# Support at Home Aged Care Cost Collection 2025

## Final Report

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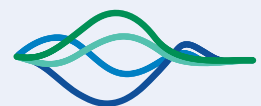

**Support at Home Aged Care Cost Collection 2025 — 26 November 2025**

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# Glossary

| Acronym | Definition |
|---|---|
| **ACFR** | Aged Care Financial Report |
| **ACN** | Aged Care Network |
| **ACPR** | Aged Care Planning Region |
| **CALD** | Culturally and Linguistically Diverse |
| **CHSP** | Commonwealth Home Support Program |
| **CMS** | Care/Client/Customer Management System |
| **department** | Department of Health, Disability and Ageing |
| **DRS** | Data Request Specification |
| **EOI** | Expression of Interest |
| **HCP** | Home Care Packages |
| **IHACPA** | Independent Health and Aged Care Pricing Authority |
| **MMM** | Modified Monash Model |
| **NAPS** | National Approved Provider System |
| **NDIS** | National Disability Insurance Scheme |
| **PII** | Personally Identifiable Information |
| **QA** | Quality Assurance |
| **QFR** | Quarterly Financial Report |
| **SAHCC25** | Support at Home Cost Collection 2025 |
| **SDMS** | Secure Data Management System |
| **STRC** | Short-Term Restorative Care |

# Table of contents

**Glossary** ... 3
**Executive Summary** ... 6
Purpose and scope ... 6
Data collection approach ... 6
Key findings ... 6
Data considerations ... 8
Recommendations ... 9
**1 Overview** ... 10
1.1 Background ... 10
1.2 Purpose and scope ... 10
**2 Methodology** ... 12
2.1 Governance, risk and ethics in project delivery ... 12
2.2 Provider engagement ... 12
2.3 Participation framework ... 13
2.4 Data collection ... 14
2.5 Quality assurance ... 18
2.6 Costing process ... 20
**3 Participant characteristics** ... 23
3.1 Population ... 23
3.2 Participants ... 24
**4 Key Findings** ... 33
4.1 Overview of the SAHCC25 ... 33
4.2 Data considerations ... 35
**5 Cost insights** ... 38
5.1 Overview ... 38
5.2 Total cost and activity volumes ... 39
5.3 Overall unit costs by subcategory ... 40
5.4 Distribution of unit costs by subcategory ... 44
5.5 Unit costs by participant characteristics ... 47
5.6 Proportion of costs by cost category ... 59
5.7 Shift type distribution ... 62

6 Recommendations for future cost collections ..... 65
7 Participant feedback ..... 72
7.1 SAHCC25 feedback ..... 72
7.2 Insights from participants ..... 72
Appendix A – Support at Home service list ..... 74
Appendix B – Information session slides ..... 85
Appendix C – Target participant characteristics ..... 89
Appendix D – Confidence intervals ..... 91
Appendix E – Detailed reporting of allied health and therapeutic service subcategories ..... 94
Appendix F – Unit costs for all subcategories ..... 96

# Executive Summary

## Purpose and scope

The Independent Health and Aged Care Pricing Authority (IHACPA) engaged Scyne Advisory to support the delivery of the Support at Home Cost Collection 2025 (SAHCC25). This cost collection aimed to strengthen the evidence base underpinning IHACPA's pricing advice to the Minister for Health and Ageing for Support at Home services for financial year (FY) 2026–27.

The SAHCC25 focused on capturing FY2023–24 branch level cost and activity data across Home Care Package (HCP) and Short-Term Restorative Care (STRC) service providers to reflect the in-coming Support at Home service list, implemented on 1 November 2025. The Commonwealth Home Support Program (CHSP) will transition no earlier than 1 July 2027 and will be included in future collections.

The SAHCC25 collection specifically aimed at exploring whether there were any variances in the cost of delivering services to the SAHCC25 target cohorts:

- Aboriginal and Torres Strait Islander peoples
- people from Culturally and Linguistically Diverse (CALD) backgrounds
- rural and remote populations.

To better identify this variation, data was collected at a branch level, using the service branch definition from the Support at Home program manual.

## Data collection approach

The SAHCC25 implemented a flexible, tiered approach to collect FY2023–24 financial, activity and workforce data to calculate unit costs for items on the Support at Home service list. Support at Home service list items such as assistive technology, home modifications, and prescribed nutrition were outside the scope of SAHCC25.

The tiered approach encouraged participation through allowing providers to choose the data submission method that was most achievable for them within the data submission period including structured templates, system data extracts or additional support.

The tiered approach effectively reduced barriers to participation, evidenced by a low provider attrition rate of 14% between confirmation and costing – an improvement compared to recent cost collections.

## Key findings

### Overview of the SAHCC25

**Objective 1: Collect cost data from 100 branches**

The first objective of the SAHCC25 was to collect and cost data from 100 branches to inform IHACPA's pricing recommendations for Support at Home services. This objective was achieved, with the SAHCC25 achieving participation from 135 branches across 40 providers, encompassing a total of 35,636 clients. One of the outputs from the collection was a set of unit costs for each Support at Home service subcategory for each participating branch.

Analysis of this data from the 135 branches revealed:

- Personal care, care management and domestic assistance made up more than 70% of reported costs and activity units. Each of the other service types contributed less than 10% to overall costs and activity volumes.
- Nursing services had the highest overall unit cost by subcategory of $216 for registered nurses and $174 for enrolled nurse (including nursing consumables), noting some providers had difficulty identifying whether brokered nursing services were provided by registered nurses or enrolled nurses. Allied health subcategories typically had the next highest unit costs services ranging between $135 for music therapy to $201 for counselling or psychotherapy, while personal care, care management and domestic assistance were lower at $83, $104 and $90 respectively.
- The majority of costs (73%) related to direct labour costs, with the remaining 27% being consumables or indirect costs.
- Approximately 51% of all costs were internal costs (staff plus associated overheads) while 49% of all costs were external third-party costs. This varied by service subcategory with allied health, meal delivery, and home repairs and maintenance service types having the highest proportion of costs that were externally brokered.
- In most cases, where branch level Modified Monash Model (MMM)[1] data was available for all categories (MM1-2, MM3-5 and MM 6-7) the unit cost for MM6-7 was higher than MM1-2 and MM3-5. This was the case for all service types except nursing, physiotherapy and direct transport.
- On average, the unit cost for branches that met the target criteria for CALD populations was lower than for the non-target cohorts across most subcategories, with the exception of total allied health services where the unit cost was similar to the non-target cohorts.
- In most cases, the unit cost for branches that met the target criteria for Aboriginal and Torres Strait Islander peoples did not show a consistent trend when compared to the non-target cohort. The unit cost for care management and personal care was 3-5% higher than the non-target cohorts, whereas unit cost for registered nurses was 54% lower than the non-target branches. The unit cost for total allied health services was demonstrated to be higher than the non-target cohort.

**Objective 2: Increase participation of target cohorts to explore variability**

The second objective of the SAHCC25 was to increase the participation of the target cohorts to explore whether there were any variances in the cost of service delivery. To achieve this, the SAHCC25 collected data at the branch level to provide better visibility over possible variations between services, moving away from the historical provider level data collection approach.

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[1] Modified Monash Model | Australian Government Department of Health, Disability and Ageing

The SAHCC25 achieved the desired participation, with 57 of the 135 participating branches (42%) falling within the target cohort group. The number of clients from these target branches was 50% (17,891) of the total clients within the SAHCC25 sample.

Despite the more granular data collection, inconsistent variation was observed across the SAHCC25 target cohorts compared to the broader sector. While there was some evidence of higher unit costs in more rural areas for certain service categories, this evidence was not sufficiently consistent to constitute a definitive finding of the project.

A number of factors may have influenced this outcome:

- While there was reasonable coverage of the target cohorts based on their proportionate representation within the sector, the sample size by branches and number of clients of the target cohort was still relatively small. As a result, the findings were influenced by a few branches with high volumes of activity. A larger sample may reveal clearer cost variation trends between cohorts.
- Some participants noted challenges in allocating costs across services and to individual branches, dampening any cost variations that may have existed. This was more prevalent amongst larger providers.
- Given that target cohorts are defined as branches with at least 50% Aboriginal and Torres Strait Islander clients, people from CALD backgrounds, or branches located in regional, rural or remote areas (MM3-7), approximately 53% of all National Approved Provider System (NAPS) service IDs across the sector (representing 46% of clients) met the criteria for inclusion in one or more target cohorts. This broad definition may limit the ability to clearly distinguish cost differences between target and non-target branches. Furthermore, since the thresholds for client characteristics were set as at least 50%, a substantial proportion of clients within a ‘target’ branch may not belong to the focus cohort, potentially distorting cost comparisons.
- While branches are typically assigned a MMM classification based on their registered location, some providers reported that branches were often situated in larger towns for operational efficiency despite serving clients in rural or remote areas. This distorted the potential cost variation of delivering services to clients based in more remote locations.

These findings, along with the data considerations below, informed the SAHCC25 recommendations.

