# A response from Victoria to

## Pricing Approach for the Support at Home service list 2025-26

**Submission by**

**SSD Connect Alliance, Eastern Sector Development Team, Bayside City Council Sector Support and Development, Grampians Regions Sector Development Team**

22 October 2024

This submission is the result of 3 roundtables held in October.

The roundtables were designed and facilitated by Enkindle Consulting.

**70 attendees from 52 organisations** actively participated in the roundtables, offering a comprehensive representation across **metro, regional, rural & remote Victoria**.

They include community health, local councils, not-for-profits, state health services and Aboriginal community-controlled organisations.

The SSD Connect Alliance is:
Banyule City Council, City of Darebin,
City of Whittlesea, cohealth, Maribyrnong City Council,
Merri-bek City Council, Sunbury and Cobaw Community Health.

Eastern Sector Development Team (EACH)

Bayside City Council Sector Support and Development

Grampians Region Sector Development Team (Ballarat Community Health).

## Acknowledgments

Thank you to the aged care leaders who shared their perspectives in the roundtables.
And thank you Jennene Buckley & Tash Edwards from Enkindle Consulting for your expert design and facilitation of the roundtables and preparing this submission.

The SSD Program is funded by the Australian Government Department of Health and Aged Care. Although funding has been provided by the Australian Government, the material contained herein does not necessarily represent the views or policies of the Australian Government.

We acknowledge the traditional Aboriginal & Torres Strait Islander custodians of Country throughout Victoria. We pay our respects to them, their culture & their Elders past and present. The regions we work in include people from diverse cultures with diverse beliefs, abilities, bodies, sexualities, genders & ages. We're committed to access, equity, participation & rights for everyone.

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# Executive Summary

This submission highlights the critical considerations that IHACPA must address to ensure the Support at Home program is sustainably priced. This will allow providers to deliver high-quality, safe care while navigating increasing regulatory, operational, and workforce pressures. Key messages centre around the need for broader provider engagement, accurate cost modelling, and proactive adjustments that reflect the complexities of aged care and the future Support at the Home model.

**Key Considerations and Actions for IHACPA:**

- **Engagement with CHSP and NATSIFACP Providers:** IHACPA must urgently engage CHSP and NATSIFACP providers in the pricing study. These providers currently deliver many of the services outlined in the Support at Home service list, especially in regional, rural, and remote areas. Their exclusion would result in an incomplete representation of the true costs of service delivery in these localities, undermining the accuracy of IHACPA's pricing advice.
- **Travel Costs Should Be Treated Separately:** Travel distance and time are significant variables that vary significantly between geographic areas. While a set unit price per service is the goal, travel costs must be treated separately from the set unit pricing to ensure flexibility and fairness, particularly in rural, remote, and congested urban areas where travel time can severely impact the cost of delivering services.
- **Incorporation of Future Regulatory Costs in 2025–2026 Pricing:** The transition to the new Aged Care Act, regulatory framework, and Support at Home program, commencing 1 July 2025, will impose immediate costs on providers. These costs must be addressed in the 2025–2026 pricing advice and not deferred to future years. Providers will face heightened compliance requirements, corporate governance shifts, and increased training needs that will significantly impact service delivery costs.
- **Time-Limited Funding for Service Transformation:** IHACPA should consider a subsidy or levy to support providers during the transition to the new regulatory framework and service delivery models (similar to the approach with NDIS transition). This time-limited funding will allow providers to invest in digital transformation, infrastructure upgrades, and service redesigns, ensuring they can continue delivering high-quality care under the new system.
- **Monitoring Workforce Costs and Wage Variations:** Given the challenges of attracting and retaining skilled staff, particularly in the face of increasing wage pressures, IHACPA must closely monitor local, state, and federal wage trends. Many providers operate with wage instruments above modern awards, and IHACPA's pricing advice must account for these market forces. Additionally, the decline in volunteer workers further strains providers' capacity to manage costs.
- **Reflecting the Growing Complexity of Client Needs:** As home care providers face increasing demand from clients with higher acuity and more complex needs, pricing must reflect the costs associated with training, capacity building, and service model development. Without these adjustments, providers may struggle to manage the growing burden of care, especially as hospitals and residential care facilities experience limited capacity to expand.
- **Ensuring True Cost Representation of Home Care Operations:** IHACPA must focus on the full cost of running a home care organisation under the Support at Home program. This includes the costs of operational management, care coordination, package management, and overheads. Providers must be able to invest in innovation, service improvement, and efficiency to maintain sustainable operations and deliver high-quality care. The pricing model must reflect the real-world costs of these essential functions, enabling providers to remain financially viable while continuing to improve service delivery.

- **Addressing the Impact of the New Client Contribution Framework:** The new client contribution framework introduces an increased risk for providers, as many older people may refuse or be unable to pay their required contribution. This will result in providers absorbing bad debts, which will significantly impact their financial viability. IHACPA's pricing advice must account for this increased risk and ensure providers are not unfairly burdened by unpaid contributions, which could jeopardise the sustainability of services.

# Background

## Voices within the submission

In October 2024, 70 participants representing 56 Home Care Providers came together for a series of roundtable discussions focused on providing a collective response to the IHACPA consultation on the pricing approach for the 2025-2026 Support at Home service list. Among the participants, **60% of the providers represented deliver Home Care Package (HCP) and Short-Term Restorative Care (STRC) programs**, while **100% are CHSP providers**. Additionally, **25% of the providers** represented deliver services in rural and remote areas, highlighting the geographical diversity of the group.

These roundtables served as a vital platform to gather insights from Victorian CHSP providers, encompassing a range of organisations, including state health services, community health services, local councils, not-for-profits, and Aboriginal community-controlled organisations. The discussions highlighted key issues, including cost challenges, workforce pressures, and service delivery challenges across metropolitan, regional, rural, and remote areas

**Role of CHSP Providers**
By way of background and context, the Commonwealth Home Support Program (CHSP) represents the largest network of home care providers in Australia, with around 1,344 organisations supporting approximately 871,565 older people annually. While often described as providing "entry-level" or "basic supports," CHSP plays a crucial role in delivering care to some of the most vulnerable and marginalised groups in the community, including culturally and linguistically diverse (CALD) populations, refugees, and individuals living with dementia or homelessness.

CHSP providers are essential in filling critical gaps in the care continuum. This includes 1) individuals approved for Home Care Packages, but waiting for an allocated place on the National Waitlist, and 2) people needing urgent post-hospital support for older individuals with post-acute needs. Services such as community nursing, allied health, personal care, transport, Meals on Wheels, assistive technologies, and home modifications are rapidly mobilised to support at-risk clients awaiting aged care assessments. Additionally, Home Care Package (HCP) and Short-Term Restorative Care (STRC) programs often rely on CHSP providers to deliver essential services and ensure the planned care for their clients is successfully implemented. This demonstrates the integrated role CHSP providers play in supporting the broader aged care system.

Notably, nearly 70% of CHSP providers are small organisations with less than $1 million in annual grant funding from the Department of Health and Aged Care. Many of these providers rely heavily on volunteers, both in service delivery and in organisational governance through their boards. Furthermore, about 60% of CHSP operators are solely reliant on CHSP funding. In contrast, organisations such as local councils and Aboriginal community-controlled organisations operate CHSP as part of a broader portfolio of services, adding complexity to their regulatory and compliance responsibilities. CHSP providers are also instrumental in thinly populated, hard-to-reach market areas, ensuring that even geographically isolated communities have access to essential care services.

## Representative Organisations

The following tables detail the representative organisations to this submission and their service demographics. Please note: A number of metro providers also operate in regional, rural and remote areas.

