, but by the broader workforce and system conditions required to make that service possible at all.

For non-clinical services, cost pressures may appear less formalised, but they are still significant and should not be underestimated. Services such as personal care, domestic assistance, social support, meal delivery and transport are often delivered across large and dispersed catchments, where travel time is high, client numbers are lower and opportunities to cluster services efficiently are limited. In metropolitan settings, these services may benefit from route efficiency, higher volume and shorter travel distances. In regional, rural and remote settings, that logic often breaks down. A service that



appears relatively low-cost on paper can become materially more expensive to deliver once travel, time, coordination and workforce availability are taken into account.

There is also a broader issue in how efficiency is interpreted across service types. If rural and remote pricing is assessed too heavily through metropolitan benchmarks, non-clinical services in particular risk being viewed as inefficient when, in reality, they are operating exactly as required within their local context. This is especially important in Aboriginal and Torres Strait Islander communities, where non-clinical services may carry a stronger relational, trust-building and community connection function than is visible through standard service classifications. In those settings, the value and cost of the service cannot be understood purely through transactional assumptions about time and task completion.

NATSIAACC's view is therefore that regional, rural and remote cost pressures apply across both clinical and non-clinical services, but that IHACPA's methodology must be capable of recognising the different ways those pressures arise. A clinical service may attract higher workforce and qualification-related costs, while a non-clinical service may attract higher travel, coordination and continuity-related costs. Both forms of cost pressure are real, both materially affect provider viability, and both should be reflected in pricing methodology.

IHACPA should avoid adopting an overly narrow approach that assumes only clinical services warrant meaningful pricing adjustment in rural and remote areas. Doing so would risk understating the operational pressures faced by providers and would fail to reflect the actual cost of delivering safe, continuous and accessible care across diverse geographic settings.

NATSIAACC Recommends

IHACPA should ensure that pricing methodologies account for rural and remote cost pressures across both clinical and non-clinical services, including through service-level analysis that captures how these costs manifest differently across service types.

Question 6: What cost pressures and supporting data and evidence should IHACPA take into account when considering pricing adjustments for services provided for people from Aboriginal and Torres Strait Islander communities?

NATSIAACC considers that IHACPA should approach this question from the starting point that delivering Aged Care services to Aboriginal and Torres Strait Islander communities is not simply a matter of delivering the same service to a different population group. In many cases, it involves a different service environment, a different relationship to care and a different set of delivery requirements that carry additional and ongoing cost.

IHACPA's consultation paper already acknowledges that stakeholders have identified higher care needs and additional costs associated with culturally safe, trauma-aware and healing-informed care, including the importance of recruiting and retaining Aboriginal and Torres Strait Islander workers and the associated cost of workforce support and cultural capability.



It also acknowledges that, for the 2026–2027 pricing advice, IHACPA did not identify pricing adjustments for Aboriginal and Torres Strait Islander Peoples due to the available data and evidence base. NATSIAACC agrees that the evidence base requires strengthening but also considers that the evidence currently available already points to a clear pattern of higher service delivery costs that should inform IHACPA's future pricing adjustment work.

A key cost pressure is the additional time required to deliver culturally safe, relationship-based care. In many Aboriginal and Torres Strait Islander communities, service effectiveness depends on trust, continuity, communication and the provider's ability to work in a way that is culturally respectful and responsive. That often requires longer visits, greater flexibility in how services are delivered, more time spent building rapport and greater continuity of workforce than may be assumed in mainstream pricing models.

There are also important workforce-related cost pressures that IHACPA should take into account. Recruiting, retaining and supporting Aboriginal and Torres Strait Islander workers, or alternatively ensuring that non-Indigenous staff are sufficiently culturally capable and supported to work in community, often involves additional cost. This may include higher recruitment costs, cultural supervision, workforce support, training, professional development, accommodation and travel, particularly in areas where local labour markets are thin or where workforce turnover is high. In practice, the cost of maintaining a culturally safe workforce can be materially higher than what is reflected in standard pricing assumptions.

A significant proportion of labour required to delivery culturally safe care remains unrecognised within current pricing assumptions. This includes cultural load, community obligations, crisis response and system navigation. These are not inefficiencies; they are core components of safe care delivery.