# Data considerations

The SAHCC25 aimed at collecting data aligned to the services defined on the Support at Home service list. Given these services were not defined during the period for which the data was collected (FY2023–24), there were some challenges experienced with data collection and limitations in the costed output produced. These challenges include:

- Many providers did not capture accurate activity data for care management staff during the FY2023–24 period as care management was not a separate service and care management fees were based on client package value rather than the number of hours of care management delivered. As a result, the SAHCC25 collected total worked hours of care

management staff and worked with providers to estimate what percentage of these hours aligned to the new chargeable service definition.
- The volume of activity data for brokered services, particularly allied health and meal delivery services, was difficult to collect for the FY2023–24 reporting period. This was due to a lack of detail in invoices from third-party providers and the capture of third-party services in Support at Home provider systems. Where activity data was unable to be collected accurately, both financial and activity data were excluded from the costing process and no unit cost was calculated.
- For many providers, the service branch level of reporting did not align to their existing operations which resulted in the allocation and apportionment costs and activity across branches, reducing the visibility of potential variances.
- Additionally, to report costs for only HCP and STRC programs, providers needed to extract information from datasets that also included CHSP services. As these 3 programs often share a common workforce, providers sometimes relied on allocation and apportionment methods, which reduced the reliability of the data provided.

# Recommendations

Drawing on insights from SAHCC25 and previous cost collections, a set of recommendations has been developed to support the ongoing improvement of cost collection efforts for the Support at Home sector. Recommendations for future cost collections include:

1. Future cost collections should aim to collect data at the most granular level possible where accuracy can be achieved, enabling any potential cost variation to be identified throughout the sector. Target cohorts should continue to be a focus for cost collections.
2. Future cost collections should continue to offer a flexible data collection approach, as this removes barriers to participation and encourages the involvement of target cohorts.
3. HCP, STRC and CHSP data should be collected for future cost collections to reduce instances of allocation and apportionment to produce the required data.
4. The timing of future cost collections should be scheduled to avoid significant reporting periods within the sector to allow key provider personnel to support the collection of required data.
5. A diverse cohort of third-party allied health and meal delivery providers should be engaged to provide additional information on their prices and volume/duration of services provided.
6. Emerging data sources aligned with the commencement of Support at Home on 1 November 2025, such as monthly client statements reported to Services Australia, should be considered to support targeted reviews into areas where further insights are required. Such areas include indirect allied health and nursing hours, and care management services.
7. IHACPA should continue to work with the department and the sector to understand availability of different data sources and the impact of Support at Home changes to future cost collections

# 1 Overview

## 1.1 Background

The Independent Health and Aged Care Pricing Authority (IHACPA) is responsible for the provision of pricing advice to the Minister for Health and Ageing on aged care services. To underpin

this advice, IHACPA conducts annual cost collections to understand the costs incurred by aged care providers during service delivery and monitors changes in these costs over time.

IHACPA engaged Scyne Advisory to support the delivery of the Support at Home Cost Collection 2025 (SAHCC25). The SAHCC25 involved collecting cost data for the financial year ending 30 June 2024 (FY2023–24) from providers of Home Care Package (HCP) and Short-Term Restorative Care (STRC) to produce a robust costed dataset and associated materials relating to the Support at Home program.

From 1 November 2025, the Support at Home program replaced the existing HCP and STRC programs. While STRC and HCP were both in scope for this cost collection, the Commonwealth Home Support Program (CHSP) has been excluded due to the Australian Government's staged approach to introduce CHSP into the Support at Home program no earlier than 1 July 2027.

The Support at Home program was initially scheduled to commence on 1 July 2025. However, on 4 June 2025, the Department of Health, Disability and Ageing announced that the commencement date would be deferred to 1 November 2025. The decision was made to provide service providers with additional time to prepare for the implementation of the program's significant reforms.

A key feature of the Support at Home program is the introduction of a formalised Support at Home service list included in **Appendix A**. The outputs from the SAHCC25 will inform IHACPA's pricing advice to the minister regarding the relevant services on this list. While most services on the Support at Home service list were delivered in some form during FY2023–24, several have since been redefined or significantly reshaped under the Support at Home service list. As such, a set of data mapping assumptions was utilised where necessary to ensure service list items could be costed.

## 1.2 Purpose and scope

The SAHCC25 was the third cost collection commissioned by IHACPA, conducted to underpin pricing advice for Support at Home services for the financial year beginning 1 July 2026 (FY2026–27). Informed by Support at Home Costing Study 2023 and the Support at Home Cost Collection 2024 sampling gaps and following consultation with the sector, IHACPA prioritised the participation and data collection from providers who have not been able to participate in previous cost collections, as well as those who provide care to underrepresented client cohorts, including:

- Aboriginal and Torres Strait Islander peoples
- people from Culturally and Linguistically Diverse (CALD) backgrounds
- rural and remote populations.

Data collection for the SAHCC25 was undertaken at the service branch level, rather than the broader provider level, in order to better capture cost variations across different cohorts and the wider sector. The Support at Home program manual's definition of a service branch was adopted for the SAHCC25.

A service delivery branch is defined as "*the place of business of the registered provider through which funded aged care services are delivered to an individual*"[2].

Throughout this report, a service delivery branch will be referred to as a "branch".

[2] *Support at Home program manual – A guide for registered providers*: Section 6.9.2

# 2 Methodology

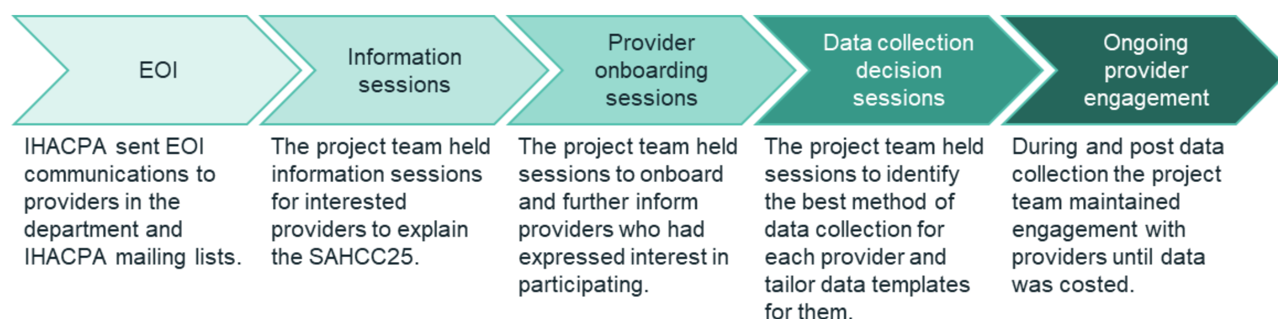
## 2.1 Governance, risk and ethics in project delivery

Robust project governance and risk and issue management processes were implemented and closely adhered to during the SAHCC25. These processes ensured visibility and accountability for all relevant stakeholders throughout the SAHCC25. Prior to commencement, a review of the scope and nature of the SAHCC25 was undertaken and it was determined that ethics approval from a Human Research and Ethics Committee was not required as the data collection fell within the regular responsibilities of IHACPA. IHACPA conducted a Privacy Impact Assessment (PIA) in 2023 which covered the scope of the data collected throughout the SAHCC25.

## 2.2 Provider engagement

Multiple channels were used to engage with providers ahead of, and during, the SAHCC25. A high-level overview of the provider engagement approach is outlined in **Figure 1** below. Before the cost collection began, IHACPA engaged with prospective participants through an expression of interest (EOI) form that was sent by the Department of Health, Disability and Ageing and IHACPA to their respective mailing lists. Once the project had commenced, EOI responses were evaluated to identify HCP and STRC providers that qualified for participation.

Figure 1 - Overview of Provider engagement process




Eligible providers were invited to join SAHCC25 information sessions co-hosted by IHACPA and Scyne. These sessions were held twice weekly over a 6 week onboarding period. After attending, participants were sent the presentation slides and a detailed SAHCC25 information pack (see **Appendix B**).

Interested providers were asked to confirm their participation and nominate a key point-of-contact from their organisation to assist with engagement and data collection throughout the SAHCC25. These stakeholders then participated in onboarding meetings designed to ensure they fully understood the project's purpose, scope, and their individual responsibilities. Onboarding meetings were followed by data collection decision sessions, during which the preferred data collection method for each participant was agreed upon and providers were given ample opportunities to ask questions and engage directly with the project team. Provider engagement continued once data collection was completed, with regular meetings and communications maintained as data progressed through the quality assurance (QA) and costing processes.

## 2.3 Participation framework

A participation framework was developed and implemented to support the identification and selection of participants for the SAHCC25. Where previous cost collections gathered data at the provider or ACPR level, the SAHCC25 focused on acquiring branch level information to improve granularity and more accurately identify cost variations.

Following consultation with the sector, SAHCC25 specifically aimed to encourage participation from branches providing services to a wide variety of clients, with particular emphasis on increasing involvement from three specific target client cohorts:

- Aboriginal and Torres Strait Islander peoples
- people from CALD backgrounds
- rural and remote populations.

The participation framework was underpinned by the HCP and STRC characteristics dataset obtained from the department that included provider and branch demographics as at 30 June 2024.

The dataset provided by the department included summary counts for total clients, Aboriginal and Torres Strait Islander clients, and people from CALD backgrounds. The department calculated these counts according to their own definitions, which were shared in the dataset documentation.

The Aboriginal and Torres Strait Islander peoples client count comprised individuals identified as 'Aboriginal but not Torres Strait Islander origin', 'Torres Strait Islander but not Aboriginal origin', or 'both Aboriginal and Torres Strait Islander origin'.