## Metro

Access Health and Community
AccessCare - City of Kingston
Alfred Health
Australian-Filipino Community Services Inc
Banyule Community Health
Bayside City Council
Better Health Network
Caladenia Dementia Care
Care Connect
City of Casey
City of Whittlesea
City of Yarra
EACH
EV (Eastern Volunteers)
Frankston City Council
HealthAbility
IPC Health
Knox City Council
mecwacare
Mentis Assist
Merri Health
Merri-bek City Council
Monash Health
Nillumbik Shire Council
Sandybeach Centre
Ranges Community Health t/a Inspiro
South East Volunteers
Southern Migrant and Refugee Centre
Brotherhood of St. Laurence
UNITED – Spanish Latin American Welfare
Wavecare Inc
Yarra City Council
Your Community Health

## Regional, Rural and remote

Alpine Health
Ballarat Community Health
Ballarat Regional Multicultural Council
Colac Area Health
Cultura
East Grampians Health Services
Gateway Health
Gippsland Lakes Complete Health
Grampians Health
Great Ocean Road Health
Gunditjmara Aboriginal Cooperative
Hesse Rural Health
Kooweerup Regional Health Service
Rural City of Wangaratta
Rural Northwest Health

Note: 4 participating organisations have requested not to be named in this submission.

### About the participating CHSP Providers

| | |
|---|---|
| **Types of Organisations:**<br>ACCO: 1<br>ACCHO: 1<br>Government Owned: 19 (mix of state health and local government)<br>NFP: 34<br>Private: 1 | **Service Delivery Locations (by how many providers):**<br>Metro: 39 providers<br>Regional: 16 providers<br>Rural: 12 providers<br>Remote: 2 providers |
| **Number of Aged Care Clients (by how many providers):**<br>1-50: 3 providers<br>51-100: 3 providers<br>101-200: 3 providers<br>201-500: 11<br>501-1000: 8<br>1001+: 28 | **Programs Delivered (by how many providers)**<br>CHSP: 56 providers<br>HCP: 33 providers<br>STRC: 4 providers<br>Transition Care: 3 providers<br>MPS: 2 providers<br>Residential Aged Care: 12 providers |

# Consultation Questions

## Support at Home Service List

### Question 1: What concerns, if any, do you have about the transition to set unit prices for services on the indicative Support at Home Service List?

While the move to set unit pricing aims to standardise costs and promote transparency, several critical concerns must be addressed to ensure that the new pricing structure reflects the true cost of service delivery and supports sustainable operations. These concerns include:

**1.1 Over-reliance on Historical Data:**
There is concern that the costing study will rely too heavily on historical data and sources rather than adequately accounting for the future operating costs under the new Support at Home model and regulatory framework commencing 1 July 2025.

**1.2 Inadequate Coverage for Package Management Costs:**
Providers are concerned that the proposed unit prices may not adequately cover the 15% reduction in package management costs, which will no longer be a separate charge within the new Support at Home model. These costs, previously part of the overall package, helped cover essential service co-ordination, care coordination, service administration and overheads.

**1.3 Insufficient Consideration for Shorter Service Intervals:**
Providers are concerned that the capped unit pricing may not accurately reflect the higher costs associated with shorter service durations (15, 30, and 45 minutes). These services are disproportionately expensive compared to a fraction of a one-hour service due to additional factors like travel time, coordination efforts, and other overheads.

> "The assumption that everything can be done in hour-long blocks is not realistic. For tasks like medication administration or check-ins, the service might only take 15 minutes, but you still have to factor in travel time."

**1.4 Limited Scope for Organisational Costs:**
While administration is included in the pricing scope, there is concern that unit prices may not fully capture

the broad range of organisational costs. These include service coordination, business processes, regulatory compliance, and necessary investment in digital transformation, workforce development, and care innovations.

**1.5 Lack of Transition Support for Operational Changes:**
The capped pricing may not accommodate the significant costs providers will incur to transition to the future operating model from 1 July 2025. In comparison, the NDIS rollout accounted for transition costs, but home care providers are simultaneously managing a funding model change and a regulatory framework shift. Providers emphasised that the transition to the new model will require investment in staff training, technology upgrades, process redesigns, and compliance efforts and are concerned that without dedicated transition funding, they will struggle to manage these additional costs effectively under the proposed capped pricing structure.

**1.6 Inadequate Travel Cost Adjustments:**
The proposed unit prices may not sufficiently address travel time and distance costs, which are significant for rural and remote areas due to distance but can also be significant in metropolitan regions where traffic congestion can make short distances costly. For example, rural areas may need to travel 40km between clients' homes to undertake personal care services, where travelling 2 km in city traffic between clients' homes may take 45 minutes, potentially doubling the service cost.

**1.7 Unaccounted Costs from Missed Appointments:**
There is concern that unit pricing will not consider the operational reality and financial impact of 'no-shows' or late cancellations. When clients cancel services at the last minute or are not at home when a worker arrives, providers still bear the cost of paying staff, coordinating services, and performing follow-up actions such as welfare checks and reporting.

**1.8 Exposure to Bad Debts:**
The unit pricing may not account for the financial burden caused by unpaid client co-contributions. As providers effectively act as debt collectors on behalf of the government, they face increased costs related to chasing outstanding payments. The concern is that the unit price will not consider the risk and write-off of bad debts, or the additional resources needed to manage debt collection efforts, such as staff time and administrative costs.

"Client contributions should account for the fact that we won't be getting them in some services"

**1.9 Inadequate Coverage for Vulnerable Populations:**
The unit pricing structure may not cover the cost of delivering services to vulnerable populations, such as those with lower socioeconomic status, individuals living in public housing, or clients with multiple chronic and complex health conditions. Furthermore, the need for interpretation/translation services, particularly for clients with limited English proficiency, adds another layer of cost that is not always reflected in previous pricing models.

**1.10 Challenges in Attracting and Retaining Workforce:**
Providers are concerned that the set pricing may not enable them to offer competitive wages comparable to those in state health services or the NDIS, making it more challenging to attract and retain workers in the aged care sector.

**1.11 Lack of Agility in Addressing Wage Adjustments:**
An annual unit pricing process may not be flexible enough to accommodate wage increases or backpay obligations that arise mid-year. As wages represent the largest cost component in home care, any unfunded wage increments will directly impact providers' financial viability.

### Question 2: In developing its advice, what factors should IHACPA take into account when setting prices for different services?

IHACPA must work closely with home care providers to understand, define, and accurately measure the key factors that influence the cost-of-service delivery. This collaboration will ensure the pricing framework reflects the true costs and complexities involved in providing high-quality care for diverse communities in diverse geographies. The following factors should be carefully considered:

**2.1 Pricing for Shorter Service Intervals:**
IHACPA should account for the costs of delivering services in increments of 15, 30, and 45 minutes, rather than basing prices solely on one-hour blocks. Many essential services, such as medication administration, catheter care, meal assistance, wellness checks, night tuck-ins, and meal preparation, typically require shorter durations. These services are disproportionately costly due to associated overheads, such as travel costs for the service and service coordination.

**2.2 Impact of Travel Costs Across All Geographic Regions:**
Travel costs are not just a rural and remote issue. While rural and remote providers must manage both long travel distances and time, metropolitan and regional areas also face travel challenges. In urban settings, traffic congestion can make even short distances costly. These factors—whether driven by distance or time—significantly impact the cost-of-service delivery and must be reflected in the pricing framework.

"In populated areas, the travel time to get from A to B, even for short distances, can make the service unviable. The time it took due to traffic means a significant loss on that domestic service."

**2.3 Costs Associated with the New Support at Home Program:**
Providers will face increased costs to implement and operate the new Support at Home program, which will involve more complex budget management, billing processes, and a client contribution framework from 1 July 2025. These operational changes will require substantial investment in project management, infrastructure, ITC system changes, and change management, including communications and training to support a smooth transition and ensure long-term compliance and efficiency.

**2.4 Compliance with the New Aged Care Act:**
The new regulatory framework will bring additional costs, including compliance with new conditions of registration, statutory duties, obligations, statements of rights, and whistleblower protections. Providers will also need to adopt supported decision-making frameworks and demonstrate delivery of high-quality care, all of which require investment in systems, training, and oversight.

**2.5 Impact of Wage Awards and Market Comparisons:**
IHACPA should consider local, state, and federal wage awards applicable to home care providers. In addition, benchmarking against sector-based Enterprise Agreements (EAs) could help ensure that the true cost of wages and allowances is accurately reflected. Comparisons with wages in other sectors, such as health, NDIS, and DVA, should also inform pricing decisions. Furthermore, regional variations in wage expectations across rural, remote, and metropolitan areas must be factored in to ensure providers can attract and retain skilled staff in all locations.