IHACPA should also recognise the additional community engagement and governance responsibilities often carried by ACCOs and other Providers working in Aboriginal and Torres Strait Islander settings. Time spent engaging with community, observing cultural protocols, liaising with family and kinship networks and ensuring that services are delivered in a way that is locally trusted and culturally appropriate is often essential to service continuity. However, much of this work is not easily visible in conventional activity-based cost models, despite the fact that it is often what allows services to be accessed and sustained in the first place. These functions are not indirect costs; they are core components of care delivery and must be reflected in pricing.

For many Providers, these cost pressures are compounded by geography, service scale and infrastructure limitations. Aboriginal and Torres Strait Islander Providers are disproportionately represented in regional, rural and remote areas, meaning that cost pressures associated with travel, workforce availability, digital access and limited economies of scale often sit on top of the cultural and relational costs already described. In this sense, the additional cost of delivering services to Aboriginal and Torres Strait Islander communities cannot always be separated neatly from the broader structural conditions in which many of those services are delivered.



NATSIAACC notes that Provider pricing evidence from within the Aboriginal and Torres Strait Islander Aged Care sector further supports the case for pricing adjustments. Preliminary analysis of pricing data from NATSIAACC member organisations delivering Support at Home services indicates a consistent pattern of higher indicative median pricing across a broad range of clinical and non-clinical service types when compared with national median prices. While this dataset is indicative and not exhaustive, it reflects a credible cross-section of Provider experience within NATSIAACC’s membership and provides relevant supporting evidence when considering whether Aboriginal and Torres Strait Islander-specific pricing adjustments are warranted.

Support at Home Service	Unit	National median price	NATSIAACC Support at Home member median price
Nursing Care			
Registered Nurse	Hour	\$160	\$183
Enrolled Nurse	Hour	\$140	\$154
Nursing Assistant	Hour	\$110	\$113
Allied health and other therapeutic services			
Allied health therapy assistant	Hour	\$122	\$129
Counsellor or Psychotherapist	Hour	\$208	\$218
Dietitian or Nutritionist	Hour	\$200	\$208
Exercise physiologist	Hour	\$190	\$194
Occupational therapist	Hour	\$200	\$212
Physiotherapist	Hour	\$185	\$207
Podiatrist	Hour	\$180	\$185
Psychologist	Hour	\$228	\$234
Social worker	Hour	\$200	\$216
Speech pathologist	Hour	\$208	\$221
Care management	Hour	\$120	\$133
Restorative care management	Hour	\$150	\$167
Personal care	Hour	\$100	\$106
Social support and community engagement	Hour	\$99	\$104
Therapeutic services for independent living	Hour	\$165	\$200
Respite	Hour	\$99	\$102
Transport	Trip	\$70	\$85
Domestic assistance	Hour	\$95	\$104
Home maintenance and repairs	Hour	\$103	\$112
Meal delivery	Meal	\$15	\$21
Meal preparation	Hour	\$97	\$106

Note: The above table is indicative and based on pricing information provided by NATSIAACC member organisations delivering Support at Home services. While it reflects a credible cross-section of Provider experience, it is not exhaustive and does not capture the full range of cost variation across all Aboriginal and Torres Strait Islander Providers.

Table 1: Indicative comparison of national median Support at Home prices and NATSIAACC member median prices for selected services

This indicative comparison demonstrates that higher pricing pressures are not limited to a small number of outlier services. Rather, they are evident across a broad range of Support at Home services, including nursing, allied health, care management, personal care, social support, transport, domestic assistance, home maintenance and meal-related services.

Importantly, this pattern is visible across both clinical and non-clinical service types, which suggests that the cost pressures associated with delivering care to Aboriginal and Torres Strait Islander communities are systemic rather than isolated. NATSIAACC notes that the table does not capture the



full extent of variation across all Aboriginal and Torres Strait Islander Providers and that a number of Providers operate above both the national median and the NATSIAACC median figures presented. Even with these limitations, the evidence is sufficient to demonstrate that the current pricing framework is not fully capturing the cost of delivering culturally safe care.

Taken together, these pressures point to a clear conclusion. The absence of Aboriginal and Torres Strait Islander-specific pricing adjustments should not be interpreted as evidence that no such adjustment is required. Rather, it reflects the fact that the current evidence base has not yet been built in a way that adequately captures the full cost of culturally safe, trauma-aware and healing-informed care. If IHACPA is to move toward equitable pricing advice, it must ensure that these pressures are explicitly recognised within both its cost collection methodology and its pricing adjustment framework.