The count of people from CALD backgrounds included all clients whose country of birth was not Australia, Ireland, New Zealand, Canada, United States of America, South Africa, England, Northern Ireland, Scotland, or Wales. It is noted that this definition may not fully capture the range of cultural and linguistic diversity among individuals born outside these countries, and that not all individuals born elsewhere will have additional care or support requirements. Furthermore, this definition may also overlook the cultural and linguistic diversity that exists within these countries.

For the purposes of the SAHCC25, branches were designated as Aboriginal and Torres Strait Islander peoples or people from CALD backgrounds-focused if at least 50% of clients belonged to the respective cohort. This aligns with other cost collections undertaken by IHACPA within the aged care sector. Branches serving rural and remote populations were identified based on their MMM classification. These branches were grouped into 2 subcategories: those in rural MM3-5 areas and those in remote MM6-7 areas.

IHACPA set a target for the SAHCC25 to include at least 100 branches. Of the participants, it was intended that at least 40% of the branches should service the SAHCC25 target client cohorts.

Wherever feasible, branches were aligned with individual NAPS service IDs. While the objective was to collect data at the most granular level possible, some providers with multiple NAPS service IDs within the same local area reported an inability to separate financial and workforce data between NAPS service IDs as their operations were not separated in this way. This was accepted as an unavoidable aspect of the branch level approach, given that the HCP and STRC programs have not previously been subject to mandatory reporting at this level of detail. As a result,

participating branches in the SAHCC25 may represent one or multiple NAPS service IDs. For providers with multiple NAPS service IDs, data aggregation to the ACPR level was permitted, provided there was a reasonable expectation of cost consistency within each ACPR.

Due to the focus on maximising participation from the target client cohorts, it was recognised from the commencement of the cost collection that the sample of participants of SAHCC25 may not be statistically representative of the broader Support at Home sector. Nevertheless, efforts were undertaken to ensure diversity in participant characteristics across the 100 branches.

**Appendix C** provides detailed information regarding the criteria used to identify branches that aligned with the SAHCC25 targeted cohort, as well as the additional characteristics considered during participant selection.

## 2.4 Data collection

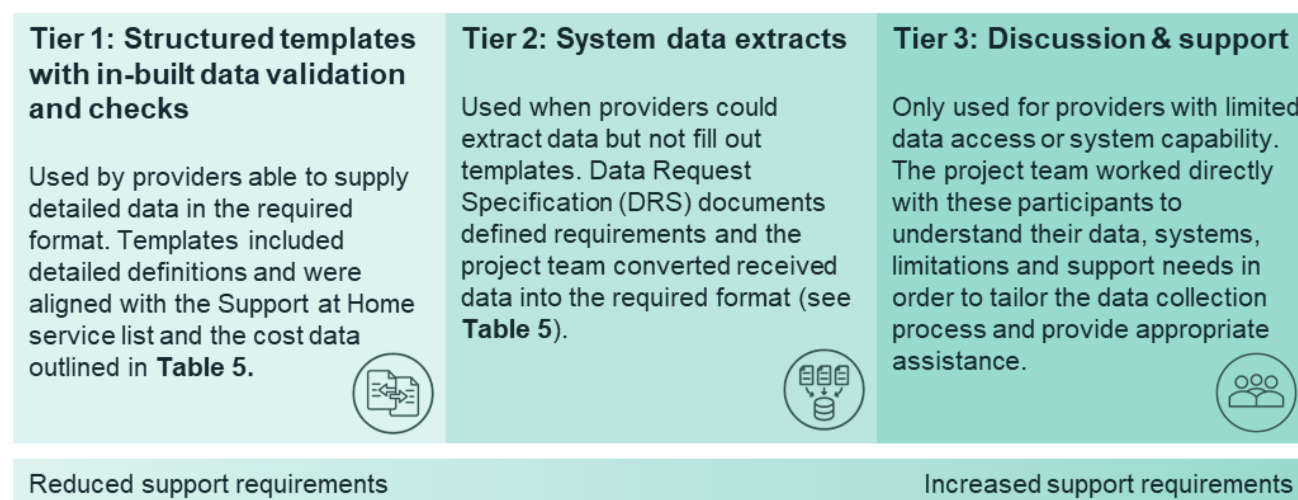
The SAHCC25 involved the collection of FY2023–24 activity, financial, and workforce data for HCP and STRC packages to calculate unit costs for services included on the Support at Home service list. In most cases, data was collected to allow for costing at the service subcategory level. However, when it was anticipated that participants could not provide such detailed information, data was gathered at the broader service type level instead.

For example, 'personal care' was reported as a single category instead of separate subcategories like self-care assistance, medication support and continence management, since providers rarely distinguish these in their systems. Items such as assistive technology, home modifications and prescribed nutrition were outside the scope of SAHCC25.

To collect data from participating branches, the project team used a flexible, tiered approach tailored to each provider's size, location, system maturity and workforce capacity. This year, the focus shifted from aggregate provider level data to more detailed branch level reporting. As this level of detail was new, there were variations in data availability and additional support was provided.

The tiered model allowed providers to mix methods across data categories. The 3 tiers are shown in **Figure 2** below.

Figure 2 - SAHCC25 data collection tiers




Across all tiers, no personally identifiable information (PII) was requested from participants.

The tiered approach to data collection was well received by providers, which is evidenced in the low SAHCC25 provider attrition rate of 14% – a reduction compared to recent cost collections.

The data items and tiered approaches are detailed in **Table 1** below. Additional information on data management is included in Section 2.4.2.

Table 1 - SAHCC25 data types

| Data type | Data items | Tier 1 data collection approach | Tier 2 data collection approach |
|---|---|---|---|
| **Activity data** | • The total number of service hours – relevant for the majority of services such as nursing care, personal care, domestic support and care management<br>• Service volumes split by time of delivery (standard business hours and non-standard business hours) and day of delivery (weekdays, Saturday, Sunday, and public holidays)<br>• Workforce role – type delivering the services<br>• The total number of meals – relevant for meal delivery<br>• Total number of trips – relevant for transport services | A detailed template was provided to participants to capture service hours at the branch level for HCP and STRC services, broken down into internal, agency and subcontracted services. The template also captured the data necessary to support the calculation of loading for services delivered outside of standard hours (e.g. weeknights, weekends and public holidays). | A DRS document was provided to participants outlining the specifics of the requested data extract (usually from their client management system). Notably, this DRS document explicitly stated that PII data was not to be included in a submission as it was recognised that there was an increased risk associated with this approach.).<br><br>Following the submission, the project team worked with the providers to understand the structure, scope and granularity of the activity data extract to enable data preparation into the Tier 1 template. |

| Data type | Data items | Tier 1 data collection approach | Tier 2 data collection approach |
|---|---|---|---|
| **Financial data** | • Direct service labour costs for employed workforce, agency staff and sub-contractors / brokered client service providers<br>• Direct service non labour costs such as consumables and transport costs<br>• Overhead and administrative costs relating to service delivery | A detailed template was provided to participants. This template was designed to resemble the ACFR to ensure familiarity for providers, with additional granularity for certain items. For example, allied health subcategories were listed separately rather than aggregated as they are in the ACFR. | A DRS document was provided to participants outlining the specifics of the requested data extract (such as a trial balance, management accounts or profit and loss accounts).<br>Following the submission, the project team worked with the providers to understand the structure, scope and granularity of the financial extract to enable data preparation into the Tier 1 template. |
| **Workforce data** | • The total paid hours by staff role type<br>• The total hours worked by staff role type<br>• The total amount paid by staff role type<br>This information was collected for participating branches where they were able to accurately separate payroll information for their HCP and STRC staff. | A template was provided to participants to capture total paid amount, total paid hours and total worked hours at the branch level for HCP and STRC services for internal employees only. | A DRS document was provided to participants outlining the specifics of the requested data extract from payroll reports, explicitly excluding PII. |
| **Additional data** | • Provider and branch names and identifier numbers (e.g. NAPS service IDs)<br>• Branch characteristics (e.g. MMM classification, ownership)<br>• Client cohort information (e.g. total number of clients, total Aboriginal and Torres Strait Islander peoples, total number of people from CALD backgrounds) | Sourced from the department. | Sourced from the department. |

## 2.4.1 Data preparation

For providers who were able to complete the Tier 1 templates, these were progressed to quality assurance with minimal adjustment. If providers were unable to provide Tier 1 branch data for one or more of the required data types, further data preparation activities were undertaken to ensure the dataset was able to be costed. These data preparation activities are detailed below.

### 2.4.1.1 Tier 2 activity data preparation

Tier 2 activity data submissions were reviewed for sufficient detail, cleansed of irrelevant fields, separated by funding program and mapped to the Support at Home service list. Timing of services was aligned with standard time categories, and further adjustments were made as needed.

#### 2.4.1.2 Tier 2 financial data preparation

For financial data, Tier 2 extracts were assessed to determine preparation needs, with provider consultation used to clarify cost centres and definitions. The data was then cleaned and manually mapped to the required level of detail, often using activity and workforce data to fill gaps and allocate aggregated costs as accurately as possible.

#### 2.4.1.3 Tier 2 workforce data preparation

Tier 2 workforce data submissions were used to calculate paid hours and wages by role type, with payroll extracts cleaned and aggregated to produce summaries. These were also mapped to service items to support costing.