"The Nursing award could index at a higher rate than another award, for example, state health wages in Victoria are rising faster (28.4% over 5 years) so we need to factor in these

**2.6 Variation in Costs Across Different Services:**
For each service type on the Support at Home service list, there is significant variance between services in the cost of personal protective equipment (PPE), consumables, tools, equipment, premises, and service delivery requirements. For instance, podiatry services require specialised tools, sterilising equipment, consumables, professional chairs, service-specific software, and dedicated clinic space. In contrast, occupational therapists incur significant non-contact time preparing drawings, quotes, and reports. To ensure sustainability, these service-specific variations must be fully recognised and reflected in the pricing structure. Refer to Table 10.1.

"There's a huge amount of escalation of care and referral in nursing. They might come back and have to write a detailed referral or just an update to the GP or the referring service."

**2.7 Direct Care Worker's Costs:**

Pricing must account for not only the client contact time but also the non-contact (face-to-face) time and associated on-costs of the direct care workforce to fully capture the true cost of service delivery. Pricing should acknowledge and account for the non-contact time required for essential tasks, including reading care plans, care notes, instructions and alerts before the service, completing reports, documenting care notes, responding to incidents, following up on customer feedback, and other administrative duties expected of service delivery staff outside of face-to-face service delivery time. These activities are essential for ensuring quality care but often go uncompensated in unit pricing models.

Below is a summary of these factors that should be considered in conjunction with Table 10.1, which notes service-specific factors.

**Table 2.7 Direct Care Worker Costs**

| **Direct Care Worker Costs**<br>Can be directly attributable to a client service | **Direct Care Worker Costs**<br>Can NOT be directly attributable to a client service | |
|---|---|---|
| Hourly Rate - Direct Care<br>Delivery<br>Travel Time<br>Travel Costs (km)<br>Parking Costs<br>Toll Road costs<br>Translator Services<br><br>**Non-Contact Time**<br>Preparation Time<br>Documentation Time<br>Post Visit Follow-up<br>Cost of “no shows”: client not home. | **Non- Chargeable**<br>Training time<br>Meeting time<br>Communications<br>Time spent with supervisors (supervision and support)<br>Paid sick leave<br>Paid public holidays<br>Paid annual leave<br>Paid other leave | **Oncosts**<br>Shift Loadings<br>Public Holiday Loadings<br>Superannuation<br>Allowances<br>Workers’ Compensation<br>Payroll Tax<br><br>Personal duress Alarms<br>Standard PPE Requirements<br>Vaccinations<br><br>See Table 10.1 for consumables equipment costs specific to service types. |

In further explanation of the table above, there is the following non-contact time spent by the direct workforce either before or after a service:

- **Preparation time:** Preparing for visits by reviewing notes, care plans, service instructions, safety instructions, risk factors, client preferences, reablement and well-being goals.
- **Documentation time:** Recording shift notes, incidents, feedback, client progress notes, client charts, quality indicators, care plan changes, recording goal attainment, and client requests.
- **Costs of no-shows:** Providers still incur costs when clients are not home or refuse a service. Including reporting and escalating to managers, welfare checks, incident reporting, and worker wages for missed services.
- **Post-visit follow-up:** Communication and follow-up on post-visit events, as described under documentation time. This can be for all worker types, including domestic, transport, allied health, nursing, personal care, and social support workers.

"What about where there's a no-show for an activity or service, like we've got the staff member at the door? How are they going to account for that?”

**2.8 Incorporating All Associate Overheads:**

In addition to the above direct care workforce costs, unit prices must also account for the full range of service-related overheads. This includes package management, service and care coordination, general overheads, infrastructure, and ongoing investment required for continuous service improvement, digital transformation, and innovation. Table 2.8 below details the operational and corporate costs of delivering Support at Home services.

- **Operational Overhead Costs – Workforce Management:** This includes the costs of recruiting, onboarding, training, supervising, scheduling, and supporting the direct care workforce. It also covers rostering teams, logistics technologies, safety systems, communication tools, and on-call supervision arrangements required to ensure smooth operations and direct service provision.
- **Operational Overhead Costs – Service Delivery and Care Coordination:** Includes costs related to the intake of clients, onboarding, agreements and information provision, managing budgets, handling claims, feedback, day-to-day enquiries, service changes and requests. It also covers the financial requirements (claims, statements, billing, reporting, etc.) of the Support at Home program, the IT platforms necessary to run services, and the administrative offices directly supporting service delivery.
- **Operational Overhead Costs – Aged Care Compliance:** This reflects the investment in resources required to meet funder requirements, the new Aged Care Act, regulatory framework, and strengthened quality standards. These compliance obligations require significant resources, which must be accounted for in the unit price of each service type.
- **Corporate Overheads Supporting Aged Care Services:** Unit pricing must also incorporate a proportional share of corporate and business services of the registered provider. In the context of this consultation paper, these may be referred to as administration costs, which are essential for operating a compliant and sustainable organisation

**Table 2.8 Associated Overheads**

| Operational (Workforce) | Operational (Service delivery & Care Co-ordination) | Operational (Aged Care specific compliance from 1/7/2025) | Corporate Overheads that support Aged Care Services |
|---|---|---|---|
| Attraction and recruitment costs<br>Onboarding<br>Orientation<br>Police checks/ screening checks<br>Vaccinations<br>Compliance checks (DL, Rego etc.)<br>Traineeship Programs<br>Training Programs<br>First Aid/CPR certificates<br>Uniforms<br>Badges<br>Supervisors and Team leaders for Direct Care Workforce Management &<br>Supervision of Brokerage<br>On call arrangements<br>Scheduling of staff<br>Payroll processes<br>Safe Systems<br>Staff amenities<br>Employee Assistance Programs<br><br>**ITC Platforms**<br>Staff Applications (Rostering/ Payroll/HRIS)<br>Communications (ie. Teams/ outlook)<br>Discipline-specific software<br>Laptops/Tables<br>Phones and Apps | **Package Management Costs**<br>Intake management (enquiries, information waitlist, communications<br>Client onboarding (agreements and service planning)<br>Managing client feedback, complaints<br>Client enquiries, service changes<br>Coordination of quotes & orders<br>Rostering and scheduling of services<br>Bookings for events<br><br>**ITC Platforms**<br>Client Management System,<br>Client applications/ portal<br>Client Relationship Management<br>Business intelligence<br>Phone Systems<br><br>**Finance Services**<br>Claiming & B2G<br>Management of Services Australia, GPMS, My Aged Care portal<br>Client Budgets & Statements, Reconciliations & Financial Monitoring<br><br>**Administration**<br>Office costs<br>Postage<br>Training/ meeting rooms<br>Marketing | Provider Governance requirements<br>Advisory Body management<br>Clinical governance systems<br>Incident Management systems<br>Quality Management and meeting new Aged Care Quality Standards<br>Feedback Management systems<br>Compliance systems<br>Consumer engagement strategy and initiatives<br>Diversity programs<br><br>**Reporting**<br>Quality Indicators (new)<br>SIRS<br>Quarterly Reporting<br>Aged Care Financial Repot<br>Suitability<br>Changes in circumstances<br>Workforce reports<br>Assurance activities<br>ACQSC visits/audits | Board of Governance<br>Financial management<br>Strategic management<br>Workforce management<br>Payroll function<br>Industrial Relations<br>Organisational Development & Culture<br>Strategic Marketing<br>Insurance<br>Procurement and contract management<br><br>**ITC**<br>ITC infrastructure<br>Cyber Security<br>Document Management<br>Finance Systems<br>HRIS and Payroll Systems<br>Learning Management Systems<br>Quality and Risk systems<br>Procurement systems<br><br>Emergency Planning and Response ( fire, flood) Costs and Pandemic Costs<br>Disaster Recovery |

## Pricing Policy Principles

### Question 3: What, if any, changes do you suggest to the proposed pricing principles to guide the development and operation of the Pricing Framework for Australian Support at Home Aged Care Services 2025-2026?