In addition to recognising these cost pressures, IHACPA should consider specific pricing mechanisms to reflect these costs, including:

- A cultural safety loading applied across relevant service types.
- Dedicated service items for community engagement and cultural connection.
- Block funding approaches for community-controlled delivery in thin markets.

These mechanisms should be flexible, locally informed and linked to outcomes, including engagement, trust and continuity of care.

NATSIAACC Recommends

IHACPA should develop and implement Aboriginal and Torres Strait Islander-specific pricing adjustments that reflect the full cost of delivering culturally safe, trauma-aware and healing-informed care, supported by stronger data collection and direct engagement with Aboriginal and Torres Strait Islander Providers.

Question 7: What cost pressures and supporting data and evidence should IHACPA take into account when considering pricing adjustments for services provided for people with diverse backgrounds and life experiences?

NATSIAACC considers that IHACPA should approach this question from the position that services delivered to people with diverse backgrounds and life experiences are not simply variations of standard service delivery, but often require different delivery models, additional functions and sustained engagement to be safe, effective and accessible.

A generalised approach to diversity risks obscuring structural inequity and failing to deliver equitable outcomes for Aboriginal and Torres Strait Islander communities.

While this question spans a broad range of population groups, it is critical that IHACPA does not adopt a generalised approach that dilutes or obscures the specific structural cost pressures associated with



Aboriginal and Torres Strait Islander communities. These pressures are distinct and require explicit recognition within the pricing framework.

At a system level, the core issue is that current pricing assumptions are based on standardised, transactional models of care that do not adequately reflect the relational, cultural and contextual factors that shape service delivery across diverse communities.

For Aboriginal and Torres Strait Islander communities, and in many cases for other populations with diverse backgrounds and life experiences, safe and effective care depends on a range of functions that are not consistently captured in pricing methodology. These include trust-building, communication, cultural understanding, community engagement, and the ability to navigate complex service systems. These are not additional or optional components of care, they are core functions that determine whether services are accessed, sustained and effective over time. However, under current pricing approaches, these functions are often treated as indirect or unpriced activities.

A key cost pressure is therefore the additional time, workforce capability and service flexibility required to deliver care in a way that is appropriate to the individual, their background and their circumstances. This may include longer engagement periods, more intensive coordination, and the need to adapt service delivery to align with cultural, social or community contexts.

There are also workforce-related implications that IHACPA should take into account. Delivering services across diverse populations requires a workforce that is appropriately trained, supported and capable of working in culturally safe and responsive ways. This often involves additional investment in training, supervision, workforce support and, in some cases, the employment of workers with specific cultural or community knowledge.

In Aboriginal and Torres Strait Islander contexts, this includes the additional cultural load carried by workers, as well as the broader community obligations and expectations that are part of delivering care in a community-controlled setting. These factors are not reflected in standard pricing assumptions but are critical to service quality and continuity.

In addition, Providers delivering services to diverse populations may face increased coordination and system navigation requirements. This includes working across multiple service systems, engaging with families and community networks, and addressing barriers to access that are not present in mainstream service delivery. These activities require time and resources but are not consistently recognised within activity-based pricing models.

The available evidence, including indicative Provider pricing data from within NATSIAACC's membership, demonstrates that where service delivery requires greater flexibility, cultural capability and relational engagement, costs are consistently higher than those reflected in national median pricing. This reinforces that current pricing assumptions do not fully capture the cost of delivering safe and effective care across diverse community contexts.

Pricing is not neutral. It determines which models of care are viable and which are not. If pricing frameworks do not explicitly recognise and fund these additional functions and cost pressures, they will continue to favour standardised service delivery models and limit the accessibility and effectiveness of care for people with diverse backgrounds and life experiences.

IHACPA should ensure that:

- Pricing frameworks recognise culturally safe and context-responsive care as a core cost driver.
- Relational, communication and engagement functions are explicitly recognised and funded.
- Workforce capability, cultural load and service delivery complexity are reflected in pricing methodology.
- Pricing approaches do not rely solely on mainstream service assumptions when applied across diverse populations.
- Targeted data collection and engagement improve the representativeness of cost data across underrepresented groups.

NATSIAACC Recommends

IHACPA should ensure that pricing adjustments for services delivered to people with diverse backgrounds and life experiences reflect the full cost of delivering context-responsive and culturally safe care, including the explicit recognition and funding of relational service functions, workforce capability requirements and additional coordination and engagement activities, supported by improved data collection and targeted engagement with underrepresented Providers and communities.