#### 2.4.1.4 Tier 3 data preparation

In Tier 3 cases, data understanding and preparation occurred concurrently, as the project team collaborated directly with participants to determine what information was available and how it could be utilised for the SAHCC25.

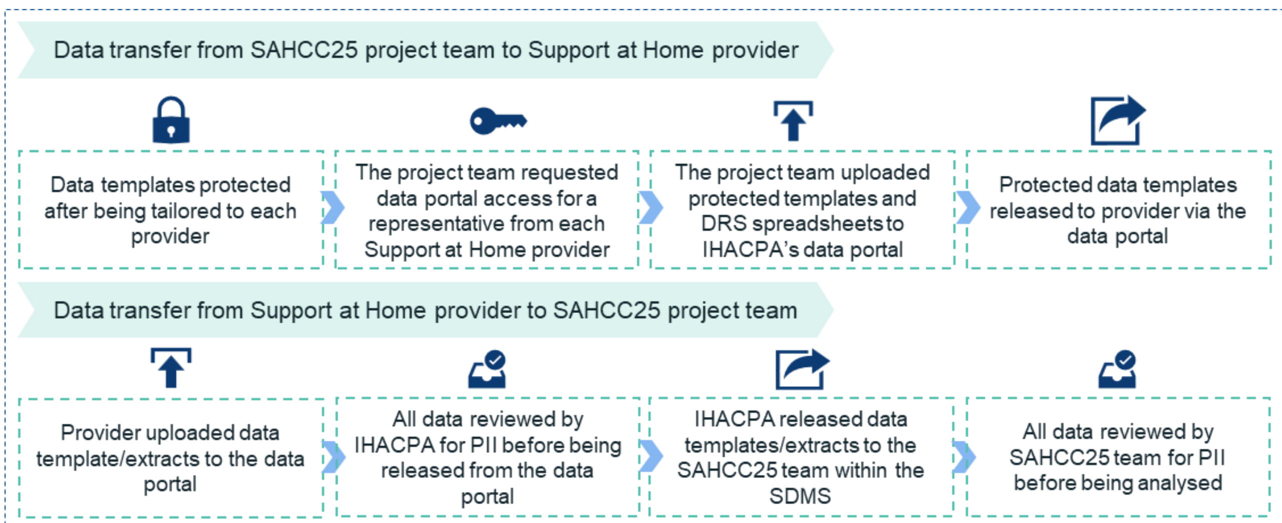
### 2.4.2 Data management plan

Throughout the data collection process, the SAHCC25 project team implemented and followed a robust data management plan.

All data collected throughout the SAHCC25 was transferred using the IHACPA Data Transfer Portal and stored within IHACPA's Secure Data Management System (SDMS). During onboarding, Support at Home providers were asked to nominate someone to receive SDMS access. No PII was requested or stored throughout the project and all data collected and accessed throughout the project complied with the Consultant Access to IHACPA Protected Data Rules. **Figure 3**Error! Reference source not found. demonstrates the data transfer process utilised throughout the SAHCC25.

Templates and DRS documents were designed outside of the SDMS and transferred to providers using the IHACPA Data Transfer Portal. Before the templates were transferred, providers participated in a meeting to tailor the data templates – removing tabs, input cells, definitions and checks that were not applicable – and to receive instructions on SDMS upload. Each template also contained clear instructions on how to transfer information safely into the SDMS and explicitly stated that no PII was to be included in any submissions. Templates were protected to ensure that only required cells could be adjusted by providers when inputting data.

Figure 3 - SAHCC25 data transfer process

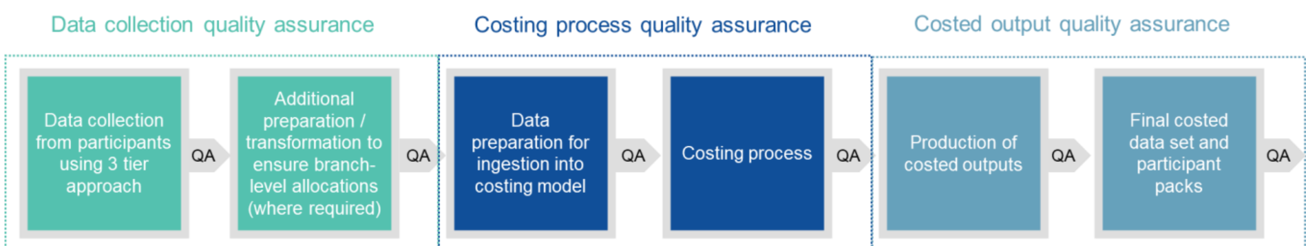



A robust data breach protocol aligned with the IHACPA Data Breach Response Plan was established for the SAHCC25 and IHACPA teams to follow in the event that SAHCC25 data was received from project participants via email or PII was uploaded into the SDMS. This protocol was adhered to during the cost collection.

## 2.5 Quality assurance

Rigorous QA controls were followed throughout each stage of the SAHCC25. **Figure 4** below shows the staged timing of quality controls and processes that were applied during data collection, costing, analysis, and reporting.

Figure 4 - Overview of the quality assurance stages for SAHCC25




Proactive and retrospective QA activities were implemented to optimise the quality of data collected and costed as part of the SAHCC25. Key activities included:

- Built-in checks within template files to ensure data was entered correctly and prevent accidental changes. They also alerted users and the SAHCC25 team if there were any data errors.
- Completeness and consistency checks at each stage to confirm all required information was received and processed accurately. Assumptions for data preparation were discussed and agreed upon with participants.
- A technical review of all data once it had been prepared into templates. This review focused on statistical techniques, professional judgement and materiality in analysing and comparing the submitted data against sector benchmark and FY2023–24 Aged Care Financial Report (ACFR) data. The following checks were conducted during this review:

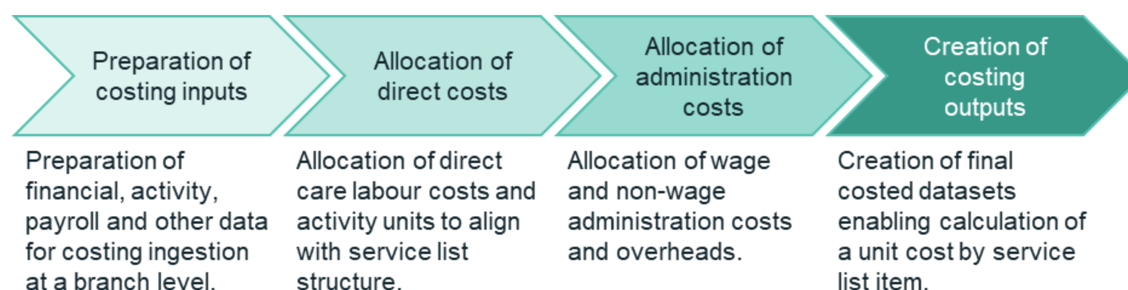
  - Confirmed data completeness by verifying that both cost and activity data were submitted for each service participants reported delivering during early onboarding calls.
  - Confirmed that initial unit costs (basic calculation) for each service were within expected ranges.
  - Confirmed overhead recovery rate (total administration costs divided by total units of activity) was within expected parameters.
  - Cross-checked financial data against ACFR data to determine instances where SAHCC25 costs for a particular category showed a variance exceeding 30% compared to ACFR data.
  - Assessed whether the proportion of billable service hours for staff fell within the expected ranges.
  - Analysed activity data to understand whether the proportionate service volumes were in line with expectations. Branches were flagged for review if they exhibited certain characteristics: specifically, if home support worker activity – covering domestic assistance, personal care, social support, and respite – accounted for less than 50% of total branch activity, or if allied health and nursing activity exceeded 50% of total activity. Both scenarios were considered inconsistent with expected service profiles.
- Final QA on costed outputs to verify data integrity, correct application of allocation rules and accuracy of results.

Any anomalies identified during QA were promptly investigated with providers. Following these discussions, data anomalies were either resolved, clarified, or excluded from the dataset.

## 2.6 Costing process

The costing process commenced after the completion of data collection, data preparation and initial QA activities. An overview of the costing methodology is presented in **Figure 5** below.

Figure 5 - Overview of the SAHCC25 costing process




| Preparation of financial, activity, payroll and other data for costing ingestion at a branch level. | Allocation of direct care labour costs and activity units to align with service list structure. | Allocation of wage and non-wage administration costs and overheads. | Creation of final costed datasets enabling calculation of a unit cost by service list item. |
|---|---|---|---|

### 2.6.1 Preparation of costing inputs

The costing process made use of all data types collected or accessed during the SAHCC25. Details regarding the different data types are provided in **Table 1**. All information was prepared to enable the cost allocation process to begin following the completion of the data preparation stage (see **Section 2.4.1**).

### 2.6.2 Allocation of direct costs

#### 2.6.2.1 Direct labour costs

The initial step involved allocating direct labour costs to each service subcategory, based on the worker types providing those services. This ensured average unit costs reflected each SAHCC25 participant's staffing profile and included all relevant workforce categories. Consequently, a subcategory could have one or more staff type costs assigned directly to it.