While the proposed pricing principles provide a solid starting point, they require **greater clarity and definition** to ensure they are practical, actionable, and effective. Refining these principles will help create a pricing framework that fully supports provider viability, fosters innovation, and ensures sustainable, high-quality care. Our suggested changes include:

**3.1 Access to Services:**
The principle should more clearly address the viability of providers across all localities to ensure sustainable operations. It must encourage new entrants into thin markets and support the ongoing viability of providers serving diverse populations, such as Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, and individuals with complex care needs.

**3.2 Quality Care and Services:**
The principle should emphasise that pricing must enable innovation in care delivery and ensure providers can meet the high standards of care outlined in the Aged Care Bill 2024. It should also underscore the need for pricing models that support providers in consistently delivering high-quality care while complying with evolving regulatory standards.

"The new standards, particularly under the Aged Care Act, will bring additional costs and responsibilities."

**3.3 Evidence-Based:**
In addition to relying on historical data, the principle should emphasise the need to forecast future financial impacts. This includes conducting detailed financial modelling of new government requirements**,** wage increases or changes to service models to understand their potential impact on providers and ensure sustainable pricing decisions.

**3.4 Efficiency – Supporting Innovation and Service Improvement:**
While efficiency is necessary, the principle should recognise the need for balanced efficiency. Providers must have funding to invest in innovation and service improvements**,** which aligns with the new Aged Care Act's aspiration for providers to deliver high-quality care**.** The pricing framework should balance efficiency with the ability to achieve these outcomes.

**3.5 Efficiency – Investment in Achieving Efficiency:**
The principle should acknowledge that achieving efficiency will involve upfront costs for providers. These may include service redesign, consultation, investment in technology, and other investments to streamline operations. The pricing framework must provide sufficient funding for providers to invest in these areas to achieve long-term efficiency and sustainability.

### Question 4: Are there any additional pricing principles for in-home aged care services that should be added? If so, please advise what they are.

The current pricing principles could be enhanced by adding **Regulatory Compliance** as a key principle. This will ensure that the pricing framework reflects the true costs associated with meeting government regulations and delivering high-quality care.

**4.1 Regulatory Compliance:**
Pricing should fairly account for the costs of complying with the regulatory framework**,** including adherence to quality standards and fulfilling reporting and auditing requirements**.** These obligations require providers to invest in systems, processes, and resources to maintain compliance. A sustainable pricing model must acknowledge these costs to ensure providers can operate effectively while meeting all regulatory obligations.

## Support at Home Cost Data Collections

### Question 5: How could IHACPA improve the representativeness of the cost collection participation across a range of domains, for example, service types, geography, specific population groups?

To accurately reflect the cost-of-service delivery, IHACPA must engage a broader range of providers across various service types, geographies, and population groups. The exclusion of CHSP (Commonwealth Home Support Program) and NATSIFACP (National Aboriginal and Torres Strait Islander Flexible Aged Care Program) providers is a missed opportunity that could compromise IHACPA's ability to capture the true costs of delivering key services outlined in the Support at Home program.

**5.1 Inclusion of CHSP and NATSIFACP Providers:**
Many services on the detailed Support at Home service list are currently delivered by CHSP and NATSIFACP providers, such as Meals on Wheels**,** Community Transport**,** Community Nursing, Therapy Centres and Centre-Based Programs**.** CHSP is the dominant program operating in regional, rural, and remote areas**,** making their inclusion essential to capturing the actual service delivery costs in these localities. Although CHSP and NATSIFACP may not be directly part of the Support at Home framework from 1 July 2025, they provide many of the services identified in the detailed service list.

"We need to make sure that the CHSP and NATSIFAC providers are considered in the pricing, especially since they provide many of the services that will fall under Support at Home. Excluding them would give an incomplete picture."

**5.2 Collaboration with the Sector Support and Development Network:**
IHACPA should engage with the Sector Support and Development network**,** funded by the Department of Health and Aged Care under CHSP. This network can facilitate diverse participation by locality, size, specialisation, service type**,** and organisation type (e.g., local government, state government, community health, NFPs, church organisations, Aboriginal Controlled Community Health organisations (ACCHOs), Aboriginal Controlled Community Organisations (ACCOs), and for-profit providers). This engagement will ensure comprehensive data collection from a wide variety of providers.

**5.3 Engagement with Key Peak Bodies:**
IHACPA should collaborate with key peak bodies such as Community Health First (Victoria)**,** Allied Health Professionals Australia, and the Victorian Health Care Association**.** These organisations can support broader participation across different provider types and ensure cost data reflects the realities of various service models.

**5.4 Active Participation in Sector Events and Communication Channels:**
IHACPA should increase its presence by participating in regular webinars, communities of practice, and forums within the sector and promoting **all** engagement opportunities through Department of Health circulars. Peak bodies can also help raise awareness and encourage participation from a more diverse range of providers.

**5.5 Direct Contact with Providers:**

**Additionally**, IHACPA could improve outreach by sending official correspondence to providers**, inviting** them to participate in the cost collection process.

## Pricing Methodology, Indexation, Price Benchmarking

Question 6: Do you support IHACPA's proposal to establish unit pricing using a cost-based approach that reflects the available data? Please provide a rationale.

**6.1 Limitations of Historical Data:**
While we understand IHACPA's intention to use a cost-based approach, relying solely on historical cost and activity data (such as the ACFR and QFR) presents significant limitations. This data does not reflect the cost realities of delivering services under the Support at Home framework from 1 July 2025. This is due to new regulatory requirements, increased reporting, changing service delivery models, and operational changes, all of which will incur additional costs that must be anticipated and incorporated into the 2025-2026 pricing.

**6.2 Exclusion of CHSP and NATSIFACP Providers:**
The exclusion of CHSP and NATSIFACP providers—representing more than 1,300 providers—from the ACFR and QFR data sets, will result in a significant portion of service delivery costs will not be included, such as the impacts of delivering services to disadvantaged groups and in regional areas. CHSP and NATSIFACP offer many services listed under the Support at Home program, particularly in regional, rural, and remote regions. To ensure an accurate study and sustainable approach, we ask for the inclusion of CHSP and NATSIFACP providers within the Support at Home pricing study.

**6.3 Importance of Direct Engagement:**
The development of accurate unit prices cannot be a desktop exercise. It is essential that IHACPA visits sites observes operations and engages directly with key personnel to gain a deeper understanding of service delivery. This includes identifying variations within service types, such as the unique demands of services in different geographic locations or the specialised needs of specific population groups. First-hand engagement will ensure the pricing framework reflects in-home care delivery's full complexity and diversity.

"A time and motion study would give a more accurate reflection of the effort required. The overheads that are allocated in a cost centre are not necessarily the true reflection of the efforts required for a particular program."

**6.4 Shorter Service Increments:**
Unit prices should not be limited to one-hour increments. 15, 30, and 45-minute services better align with the nature of many Support at Home services (e.g., medication administration, wellness checks). The disproportionate costs for 15, 30, and 45-minute services must be considered; overhead costs and travel make these services much more expensive than a simple hourly fraction.

Question 7: Are there any alternative approaches to pricing that IHACPA should consider? Please provide a rationale.

**7.1 Financial Impact Analysis:**
IHACPA could conduct a financial impact analysis (or similar methodology) to determine the costs of compliance under the new Aged Care Act and the additional operational costs associated with the Support at Home program that will impact providers from 1 July 2025.

**7.2 Calculate Time-Limited Loadings for Implementation Costs:**
In addition to unit pricing, IHACPA could calculate time-limited loadings (on top of the capped pricing)—similar to those offered to providers during the NDIS transition—to support providers with the project, change management, system upgrade and other associated transition activities required to implement the new Aged Care Act and the Support at Home program from 1 July 2025. These loadings would provide temporary financial relief during the transition period, ensuring providers can adapt effectively without compromising service quality.

**7.3 Onsite Visits and Detailed Cost Analysis:**
The available data does not provide a complete picture of home care service provision, as many costs are absorbed by organisations and not reflected in standard reporting. IHACPA could visit providers onsite, conduct interviews, and undertake time and motion studies to understand better how services are delivered. Additionally, understanding how providers allocate overheads, and indirect costs would allow IHACPA to develop a more accurate and realistic cost structure.