Question 8: Do higher costs or different cost pressures associated with services provided for people from Aboriginal and Torres Strait Islander communities, or people with diverse backgrounds and life experiences, apply to all service types, or only to specific services? For example, clinical services in comparison to non-clinical services.

As reflected in NATSIAACC's response to Question 6, the higher costs associated with delivering services to Aboriginal and Torres Strait Islander communities should not be understood as limited to only certain service categories. Rather, these cost pressures extend across the full spectrum of Support at Home services, although they may present differently depending on whether the service is clinical or non-clinical in nature.

For clinical services, the additional cost pressures often arise through workforce-related factors, continuity of care requirements, cultural capability and the need to deliver care in a way that is trauma-aware, healing-informed and culturally safe. In practice, this can require longer engagement, stronger workforce continuity, greater trust-building and additional investment in recruitment, retention and staff support than might be assumed in mainstream pricing models. Clinical care in Aboriginal and Torres Strait Islander contexts is therefore not simply just a technical service delivered in isolation, but one that often depends on broader relational and cultural conditions being in place for the service to be effective.



For non-clinical services such as personal care, social support, transport, domestic assistance, meal delivery and home maintenance are often delivered in contexts where relationship-building, flexibility, continuity and community trust are essential to whether the service is accepted and sustained. In many Aboriginal and Torres Strait Islander communities, these services also carry a broader function in maintaining connection, supporting wellbeing and enabling our Elders and Older People to remain engaged with community and culture. That means the cost of delivery cannot be understood purely through a transactional lens of task completion or service duration.

This is also reflected in the indicative Provider pricing evidence available through NATSIAACC's membership, which shows a consistent pattern of higher median pricing across both clinical and non-clinical service types. That pattern is important because it suggests the cost pressures associated with delivering care to Aboriginal and Torres Strait Islander communities are not confined to one part of the service system but are more systemic in nature. They sit within the broader realities of culturally safe service delivery, community-controlled practice, workforce challenges and, in some cases, regional, rural and remote operating conditions.

NATSIAACC therefore considers that IHACPA should avoid adopting a narrow view that pricing adjustments are only relevant to services that are more obviously complex or clinical. Such an approach would risk understating the cost of delivering non-clinical services that are often central to continuity of care, trust, prevention and community connection. It would also fail to reflect the way culturally safe care is actually delivered in practice, where the distinction between clinical and non-clinical service value is not always as clear-cut as it may appear in a pricing framework.

NATSIAACC Recommends

IHACPA should embed culturally safe care as a system-wide pricing consideration across both clinical and non-clinical services, ensuring that pricing reflects the delivery model required for Aboriginal and Torres Strait Islander communities.



Conclusion

NATSIAACC welcomes IHACPA's continued engagement on the development of the Pricing Framework for Australian Support at Home Aged Care Services 2027–2028. As this submission has outlined, the current framework remains constrained by data and engagement limitations that risk understating the true cost of delivering culturally safe, trauma-aware and healing-informed care to Aboriginal and Torres Strait Islander communities.

The evidence available to NATSIAACC, including indicative Provider pricing data from within our membership, points to a consistent pattern of higher service delivery costs across both clinical and non-clinical service types. These pressures are not incidental or confined to a small number of services. They are structural and reflect the realities of delivering care from every aspect in Aboriginal and Torres Strait Islander contexts, particularly where Providers must also navigate thin markets, workforce shortages, travel burdens, community obligations and infrastructure limitations.

NATSIAACC's position is that the absence of Aboriginal and Torres Strait Islander-specific pricing adjustments should not be interpreted as evidence that such adjustments are unnecessary. Rather, it reflects the fact that the current evidence base has not yet been developed in a way that fully captures the cost of culturally safe service delivery. This is a point IHACPA itself acknowledges in the consultation paper.

For that reason, NATSIAACC urges IHACPA to move beyond a reliance on mainstream assumptions, submission-driven engagement and incomplete datasets when considering future pricing advice. The development of Aboriginal and Torres Strait Islander-specific pricing adjustments should now be pursued alongside stronger data collection, more tailored methodologies, and direct, place-based engagement with Providers and communities.

The pricing framework must move beyond reflecting average market conditions and instead be designed to support culturally safe, community-controlled models of care. Without this shift, pricing reform risks reinforcing the very inequities it seeks to address.



NATSIAACC