The unit cost calculations for most service subcategories were allocated using the number of billable service hours delivered for that subcategory. During data collection and costing for the SAHCC25, Support at Home pricing guidance only permitted billing for face-to-face time with clients. An exception was made for care management, which had slightly different but clearly defined parameters for billable time[3]. Allocating costs based on billable service hours, as opposed to paid or worked hours, ensured that unit costs reflected the actual volume of services delivered by each branch. Service delivery volumes can be influenced by various factors including travel time and distance between clients, client reporting requirements, workforce capacity and rostering practices. Unit costs for direct transport and meal delivery were not allocated based on service hours as they used different activity units – trips for direct transport and number of meals for meal delivery.

Direct labour costs were also allocated by worker type (employee, agency staff or externally brokered service provider) to reflect different service delivery models.

[3] Support at Home pricing guidance for allied health and nursing services was updated in October 2025, to allow certain indirect activities, such as documentation, coordination and case management, service planning, and development, to be billable for nursing and allied health. This change occurred after the completion of the costing process.

#### 2.6.2.2 Other direct costs

After allocating direct labour costs, other direct costs were distributed across service subcategories. Consumables were assigned based on service type, for example, nursing consumables to nursing services, cleaning consumables to domestic assistance (unless otherwise directed by participants), and non-reimbursed meal consumables to meal preparation or delivery. Some exceptions to these rules were made, for example, where nursing consumables existed but the branch had no nursing activity, the consumables were allocated to personal care after agreeing with the participant. Where activity volumes were available, they were used to allocate costs; otherwise, labour costs were used. This consistent method was applied to all remaining direct costs.

### 2.6.3 Allocation of administration costs

Administration and overhead costs were allocated to service subcategories using a combination of 2 methods for each branch.

- Wage-related expenses like workers compensation and payroll tax were allocated based on expenditure as these costs would be expected to change proportionally to labour costs.
- Other overhead costs such as rent and utilities were distributed using service unit volumes (hours). However, for meal delivery and transport services not measured in hours, these costs were allocated based on expenditure.

Administration costs were also split between internal and external delivery, using activity volumes where available or expenditure when necessary.

### 2.6.4 Creation of costing outputs

#### 2.6.4.1 Costed output dataset

The costing process produced a dataset with unit costs for each service subcategory and branch. Costs were split into different cost categories for direct labour (by worker type and staffing model), consumables, meal delivery and transport, administration and support, and payroll tax. The dataset also includes provider and branch names, NAPS service IDs, and characteristics (e.g. MMM classification, ownership) to enable population weighting and further analysis.

Data flags were also added to the final dataset to identify quality concerns or special conditions for individual data points. The types of data quality flags used are presented in **Table 2** below.

Table 2 - SAHCC25 data flags

| Flag type | Flag definition |
|---|---|
| Missing data | Used to indicate missing labour costs or activity for internal, external and aggregated data. |
| Data quality | Used to indicate where data was outside QA parameter ranges. |
| Manual comments | Used to provide additional context to a data point that may have fallen outside of reasonable parameters or where specific treatment of costs or activity were indicated by providers. |
| Unallocated group activity | Used to indicate where a subcategory included group activity but the average number of participants was missing. |

| Flag type | Flag definition |
|---|---|
| Actual care management hours | Used to indicate where a provider directly captured and supplied care management activity as opposed to providing an estimate based on total worked hours. |

QA checks were undertaken on the costed dataset prior to its finalisation (see **Section 2.5** for details).

#### 2.6.4.2 Weighting to population

After developing the costed dataset, sample weights were created based on the dataset provided by the department to align the SAHCC25 sample with the broader in-home aged care provider population. Weighting helped adjust for over- or under-representation and aimed to reflect population characteristics more accurately.

Although data was collected at an operational branch level, it is recognised that each branch serves a diverse range of clients. Given the focus on understanding potential cost variations between client cohorts, weights were applied based on branch State and Territory, ownership type, aged care program (HCP or STRC), and client distribution by client MMM category. The use of client MMM category for weighting purposes is distinct from the classification and reporting of participating branch characteristics and data insights, which are based on branch MMM.

Raking (iterative proportional fitting) was used to apply weights across multiple variables simultaneously, ensuring alignment with population distributions. A weighted cost dataset was then provided to IHACPA.

#### 2.6.4.3 Distribution of services by time and day of delivery

Recognising that labour costs vary depending on when services are delivered, a supplementary dataset was also developed using the data collected for the time of delivery (standard business hours and non-standard business hours) and day of delivery (weekdays, Saturday, Sunday and public holidays).

This dataset captured total activity volumes for these shift categories for each participating branch and service subcategory, enabling IHACPA to analyse service delivery patterns.

#### 2.6.4.4 Confidence intervals

For each service subcategory, a 95% confidence interval was calculated for the estimated unit cost. The confidence intervals represent the range within which the unit cost for the total population is likely to fall, based on the sample data collected. The more varied the sample data, the wider the resulting confidence intervals needed to be 95% confident that the true unit cost for the population lies within the range. The SAHCC25 confidence intervals for each service subcategory is available in **Appendix D.**

# 3 Participant characteristics

## 3.1 Population

As at 30 June 2024, there were 2,084 active NAPS service IDs in Australia, delivering HCP and STRC services to 276,078 clients. These active NAPS service IDs were aligned with 833 unique NAPS provider IDs.

The purpose of the SAHCC25 was to collect data from a broad range of branches, with a particular focus on collecting data from 3 target cohorts:

- Aboriginal and Torres Strait Islander peoples
- people from CALD backgrounds
- rural and remote populations.

**Table 3** presents a summary of the HCP and STRC population for FY2023–24. This table shows that over half (53%) of active HCP and STRC NAPS service IDs met the criteria of the target SAHCC25 cohorts, representing 46% of clients. Furthermore, a considerable proportion of NAPS service IDs met the criteria to be classified as servicing people from CALD backgrounds (28%) and MM3-5 populations (22%), with these also having the largest number of clients of any of the target cohorts, 28% and 16% respectively.

Table 3 - HCP and STRC population FY2023–24

| Cohort | Sector | |
|---|---|---|
| | # of NAPS service IDs | Total # of clients within these NAPS service IDs |
| **Target SAHCC25 cohorts[4,5]** | 1,110 (53%) | 125,717 (46%) |
| **Aboriginal and Torres Strait Islander peoples** | 94 (5%) | 3,475 (1%) |
| **People from CALD backgrounds** | 586 (28%) | 77,239 (28%) |
| **MM3-5** | 451 (22%) | 45,271 (16%) |
| **MM6-7** | 62 (3%) | 1,699 (<1%) |
| **Other SAHCC25 participants** | 974 (47%) | 150,361 (54%) |
| **Total** | **2,084** | **276,078** |

As previously detailed, a minimum threshold of 50% Aboriginal and Torres Strait Islander peoples or people from CALD backgrounds was used to identify specialised branches, consistent with

[4] The total number of branches and clients listed in the aggregated 'target SAHCC25 cohorts' row differs from the detailed breakdown, as some participating branches belong to multiple target cohorts.
[5] The dataset provided by the department contains 41 operational NAPS service IDs (4,874 clients) without an associated MMM classification. As such, these numbers may be slightly understated.

IHACPA's approach in other aged care costing studies. This was intended to ensure cost variations linked to these cohorts were not diluted. However, in practice, nearly one third of all NAPS service IDs and clients meet the target cohort definition for Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds. When rural and remote criteria are also considered, almost half of all NAPS service IDs and clients meet a target cohort definition for the SAHCC25, which may make it difficult to observe clear cost differences between target and non-target branches. Additionally, because the threshold is set as at least 50%, a significant proportion of clients within a 'target' branch may still fall outside the focus cohort, potentially distorting cost comparisons.

Furthermore, while branches typically serve clients residing in areas that align with their registered MMM classification, some providers noted that branches are often located in larger towns for operational efficiency, even when serving rural and remote clients. Consequently, the branch's MMM classification may not always reflect the characteristics of its client base.

Given that both target and non-target cohort branches serve a diverse client base, the opportunity to discern significant cost differences between these groups may be reduced. This may be more evident in services focussing on people from CALD backgrounds, as defining the status of people from CALD backgrounds by country of birth might not consistently reflect differences in care or support requirements.

## 3.2 Participants

The SAHCC25 aimed to collect data from 100 branches, which equates to roughly 5% of the sector based on a presumed 1:1 correspondence between NAPS service IDs and operational branches. It was also required that at least 40 participating branches be selected from the SAHCC25 target cohorts.

Engagement with providers revealed that many organisations do not align their operating structures on a 1:1 basis with individual NAPS service IDs. While clients are registered to a specific NAPS service ID, organisations often manage workforce, operations, and financial reporting through geographic hubs, with limited or no ability to report data at the individual NAPS service ID level.

As detailed previously, while the SAHCC25 aimed to collect data at the most granular level possible, some providers reported aggregated data for multiple NAPS service IDs together under a single branch up to the ACPR level. Aggregation was not permitted across ACPRs or where costs were expected to vary greatly within an ACPR. Conversely, there were also instances where providers submitted data at a more detailed level than the NAPS Service IDs.

### 3.2.1 Summary

At the completion of the SAHCC25, data was costed for 191 NAPS service IDs (equivalent to 9% of operational NAPS service IDs) across 40 NAPS provider IDs. There were 35,636 clients associated with these NAPS service IDs. Due to aggregation, this equated to 135 operational branches, of which 57 branches (76 NAPS service IDs) related to the target SAHCC25 cohorts.