**7.4 Benchmarking Industry Transformation Costs:**
IHACPA could benchmark the costs of digital and service transformation by studying other industries (e.g., banks and other service sectors) to understand the investment required for home care providers to reinvent and modernise their service delivery models. This could include, for example, the cost of investing in digital transformation to modernise software and infrastructure, enhance operational efficiency, improve data security and improve the client and staff experience.

**7.5 Separate Travel Costs from Unit Prices:**
For highly variable components, such as travel distance and travel time, IHACPA could consider treating these costs separately from unit prices. This would involve establishing separate pricing rules for travel to reflect geographic and operational differences more accurately, ensuring fairness for providers operating in metropolitan, regional, rural, and remote areas.

"By separating travel costs from the service price cap, providers would be able to deliver services effectively, no matter the geographic area."

## Question 8: What else should be considered in development of an indexation methodology for Support at Home unit prices?

In developing the indexation methodology, IHACPA should carefully consider changing market dynamics and the evolving landscape of aged care service delivery. The framework must reflect current operational realities and the dynamic financial, regulatory, and workforce challenges providers will face in the future. The following considerations are essential to build a sustainable and responsive indexation model:

**8.1 Alignment with the Aged Care Transformation Roadmap and New Regulatory Requirements:**
The indexation methodology must account for the Aged Care Transformation Roadmap and additional regulatory requirements, such as the future implementation of Quality Indicators in-home care.

**8.2 Workforce-Related Costs and Client Complexity:**

Providers will face higher workforce costs as client needs become more complex. This includes the cost of specialised training to enhance the skills and capabilities of the aged care workforce. Any indexation should also account for training requirements associated with worker regulation and strengthened quality standards, ensuring providers can meet these new obligations effectively.

**8.3 Increased Software Licensing Costs:**
Consider the likely increased cost of software licensing, as vendors will look to pass on the costs of changes associated with the new Support at Home program and the new Aged Care Act to providers. These increases must be reflected in unit price adjustments.

**8.4 Governance and Board Costs:**
The governance responsibilities of aged care providers are growing, with many volunteer boards transitioning to a remuneration model to attract skilled directors. This shift acknowledges the significant responsibilities placed on board members under the Aged Care Act, including increased risks, civil penalties, and enhanced legal obligations and statutory due diligence requirements. Providers have expressed concerns that these heightened governance demands are reducing volunteerism, and many fear they will need to compensate board members to ensure compliance. It is essential that indexation reflects these governance-related costs to maintain strong, accountable leadership structures.

**8.5 Replacement of Volunteers with Paid Staff:**
Providers are experiencing a decline in volunteerism, requiring them to replace volunteers with paid workers, especially for services like Meals on Wheels, community transport, social support, and group activities.

"The reduction of volunteer boards might be an example. In some areas, if the volunteers drop, the service price will skyrocket because we will need to hire paid staff."

**8.6 Increased Insurance Costs:**
Insurance costs are rising due to additional risks associated with the new regulatory framework, including civil penalties and compensation provisions. These costs need to be reflected in the indexation methodology.

**8.7 Non-Labour Costs, including Fuel Prices:**
Indexation should include provisions for non-labour costs, such as the fuel price index, as these directly impact service delivery costs, especially in transport-heavy activities.

**8.8 Wage Increases and Award Variations Across Jurisdictions:**
Wage increases must reflect Fair Work rulings and account for variations across state and territory Awards and Enterprise Agreements. Additionally, market rates need to be competitive with health and NDIS sectors to attract and retain a qualified workforce in a competitive environment.

"Indexation needs to align with EBA and award increases. There's a lot of advocacy, particularly in allied health and nursing, around huge pay increases in those disciplines."

Question 9: To what extent should IHACPA consider price benchmarking for similar services provided under comparable schemes in adjacent sectors (for example, NDIS, DVA) and why?

While some level of benchmarking with comparable schemes such as NDIS and DVA is important, this should be approached with caution to ensure the unique aspects of each sector are properly accounted for. Key considerations include:

**9.1 Comparison of Regulatory and Operational Costs:**
Any benchmarking exercise must also consider the cost of regulatory compliance and the operational demands within each funding model (NDIS, DVA, and Support at Home). For example, DVA services have fewer regulatory pressures and operational complexity than the proposed Support at Home program, significantly impacting cost structures.

**9.2 Limitations of Existing Program Prices:**
It cannot be assumed that the unit prices set under other programs, such as NDIS or DVA, adequately or accurately reflect the true cost of service provision. Providers have indicated that NDIS unit prices often fail to cover the total delivery cost, with some suggesting that rates need to increase by 30%. Any benchmarking exercise for Support at Home must account for such disparities. A comparable pricing methodology must clearly define the operational and regulatory cost differences between these sectors to ensure the benchmarked prices are meaningful and appropriate.

**9.3 Ensuring Competitive Aged Care Pricing**:
In saying the above, although there will be variances between sectors, it is critical that aged care pricing remains competitive with NDIS and DVA. Providers have increasingly opted to offer their services to the NDIS rather than aged care due to more attractive pricing structures. Furthermore, higher pricing in NDIS has historically impacted the aged care workforce, where they have chosen to work in the sector that 'pays more'. This trend creates disparities in service availability, reducing the accessibility of essential services for aged care clients.

## Pricing Adjustments

Question 10: What factors, if any, should be considered as cost differences that should be accounted for in the pricing of in-home aged care services?

In answering this question, it is important to consider the unique cost factors associated with each service type**.** Below is a table summarising the high-level cost factors specific to various in-home aged care services, highlighting the resources, equipment, and non-contact time required for effective service delivery.

**Table 10.1: Cost Factors for Individual Service Types**

| | |
|---|---|
| **Nursing Services** | **PPE:** Gloves, handwash/sanitiser, aprons, masks<br>**Equipment & Tools:** Nurses are usually equipped with a 'kit bag' from their organisation that includes essential equipment such as stethoscopes, blood pressure monitors, blood sugar monitors, scales, thermometers, pulse oxymeters, bladder scanners and first aid kits<br>**ITC:** Phones, laptop/tablets, sim cards and monthly phone expenses, and licences for the software programs<br>**Consumables**: Dressings, catheters, syringes, cotton balls and tips, saline.<br>**Additional Costs** include stock management, equipment calibration (though often cheaper to replace), and safety systems for tracking staff in the field. They also include EAs and organisational policies, including covering the costs for CPD (Continuing Professional Development) and registrations. Fleet vehicles require clinicians to fill with petrol and provide vehicle maintenance/ safety checks regularly.<br>**Non-contact Time:** Documentation. Providers spoke of the clinical supervision and case conferencing costs that usually occur before and after a client visit. There were also comments around 'reflective practice time' that needed to be considered. |
| **Allied Health Individual** | **PPE:** Gloves, handwash/sanitiser, aprons, masks<br>**Equipment**: Varies by discipline – some examples:<br>*Podiatrist:* Use multiple-use medical instruments or disposable medical instruments. If multiple-use equipment is used, there are additional sterilising costs such as sterilising equipment, equipment maintenance and audits.<br>*OT (occupational therapy):* Tape measure, mobility equipment, exercise equipment.<br>*Physiotherapist:* Exercise equipment (balls, bands, weights), mobile massage table.<br>**ITC:** Phones, laptops/tablets, SIM cards, monthly phone expenses, and licences for software programs (for example, OTs might use software like OT Draw for prescription activities).<br>**Consumables**: Dressings<br>**Additional Costs** include equipment maintenance and replacement, as well as sterilisation and sanitisation of equipment. Safety systems/duress for tracking staff in the field. As well as EAs and organisational policies, including covering the costs for CPD (Continuing Professional Development) and registrations. Fleet vehicles require clinicians to fill with petrol and provide vehicle maintenance/safety checks regularly.<br>**Non-Contact Time**: Loading equipment in and out of the vehicle, documentation, care planning, and report writing. Technical drawing for home modifications. Clinical supervision, training, and buddy systems for new staff and students also take significant time and cost. |
| **Allied Health Group** | **PPE:** Gloves, handwash/sanitiser, masks<br>**ITC:** Phones, laptops/tablets, sim cards, monthly phone expenses, and licences for the software programs<br>**Equipment:** Larger exercise equipment such as treadmills, recumbent bikes, and hydrotherapy pools. Smaller exercise equipment such as balls, resistance bands, balance boards, and chairs (for chair exercises)<br>**Additional Costs** include maintaining gym equipment, hiring space (e.g., hydrotherapy pools), and marketing for group services. As well as EAs and organisational policies, including covering the costs for CPD (Continuing Professional Development) and registrations.<br>**Venue Costs** include maintenance, rental/rates, insurance, security and cleaning of venue<br>**Non-Contact Time:** Setup and cleanup/sanitisation time for group activities, administrative tasks (coordinating bookings, scheduling, and confirming attendance), and marketing of group sessions.<br>**Staffing:** Allied health assistants may support groups under an allied health practitioner (in many cases multiple staff may be required for group support)<br>**Other considerations:** Attendee cancellations can impact the overall viability of a group exercise class. If 2-3 people cancel, the group service may no longer be viable, but we still have to run it for the other attendees. Time to load equipment in and out of car if not a permanent venue. |