Where data was reported at a level more granular than the NAPS Service ID, the characteristics of the corresponding NAPS Service ID were applied to all associated branches.

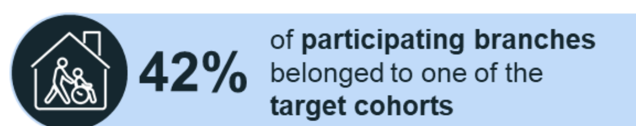
The remainder of this report will focus on participant characteristics and data insights for the 135 operational branches (unless specified otherwise).

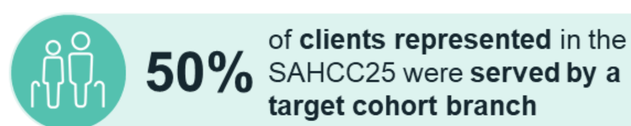
Due to unresolved quality concerns identified during the QA process, data from 2 additional providers, representing a total of 19 operational branches, was excluded from costing and from the statistics presented within this report.

### Table 4 - SAHCC25 participant summary

| Cohort | Participating branches | | |
|---|---|---|---|
| | # of branches | # of corresponding NAPS service IDs | Total # of clients within these branches |
| **Target SAHCC25 cohorts**[6,7] | 57 (42%) | 76 (40%) | 17,891 (50%) |
| **Aboriginal and Torres Strait Islander peoples** | 9 (7%) | 5 (3%) | 988 (3%) |
| **People from CALD backgrounds** | 17 (13%) | 18 (9%) | 11,871 (33%) |
| **MM3-5** | 25 (19%) | 45 (24%) | 4,822 (14%) |
| **MM6-7** | 9 (7%) | 11 (6%) | 253 (<1%) |
| **Other SAHCC25 participants** | 78 (58%) | 115 (60%) | 17,745 (50%) |
| **Total** | **135** | **191** | **35,636** |

**Table 4** provides a breakdown of the SAHCC25 participants by cohort. NAPS service IDs and branch numbers are presented in this table for comparative purposes with the wider sector, however there are certain limitations with both comparisons. The evaluation of whether a branch qualified as one of the target cohorts was conducted at the operational branch level, resulting in all NAPS service IDs within an operational branch being included in the totals shown. As a result, some NAPS service IDs that were initially included in a target cohort no longer met the criteria if their corresponding operational branch did not fulfill the requisite conditions. These services are reported among the 115 NAPS service IDs linked to the 78 branches that did not meet the classification standards for a target cohort. It was not possible to aggregate NAPS service IDs for the general population into operational branches in the same way as was done for the participant group.




Among the participants, 42% of operational branches belonged to a designated target cohort. Specifically, 19% of participating branches were included in the MM3-5 cohort while 13% met the criteria for the for servicing people from CALD backgrounds. Client representation was higher, with 50% of clients in the SAHCC25 sample belonging to a target cohort branch. Although the people

[6] The total number of branches and clients listed in the aggregated 'target SAHCC25 cohorts' row differs from the detailed breakdown, as some participating branches belong to multiple target cohorts.
[7] The dataset provided by the department contains 41 operational NAPS Service IDs (4,874 clients) without an associated MMM classification. As such, some of these numbers may be slightly understated.

from CALD backgrounds and MM3-5 cohorts continued to demonstrate strong representation within SAHCC25, their respective proportions shifted when considering client numbers, with coverage rates of 33% and 14%.

Based on client numbers, the coverage of the SAHCC25 largely was aligned with the sector. The SAHCC25 included a modestly higher representation of branches that met the criteria for Aboriginal and Torres Strait Islander peoples (+2%) and people from CALD backgrounds branches (+5%) compared to the general population, while exhibiting a slightly reduced proportion of clients within MM3-5 branches (-3%). The proportion of clients within MM6-7 branches aligned with that of the overall population, however no MM7 branches were included in the costed dataset despite targeted attempts to recruit this cohort. There was a participant with a small number of MM7 branches however this provider was excluded from costing due to unresolved quality concerns identified during the QA process.

As stated earlier in this report, due to the focus on maximising participation from the target client cohorts, it was not the intent of the SAHCC25 sample to be representative of the broader Support at Home sector. **Figure 6** and **Figure 7** present the proportion of clients served by branches that met the target criteria for Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds in the Support at Home sector against the proportion of clients served by such branches in the SAHCC25 sample respectively. Aboriginal and Torres Strait Islander peoples in the Support at Home sector against the proportion of clients served by such branches in the SAHCC25 sample respectively.

Figure 6 - Clients served by branches that met the target criteria for people from CALD backgrounds

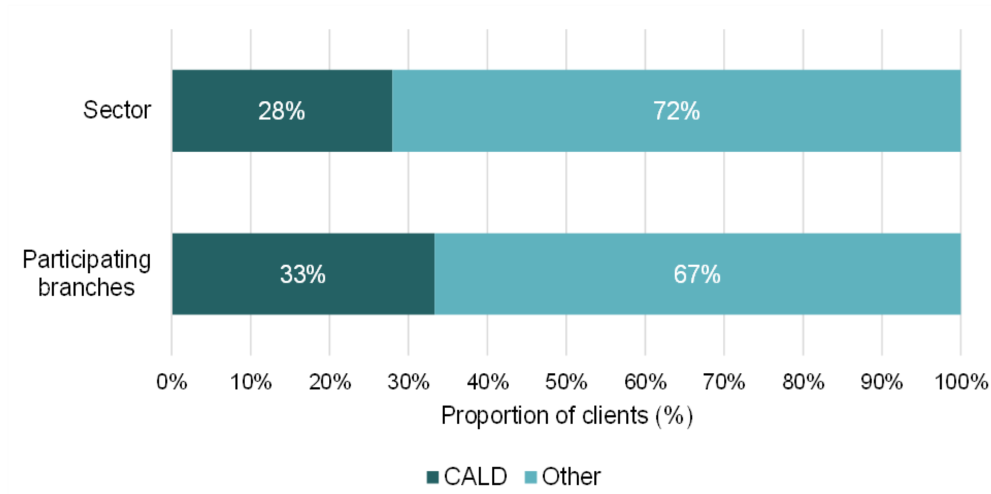
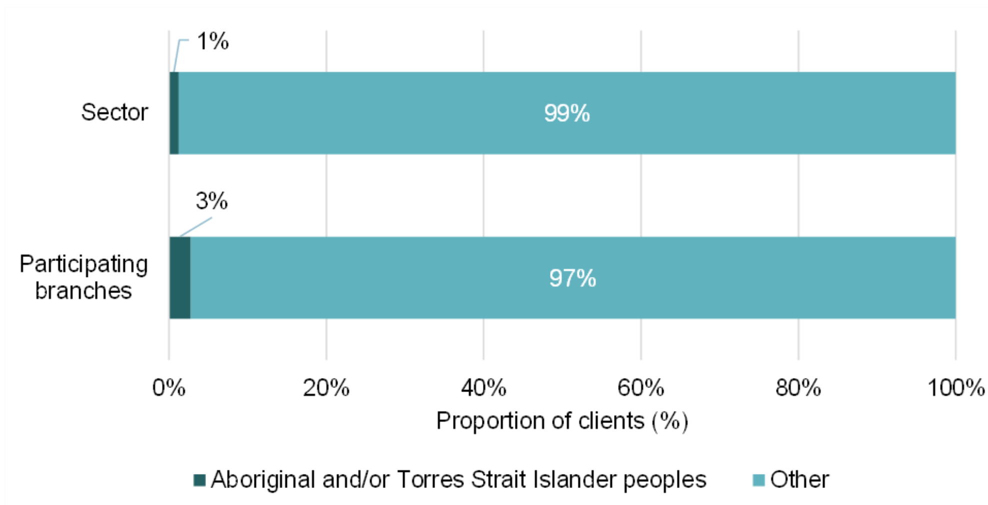


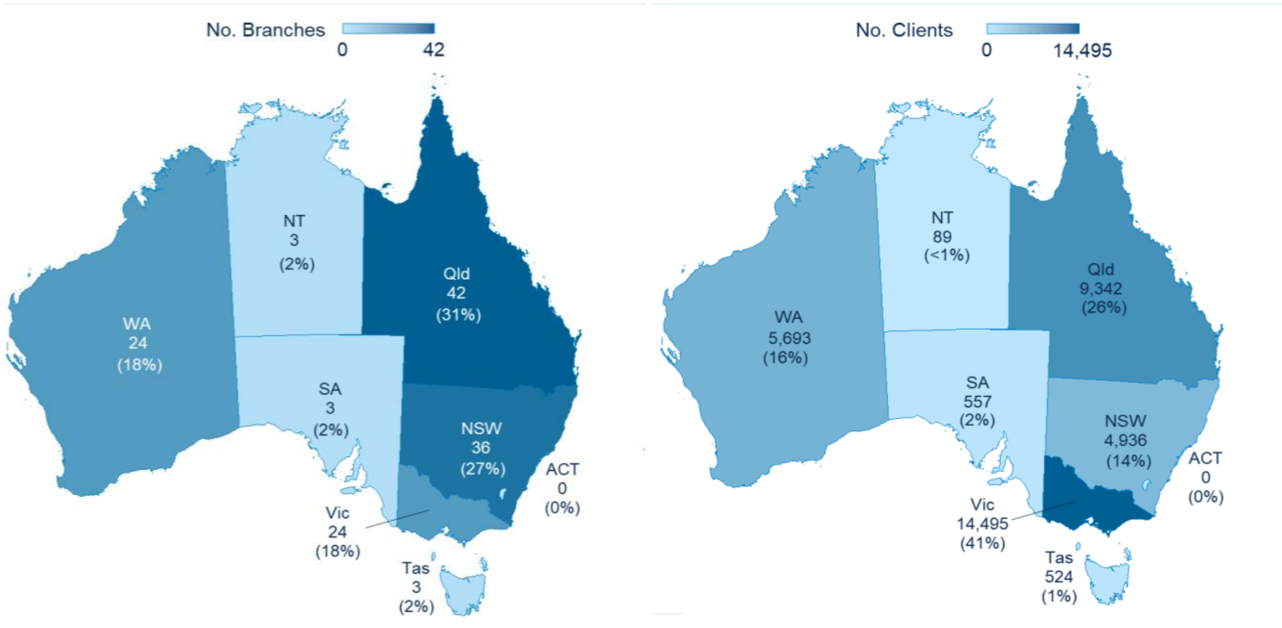
Figure 7 - Clients served by branches that met the target criteria for Aboriginal and Torres Strait Islander peoples




## 3.2.2 State and Territory

**Figure 8** below shows the number of Support at Home branches per State and Territory that participated in the SAHCC25, along with the number of clients served by these branches.

Figure 8 - Distribution of SAHCC25 participants by State and Territory



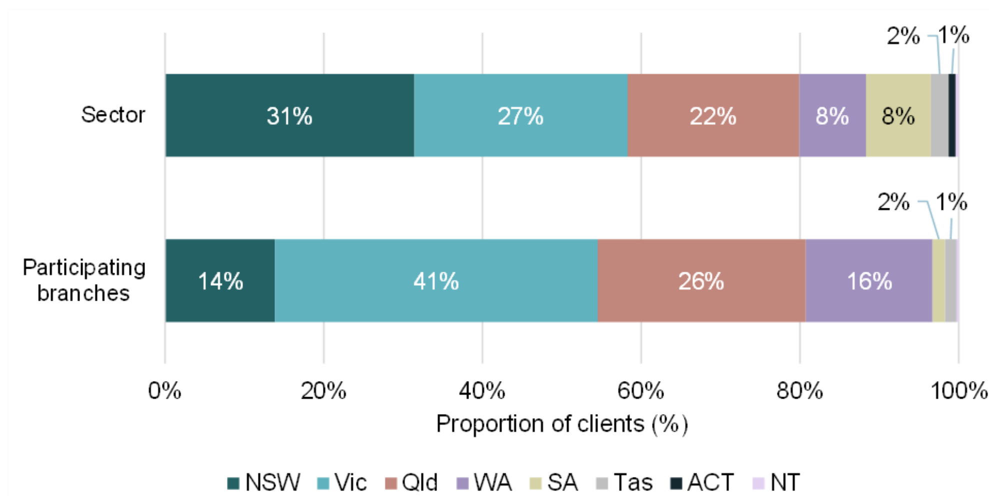

New South Wales, Victoria, Queensland and Western Australia accounted for 93% of participating branches and 97% of participating clients. While Queensland and New South Wales represented a majority of the participating branches, this did not translate to a majority of participating clients, with Victoria providing 40% of client representation within the SAHCC25 sample due to the presence of some particularly large branches.

South Australia, Tasmania and the Northern Territory each had fewer than 5 participating branches and made up the remaining 7% of branches and 3% of clients. No branches or clients from the Australian Capital Territory took part in SAHCC25. Limited participation in these regions was

primarily due to recruitment challenges, particularly in Tasmania, the Australian Capital Territory and the Northern Territory where the number of providers was limited. There was also provider attrition due to withdrawals and inadequate data quality.

As stated earlier in this report, due to the focus on maximising participation from the target client cohorts, it was not the intent of the SAHCC25 sample to be representative of the broader Support at Home sector. Nevertheless, efforts were made to ensure diversity in participant characteristics. **Figure 9** shows the client distribution by jurisdiction for the Support at Home sector against the client distribution by jurisdiction of the SAHCC25 participants.

Figure 9 - Sector and SAHCC25 sample client distribution by jurisdiction




## 3.2.3 Modified Monash Model (MMM)

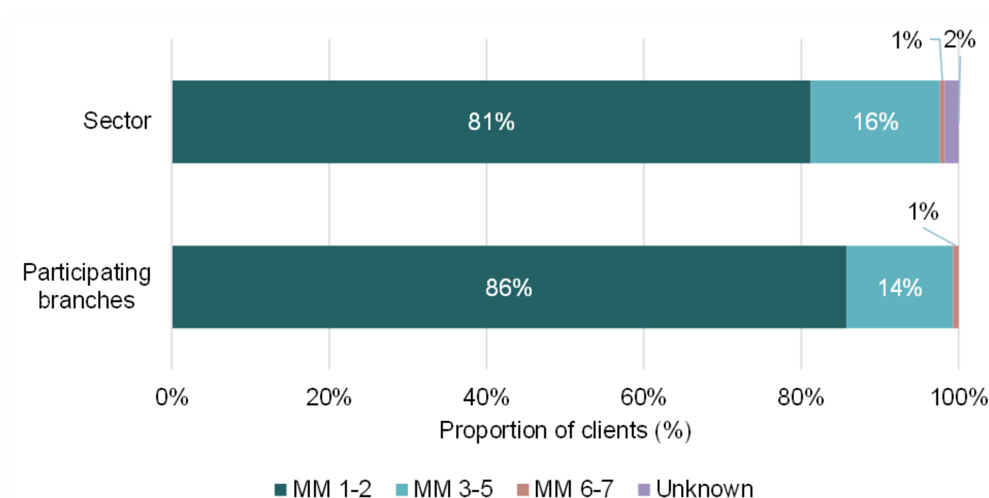
**Table 5** presents the distribution of participating branches according to branch MMM classification. The majority of both branches and clients were located in more densely populated areas, with 75% of branches and 86% of clients registered in MM1 and MM2 regions. This pattern was also evident among branches meeting the criteria for Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds, which showed higher counts of branches and clients in urban areas. Although the SAHCC25 targeted rural and remote areas, these regions still had fewer branches and clients, especially in more remote communities (MM6 and MM7).

## Table 5 - Distribution of SAHCC25 participants by MMM

| MMM | All participating branches | | Aboriginal and Torres Strait Islander peoples | | People from CALD backgrounds | |
|---|---|---|---|---|---|---|
| | # of branches | # of clients | # of branches | # of clients | # of branches | # of clients |
| **1 Metropolitan area** | 80 (59%) | 24,813 (70%) | 6 (67%) | 945 (96%) | 16 (94%) | 11,837 (100%) |
| **2 Regional centre** | 21 (16%) | 5,748 (16%) | 0 | 0 | 1 (6%) | 34 (<1%) |
| **3 Large rural town** | 16 (12%) | 2,855 (8%) | 1 (11%) | 36 (4%) | 0 | 0 |
| **4 Medium rural town** | 3 (2%) | 542 (2%) | 0 | 0 | 0 | 0 |
| **5 Small rural town** | 6 (4%) | 1,425 (4%) | 0 | 0 | 0 | 0 |
| **6 Remote community**[8] | 9 (7%) | 253 (<1%) | 2 (22%) | 7 (<1%) | N/A | N/A |
| **7 Very remote community** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **135** | **35,636** | **9** | **988** | **17** | **11,871** |

**Figure 10** presents the distribution of clients by MMM group (MM1-2, MM3-5, MM6-7) for both the Support at Home sector and the SAHCC25 participants. While the SAHCC25 was not designed to be statistically representative of the broader sector, the composition of the national population and project participants is broadly similar across MMM groups.

## Figure 10 - Sector and SAHCC25 sample client distribution by MMM group




[8] N/A indicates that no branches in the national population met the relevant criteria.

### 3.2.4 Branch size

**Table 6** presents the distribution of participating branches according to the number of clients they support. The data showed significant variation in branch capacities, with the 71 branches serving 100 or fewer clients accounting for just 9% of all participating clients, compared to the largest 11 branches which cover 59% of participating clients.

Although there is considerable variation in the size between the people from CALD backgrounds branches, this variation is less pronounced among the branches meeting the criteria for Aboriginal and Torres Strait Islander peoples and the MM3-5 branches. The notable exception to this is 2 MM3-5 branches with over 1,000 clients each. There were no MM6-7 branches in the SAHCC25 with over 100 clients.