| | |
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| **Therapeutic Services** | **PPE:** Gloves, handwash/sanitiser, masks<br>**ITC:** Phones, laptops/tablets, sim cards, monthly phone expenses, and licences for the software programs<br>**Equipment:** Varies by discipline- – some examples:<br>*Acupuncturists:* Need needles, sterilisation equipment, sharps containers, heat lamps.<br>*Chiropractors and Osteopaths:* Require equipment like physiotherapists, such as treatment tables.<br>*Art Therapists:* Art supplies, sometimes digital tools (e.g., VR technology for therapy sessions).<br>*Remedial Masseuses:* Portable massage beds, oils, and linens (including the cost of cleaning and sterilisation).<br>**Additional costs:** include sterilisation materials, procedures and equipment maintenance, especially for acupuncturists and chiropractors.<br>Other considerations: setup and cleanup time (e.g., for massage beds or art therapy sessions). |
| **Domestic Services** | **PPE:** Gloves, handwash/sanitiser, masks, safety switches.<br>**Consumables:** Cleaning products (varies across organisations).<br>**ITC:** Phones/Tablet sim cards, phone expenses, and licences for the software programs.<br>**Additional Costs:** Safety systems/duress for tracking staff in the field. Providers also stated additional training expenses as the workers are often unqualified entry-level employees. They also said that even if qualified additional training was undertaken, the training is needed as staff are not trained in domestic services under the current Cert III<br>**Rostering**: Additional rostering time is often needed as rostering staff must consider ergonomic and manual handling impacts and roster staff to avoid repetitive strain on workers. |
| **Personal Care** | **PPE:** Gloves, handwash/sanitiser, aprons masks, shoe covers<br>**ITC:** Phones/Tablet sim cards, monthly phone expenses, and licences for the software programs.<br>**Additional Costs:** Safety systems/duress for tracking staff in the field.<br>**Other Considerations:** Services may be shorter in length (meal and medication prompting/ assistance, night tuck-ins). |
| **Social Support Individual** | **PPE:** Gloves, handwash/sanitiser, masks<br>**ITC:** Phones/Tablet sim cards, monthly phone expenses, and licences for the software programs.<br>**Additional Costs:** Safety systems/duress for tracking staff in the field. Reimbursement for expenses like coffee during outings for volunteers/workers.<br>**Other Considerations:** Reliance on volunteers for social support; should volunteering be reduced, this would need to be paid work. |
| **Social Support Group** | **PPE:** Gloves, handwash/sanitiser, masks<br>**Equipment:** Furniture, equipped kitchen, maintenance of kitchen appliances and equipment, and activity supplies (craft materials, board games, etc.).<br>**Consumables:** Food and refreshments.<br>**Venue Costs:** include maintenance, rental/rates, insurance, security and cleaning of venue.<br>**ITC:** Phones/Tablet, sim cards, monthly phone expenses, and licences for the software programs.<br>**Other Considerations:** Reliance on volunteers; should volunteering reduce, this would need to be paid work. |

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| **Respite Services (Centre-based or Cottage)** | **PPE:** Gloves, handwash/sanitiser, masks<br>**Equipment:** Furniture, an equipped kitchen, maintenance of kitchen appliances and equipment, and activity supplies (craft materials, board games, etc.).<br>**Consumables**: Food, back up continence supplies.<br>**Venue Costs** include maintenance, rental/rates, insurance, security and cleaning of venue<br>**ITC:** Phones/Tablet, sim cards, monthly phone expenses, and licences for the software programs.<br>**Additional costs:** food safety compliance.<br>**Other Considerations:** Reliance on volunteers; should volunteering reduce, this would need to be paid work. |
| **Transport Services** | **PPE:** Gloves, handwash/sanitiser, masks<br>**ITC:** Phones/Tablet sim, cards, phone expenses, and licences for the software programs<br>**Equipment:** The fleet vehicles, car mats, seat protectors, hoists.<br>**Fleet Maintenance**: Servicing costs, repair costs, insurance costs, registration.<br>**Additional costs** include driver certification and training, parking, and toll fees. The cost of administrating checks that driver licences are current and unrestricted as well as the cost of utilisation of staff own vehicles administrating registration and insurance checks<br>**Other Considerations:** Downtime for vehicle servicing/maintenance, sanitisation/cleaning between clients/trips. Rising petrol prices significantly affect operating costs. Compliance with new bus regulations. |
| **Home Maintenance** | **PPE:** Gloves; boot covers, handwash/sanitiser, masks, goggles, safety switches<br>**ITC:** Phones/Tablet, sim cards, monthly phone expenses, and licences for the software programs.<br>**Equipment:** Gardening tools, lawnmowers, trailer or larger vehicle to transport equipment and a supply of materials<br>**Additional costs** include fuel for equipment and stock management, storage space/shed, tip fees.<br>**Other considerations:** The travel time to the local hardware store or office to get supplies needed. Some jobs may require two people, increasing labour costs (for example, gutter cleaning). |
| **Care Management** | **PPE:** Handwash/sanitiser, masks.<br>**ITC:** Phones, laptops/tablets, sim cards, phone expenses, and licences for the software programs and mobile printers.<br>**Equipment:** Fleet vehicle and associated costs.<br>**Additional costs** include managing a clinical workforce, including clinical supervision, and, depending on EA or organisational policy, the cost of CPD and registrations.<br>**Non-Contact Time**: Documentation, care planning, and report writing.<br>Clinical supervision, training, and buddy systems for new staff and case conferencing. |
| **Restorative care management** | **PPE:** Handwash/sanitiser, masks.<br>**ITC:** Phones, laptops/tablets, sim cards, phone expenses, and licences for the software programs and mobile printers.<br>**Equipment:** Fleet vehicle and associated costs.<br>**Additional costs** include managing a clinical workforce, including clinical supervision, and, depending on EA or organisational policy, the cost of CPD and registrations.<br>**Non-Contact Time**: Documentation, care planning, and report writing.<br>Clinical supervision, training, and buddy systems for new staff and case conferencing. |

| | |
|---|---|
| **Meal Preparation** | **PPE:** Gloves, handwash/sanitiser, masks, hair nets.<br>**ITC:** Phones, laptops/tablets, sim cards, phone expenses, and licences for the software programs.<br>**Kitchen equipment:** Commercially equipped kitchen, including appliances and backup generators.<br>**Kitchen maintenance:** Maintenance and replacement of equipment. Regular cleaning of kitchen and appliances.<br>**Consumables:** Perishables/ food, packaging costs, labelling costs<br>**Additional costs** include food safety compliance and audits, including thermometers, monitoring and documentation time, waste management, and food stocktake. Cost of a nutritionist to advise on menus. Special diet certifications (i.e. Halal). |
| **Meal delivery** | **PPE:** Handwash/sanitiser, masks.<br>**Equipment:** The fleet vehicles, car mats, seat protectors, boxes/ Eskys to transport food in.<br>**Fleet Maintenance**: Servicing costs, repair costs, insurance costs, registration.<br>**Additional costs** include parking and toll fees. The cost of administrating checks that driver licences are current and unrestricted as well as the cost of utilisation of staff own vehicles administrating registration and insurance checks.<br>**Other considerations:** The social aspects of delivery (checking the client's well-being, ensuring previous meals were consumed) and disposing of uneaten food. Reliance on volunteers; should volunteering be reduced, this would need to be paid work. |

Question 11: What factors should be considered in the pricing adjustments to allow for differences in costs within a given service type, and why? Please provide rationale and evidence to support your answer.

Below are key considerations that must be reflected in the pricing structure to ensure it accurately represents the true cost of service delivery.

**11.1 Professional Discipline-Specific Costs:**
Please refer to Table 10.1 for a detailed breakdown of Allied Health and Therapy services. It's important to recognise that these services encompass a variety of professional disciplines, each with its own unique cost structures. For example, podiatrists, occupational therapists, and physiotherapists have different equipment, tools, and operational requirements. In addition, Allied Health salaries vary between disciplines. As part of the costing study, engaging directly with these professional groups is essential to understanding and fully quantifying these specific cost variables.

**11.2 Service Setting Variability:**
Service setting is another key factor. The cost of providing an hour of physiotherapy, for instance, can vary depending on whether it is delivered in a clinic, in a client's home, or via telehealth. A clinic setting incurs costs related to the space—whether rented or owned—while in-home services require consideration of travel expenses, and virtual services depend on telehealth equipment. Many providers operate a hybrid model, combining these delivery settings, which must be factored into the pricing adjustments. This variability applies across allied health, therapeutic, and nursing services.

**11.3 Reliance on Volunteers:**
Another important variable is the reliance on volunteers to deliver certain services. This can differ significantly between home care organisations. Some providers rely heavily on volunteers to deliver or supplement services—such as transport drivers, social support groups, and Meals on Wheels—and even in day-to-day operational management, reducing direct costs. Conversely, other providers must employ a paid workforce to fulfil these roles, increasing costs. These differences in volunteer usage must be accurately represented in the pricing study. Furthermore, when considering volunteers it should not be overlooked that the same workforce management costs such as recruiting, onboarding, training, rostering, supervision and support, insurance etc apply.

**11.4 Higher-Risk or Specialised Client Groups:**
Some services within the same service type cater to higher-risk or specialised client groups, such as those with dementia or low socioeconomic status. These services may require higher staffing ratios (e.g., sending

two staff members for personal care services due to safety concerns like substance abuse) or the use of more skilled workers (e.g., dementia-specific social support programs). These variables should be considered when making pricing adjustments.

**11.5 Social Support Program Variability:**
The nature of social support groups' programs can also cause cost variations. Some programs are centre-based, incurring costs for premises (rent, lease, or ownership), while others are outing-based, where coordination of group outings or events becomes a significant cost consideration. A hidden expense for Social Support Programs is the cost of transport of individuals to and from the group setting. As with other service types, some programs may also rely on volunteers, while others require a fully paid workforce.

**11.6 Transport Service Variability:**
Transport services can vary significantly, not only due to travel time and travel distance but also because of client-related variables. For example, some clients require door-to-door service, where assistance is needed to help the client out of the house, into the vehicle, and then into a destination such as a doctor's surgery. Other scenarios include clients who decline a scheduled service after the transport provider has already arrived, clients who are not ready when the transport service arrives, or clients who are not at the agreed pick-up location. These factors add complexity, time and impact cost to transport services, which should all be considered in pricing adjustments.

Question 12: Should particular service types be considered for additional pricing adjustments to recognise social support aspects of the service? Which services? Please provide a rationale and evidence to support your answer?

**12.1 The Importance of Social Support Across Services:**
Providers consistently agree that none of the services they deliver is **"just the service provided."** Many clients experience isolation and loneliness, so making contact with staff and social interactions are vital to their well-being. A simple phone call to check on a detail can easily turn into a 20-minute conversation, offering crucial social support.

Building rapport and trust is essential when visiting a client for the first time in their home. For instance, imagine entering the home of an older person you've never met and needing to assist them with personal care, such as showering. Before the service begins, time must be allocated to establish trust and comfort.

"None of our services are 'just' the service we provide — Meals on Wheels provides essential monitoring and companionship. Any group service provides a one-to-one service as well — informal referral chat, informal counselling, checking in on people."

**12.2 Follow-Up and Check-Ins During Key Events:**
Additional costs arise when following up with clients during events like hospitalisation, extreme weather conditions, pandemics, or instances where the client is not at home. Providers must check on the client's safety and well-being, which incurs significant follow-up costs.

**12.3 Service Types Requiring Additional Pricing Adjustments for Social Support:**
Key service areas where social support aspects are particularly relevant and should be considered for additional pricing adjustments include:

- **Meals on Wheels:** Meals delivered through Meals on Wheels are critical in providing welfare checks and social interaction for clients, many of whom may not speak to anyone else all day. This is distinctly different from bulk meal delivery services, where meals are dropped at the door, offering little or no social interaction.
- **Rural and Remote Areas (Thin Markets):** In rural and remote areas, there are fewer face-to-face assessment services and fewer care finders or system navigators willing to travel. In many cases, local providers are left to support clients with access to services, help with My Aged Care questions, and other navigation issues. The social component is heightened in these areas where services are less frequent, and clients often rely more heavily on their local provider for both practical and emotional support.
- **Specialist Programs (e.g., Dementia Care):** Programs like dementia care involve increased personal interaction and support. Carers and clients themselves can often require a higher degree of social engagement, reassurance, and emotional support that extends beyond the technical aspects of care.
- **Social Support Groups:** Social support groups, such as exercise classes, extend beyond the activity. Once a group session ends, clients often wish to engage with staff individually or connect socially with other group members. This additional time and interaction come at a cost, as staff must extend their engagement beyond the allocated session time. This is mirrored in allied health group classes.

- **No-Shows and Welfare Checks:** All service types incur costs when clients are no-shows or fail to answer their door or phone. Providers are often required to conduct welfare checks, which can involve contacting family members, speaking with neighbours, calling the police, or filing serious incident reports. These activities involve a combination of the direct care worker, office staff, managers, and other personnel, contributing to the overall cost of providing care.

## Question 13: Is the pricing method fit-for-purpose across all geographic areas, including areas where there are think markets?

**13.1 Challenges in Rural, Remote, and Thin Markets:**
Rural and remote areas and thin markets face clear disadvantages that must be addressed in the pricing method. These areas face unique challenges, including the cost of travel distance and travel time, as well as higher costs for essential goods and services necessary for operations. This includes fuel expenses, training, technology support, recruitment incentives, relocation costs for staff, living-away-from-home allowances, and locum services, amongst others.

**13.2 Travel Costs Beyond Rural and Remote Areas:**
As highlighted in questions 1 and 2, while rural and remote areas are often the focus when discussing travel-related costs, it's essential to recognise that travel expenses can also be significant in metropolitan and regional areas. For example, the cost and time required to deliver services can increase dramatically in growing urban areas or regions undergoing infrastructure development, such as roadworks. A clear example is found in areas like the lower Gold Coast in Queensland or the Northern Rivers region of New South Wales, where roadworks spanning 2-3 years can severely impact service delivery times and unit pricing. In some instances, attempting to travel just 2 kilometres through city traffic or roadworks can take as long as the service itself.

How can a transport trip involving a 10-minute drive to a GP be priced the same as a 1.5-hour trip to a specialist in a nearby regional town? Similarly, how can a 2-kilometer trip taking 45 minutes through heavy traffic for a personal care worker cost the same as a 2-kilometer trip that takes only 5 minutes in less congested conditions?

How can a transport trip involving a 10-minute drive to a GP be priced the same as a 1.5-hour trip to a specialist in a nearby regional town? Similarly, how can a 2 km trip take 45 minutes through heavy traffic for a personal care worker cost the same as a 2 km trip that takes only 5 minutes in less congested conditions?

These significant variations in travel times and distances must be considered when setting service unit prices.

**13.3 Proposal to Treat Travel Costs Separately:**
While the goal may be to establish a set price for each service, treating travel costs separately from the capped pricing model may be beneficial. Travel is a variable that cannot be consistently contained within the same pricing parameters, particularly in areas with significant geographical challenges, infrastructure issues, or extended travel times. By separating travel costs from the service price cap, the pricing method would allow for more flexibility and fairness across all regions, ensuring that providers can deliver services effectively, regardless of geographic area
.

## Priorities For Future Developments

Question 14: For future years, what do you see as the priority areas for IHACPA to consider when developing advice on adjustments to the service list unit prices?

**14.1 Inclusion of CHSP and NATSIFACP Providers:**
As detailed in Section 5.1, including CHSP and NATSIFACP providers in future pricing studies is essential. Many services on the Support at Home service list, such as Meals on Wheels, Community Transport, Community Nursing, Therapy Centres, and Centre-Based Programs, are currently delivered by these providers. CHSP is the dominant program operating in regional, rural, and remote areas, making their inclusion critical to capturing the true service delivery costs in these locations. Although CHSP and NATSIFACP may not be part of the Support at Home framework from 1 July 2025, they remain a major delivery partner, (as the entry-level home care provider) and in some cases to HCP providers as subcontractors/ brokers) of services identified in the detailed service list.

**14.2 Addressing Regulatory Costs in 2025–2026:**
While IHACPA may suggest that pricing adjustments be made in future years to account for changing regulatory costs, these considerations must be brought forward to the **2025–2026 pricing advice**. The transition to the new Aged Care Act, the new regulatory framework, and the Support at Home program, commencing 1 July 2025, has already started to 'cost' organisations as they work through the changes and start to plan for them. The increased regulatory cost impacts must be accounted for in unit prices from the outset.

"Meeting quality standards: there will be project management, change management, training costs and time to meet standards and how do we fund this"?

**14.3 Time-Limited Funding for Service Transformation:**
Considering a subsidy or levy applied to the capped pricing will be essential to provide time-limited additional funding to support home care providers during the transition to the new regulatory framework and the Support at Home model. This funding would help providers invest in the **service transformation** and regulatory compliance required under the new system.

Question 15: What provider or participant-based factors are important for these or other pricing adjustments? Please provide supporting evidence. Where available.

When considering pricing adjustments, several provider and participant-based factors must be addressed to ensure the sustainability and quality of care in the aged care sector.

**15.1 Increased Costs of Corporate Governance:**
The increased costs associated with corporate governance should also be considered, especially for **non-profit organisations** that traditionally rely on volunteer boards. The shift towards remunerated boards with enhanced responsibilities, due diligence requirements, and increased accountability will add significant costs to these organisations.

**15.2 Costs of Achieving Efficiency:**
IHACPA must recognise that **achieving efficiency comes at a cost**. Investing in digital transformation and service redesign will require significant financial capacity. Providers need the ability to invest in infrastructure and transformation initiatives to ensure they can deliver sustainable, high-quality care. Lessons from other industries that have undergone sector-wide transformation should be considered to develop realistic pricing models that support long-term investment.

**15.3 Managing Growing Complexity and Acuity of Clients:**
As the demand for home care services grows, driven by the limited expansion of hospitals and residential aged care, home care providers will face increasing pressure to manage more complex and acute cases. The **cost of training, capacity building, and the development of new service models** will be vital to ensure that home care providers can meet this growing demand.

**15.4 Decline in Volunteer Workforce:**
The continued decline in the volunteer workforce and the growing reliance on a paid workforce will significantly impact future unit costs. Many services have traditionally depended on volunteers, and replacing these roles with paid staff will increase operational costs, which must be reflected in future pricing adjustments.

**15.5 Preparing for and Managing Natural Disasters and Climate Change:**
The costs of preparing for and managing **natural disasters** and the ongoing impact of **climate change** should also be considered. The increasing frequency of floods, fires, and pandemics adds unforeseen costs to home care providers, which need to be factored into future pricing models.

"Consideration for the cost of natural disasters and continuity of service is needed"

**15.6 Closer Monitoring of the Workforce Market:**
IHACPA should also closely monitor **workforce market trends**, including the costs of salaries and wages at local, state, and federal levels. Not all providers operate within national awards, and it is important to recognise that many providers operate with wage instruments and market forces that are above modern awards. Providers must be able to offer competitive wages to attract and retain staff, especially in a tightening labour market, and these factors should be considered in future pricing adjustments.

## Question 16: Providers are required to provide safe and high-quality care. What safety and quality of care issues should be considered as part of IHACPA's pricing advice?

Providers are responsible for delivering safe, high-quality care under increasingly complex regulatory and operational conditions. Several key issues related to safety and quality of care must be considered in IHACPA's pricing advice to ensure that providers can sustainably meet these standards.

**16.1 Compliance with Regulatory Frameworks and Quality Standards:**
Transitioning to the new Aged Care Act and strengthened regulatory frameworks brings new safety and quality obligations. Providers must allocate resources for compliance with updated **Aged Care Quality Standards**, which include expanded requirements for clinical governance, supported decision-making, and rights protections. The costs associated with meeting these standards—such as staff training, auditing, and compliance reporting—must be incorporated into pricing to ensure that providers can maintain safe, high-quality care.

**16.2 Managing High-Risk and Complex Clients:**
As the acuity and complexity of clients in home care increases, providers are required to manage more specialised care. This includes higher staffing ratios for clients with dementia or behavioural concerns and the need for more experienced and qualified staff. Additionally, providers must be able to respond to **incidents, health emergencies, and changing care needs**. These considerations drive up the cost of service delivery and must be reflected in pricing.

**16.3 Training and Workforce Development:**
Maintaining a well-trained workforce is central to ensuring safety and quality of care. Providers face significant costs related to ongoing staff training, upskilling to meet new care requirements, and ensuring that workers are knowledgeable about **infection control, manual handling, medication administration**, and other critical safety protocols. This is especially important in managing higher-acuity clients or during public health emergencies like pandemics. Adequate funding for training must be included in unit pricing to maintain the necessary safety standards.

**16.4 Non-Contact Time and Documentation:**
To ensure safe and high-quality care, staff require time to engage in non-contact activities such as **reading care plans, documenting incidents, following up on feedback, and care coordination**. These administrative tasks are crucial to monitoring client safety and ensuring that care is delivered according to best practices, but they are often uncompensated in pricing models. Pricing advice should account for the time and resources required for proper documentation, communication, and compliance with safety protocols.

**16.5 Addressing Workforce Pressures:**
The quality of care is closely linked to attracting and retaining a skilled workforce. Providers must offer competitive wages, especially given the challenges in hiring and retaining staff in rural, remote, and thin markets. With increasing wage demands, particularly above modern awards in some regions, and the **decline in volunteer workers**, pricing models must reflect rising labour costs to maintain adequate staffing levels and ensure continuous safe care.

"Indexation needs to align with EBA and award increases. There's a lot of advocacy, particularly in Allied Health and Nursing, around huge pay increases in those disciplines."

**16.6 Response to Emergencies and Disasters:**
The ability to respond to natural disasters, pandemics, and other emergencies is a critical aspect of ensuring client safety. Providers must invest in **contingency planning**, protective equipment (PPE), duress alarms, and other safety measures to protect staff and clients. In cases where clients are no-shows or welfare concerns, providers also need to conduct welfare checks, which involve coordination among various staff members and external stakeholders. These unpredictable costs, linked to ensuring safety and quality, should be factored into pricing.

**16.7 Technology and Digital Transformation:**

Providers increasingly rely on technology to monitor client health and ensure safety through telehealth, digital health records, and remote monitoring. The costs of **implementing and maintaining these technologies**, along with ensuring data security and privacy compliance, are rising. Digital transformation is crucial to improving safety and quality of care, and adequate pricing should support these investments.

IHACPA's pricing advice must reflect the comprehensive costs associated with maintaining safety and high-quality care in home care services. This includes compliance with regulatory standards, managing complex care needs, ongoing staff training, non-contact time for administrative duties, workforce challenges, emergency preparedness, and investments in technology. By factoring in these considerations, IHACPA can ensure that providers are equipped to deliver care that meets the safety and quality expectations of both clients and the broader aged care sector.

# Contacts

Thank you for the opportunity to submit a response to the consultation on the exposure draft for the new Aged Care Act. If you have any questions or would like to discuss the recommendations provided, please contact:

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