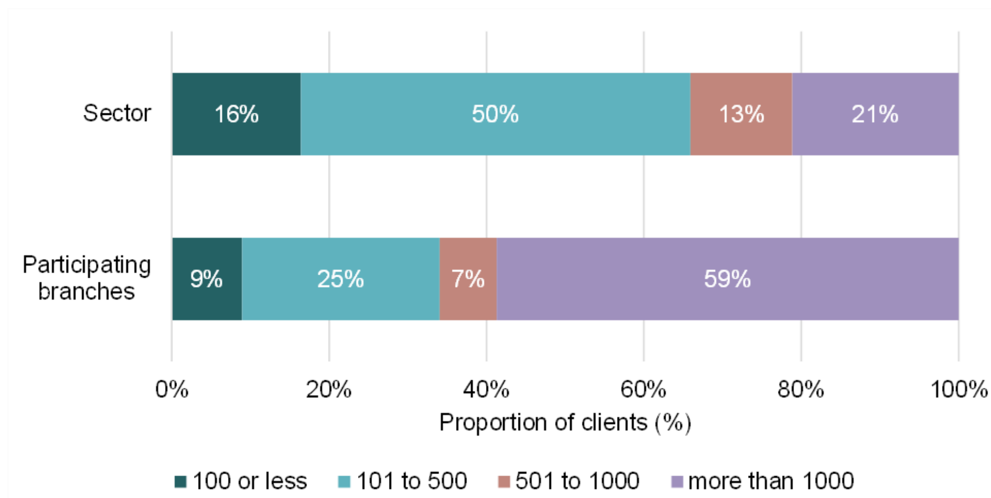
Table 6 - Distribution of SAHCC25 participants by branch[9]

| Branch size | All participating branches | | Aboriginal and Torres Strait Islander peoples | | People from CALD backgrounds | | MM3-5 | | MM6-7 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | # of branches | # of clients | # of branches | # of clients | # of branches | # of clients | # of branches | # of clients | # of branches | # of clients |
| **100 or less clients** | 71 (53%) | 3,187 (9%) | 3 (33%) | 43 (4%) | 6 (35%) | 222 (2%) | 14 (56%) | 660 (14%) | 9 (100%) | 253 (100%) |
| **101 to 500 clients** | 49 (36%) | 8,948 (25%) | 6 (67%) | 945 (96%) | 4 (24%) | 597 (5%) | 9 (36%) | 1,534 (32%) | 0 | 0 |
| **501 to 1000 clients[10]** | 4 (3%) | 2,577 (7%) | N/A | N/A | 2 (12%) | 1,337 (11%) | 0 | 0 | N/A | N/A |
| **More than 1,000 clients[10]** | 11 (8%) | 20,924 (59%) | N/A | N/A | 5 (29%) | 9,715 (82%) | 2 (8%) | 2,628 (55%) | N/A | N/A |
| **Total** | 135 | 35,636 | 9 | 988 | 17 | 11,871 | 25 | 4,822 | 9 | 253 |

[9] Where providers have submitted data for multiple branches under a single NAPS Service ID, client numbers have been apportioned to prevent double counting and avoid overstating branch size.
[10] N/A indicates that no branches in the national population met the relevant criteria.

**Figure 11** presents the distribution of clients by branch size for both the Support at Home sector and the SAHCC25 participants. As mentioned throughout this report, the SAHCC25 was not designed to be statistically representative of the broader sector.

Figure 11 - Sector and SAHCC25 sample client distribution by branch size




### 3.2.5 Ownership

**Table 7** presents the number of participating branches by organisational ownership. Participation from branches within Government owned organisations was low in the SAHCC25, particularly in the cohorts servicing Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds. This reflects the very small proportion of government-run branches nationally (7%), with fewer than 2% meeting the criteria to qualify as an Aboriginal and Torres Strait Islander or people from CALD backgrounds focused branch.

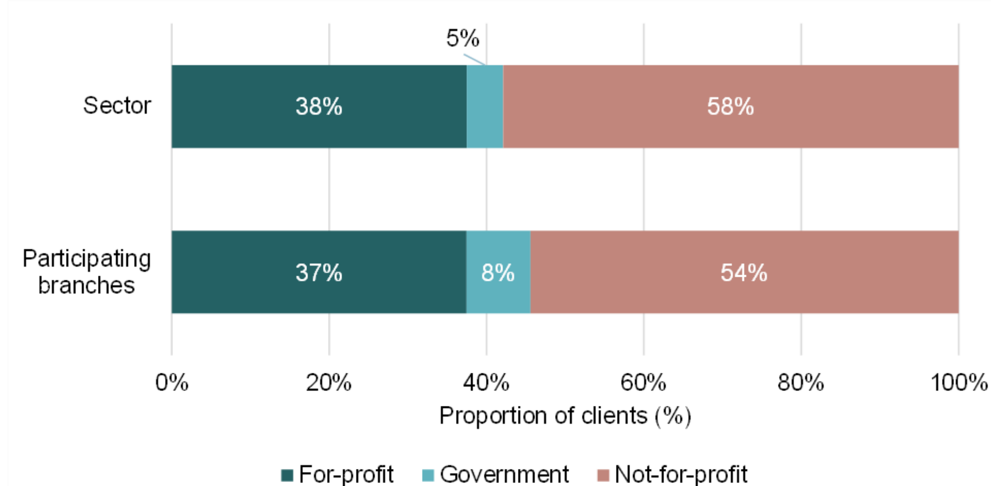
Representation of rural and remote communities within the SAHCC25 was largely through not-for-profit entities. For-profit providers participating in SAHCC25 tended to be based in major towns and metropolitan areas. Participation from larger providers with multiple branches affected the distribution of branches within the sample.

Table 7 - Distribution SAHCC25 participants by ownership

| Ownership | All participating branches | | Aboriginal and Torres Strait Islander peoples | | People from CALD backgrounds | | MM3-5 | | MM6-7 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | # of branches | # of clients | # of branches | # of clients | # of branches | # of clients | # of branches | # of clients | # of branches | # of clients |
| **For-profit** | 29 (21%) | 13,354 (38%) | 5 (56%) | 783 (79%) | 8 (47%) | 11,235 (95%) | 1 (4%) | 197 (4%) | 1 (11%) | 49 (19%) |
| **Government** | 10 (7%) | 2,883 (8%) | 0 | 0 | 0 | 0 | 3 (12%) | 1,640 (34%) | 2 (22%) | 78 (31%) |
| **Not-for-profit** | 96 (71%) | 19,399 (54%) | 4 (44%) | 205 (21%) | 9 (53%) | 636 (5%) | 21 (84%) | 2,985 (62%) | 6 (67%) | 126 (50%) |
| **Total** | **135** | **35,636** | **9** | **988** | **17** | **11,871** | **25** | **4,822** | **9** | **253** |

**Figure 12** presents the distribution of clients by ownership type (for-profit, government, not-for-profit) for both the Support at Home sector and the SAHCC25 participants. As mentioned throughout this report, while the SAHCC25 was not designed to be statistically representative of the broader sector, the composition of the national population and project participants is broadly similar across ownership types.

Figure 12 - Sector and SAHCC25 sample client distribution by ownership type



# 4 Key Findings

## 4.1 Overview of the SAHCC25

**Objective 1: Collect data from 100 branches**

The SAHCC25 sought to collect and cost data from 100 branches to inform IHACPA's pricing recommendations for Support at Home services. Of these, a minimum of 40 branches were to be selected from the target cohorts. This year, data collection occurred at the branch level to facilitate more accurate identification of potential cost variations between target cohorts and other participating branches.

Based on the definition of a service branch from the Support at Home program manual, data was collected and costed for 135 branches across 40 providers, encompassing a total of 35,636 clients.

Analysis of total costs and activity by Support at Home service type revealed that more than 70% of both reported costs and activity units were attributed to personal care, care management and domestic assistance. The other service types each contributed less than 10% to overall costs and activity volumes.

Nursing services had the highest overall unit cost by subcategory, with the hourly unit cost for registered nurses at $216 and enrolled nurses at $174 (including nursing consumables), noting some providers had difficulty identifying whether brokered nursing services were provided by registered nurses or enrolled nurses. The next highest unit costs were typically associated with different allied health service subcategories, ranging between $135 for music therapy to $201 for counselling or psychotherapy, though most subcategories ranged between $150 and $170 per hour. Unit costs for the high-volume services of personal care, care management and domestic assistance were $83, $104 and $90 respectively. As expected, meal delivery had the lowest unit cost as this was calculated on a per meal basis.

Approximately 73% of the reported costs were attributable to direct labour, while the remaining portion comprised consumables and indirect expenses. Most direct labour costs were related to home care workers' salaries.

In most cases, where branch level Modified Monash Model (MMM)[11] data was available for all categories (MM1-2, MM3-5 and MM6-7) the unit cost for MM6-7 was higher than MM1-2 and MM 3-5. This was the case for all service types except nursing, physiotherapy and direct transport.

On average, the unit cost for branches focused on service delivery to people with culturally and linguistically diverse backgrounds was lower than for the non-target cohorts across most subcategories, with the exception of total allied health services where the unit cost was similar to the non-target cohorts.

In most cases, the unit cost for branches that met the target criteria for Aboriginal and Torres Strait Islander peoples did not show a consistent trend when compared to the non-target cohort. The unit

[11] Modified Monash Model | Australian Government Department of Health, Disability and Ageing

cost for care management and personal care was 3-5% higher than the non-target cohorts, whereas unit cost for registered nurses was 54% lower than the non-target branches. The unit cost for total allied health services was observed to be higher than the non-target cohort for the SAHCC25 sample.

Internal expenses, encompassing staff costs and related overheads, constituted approximately 53% of total expenditures, while external third-party costs represented the remaining 47%. Services such as allied health, meal delivery, and home repairs and maintenance exhibited the highest proportion of externally brokered costs, although this distribution differed across specific service subcategories.

**Objective 2: Increase participation of target cohorts to explore variability**

This year, a tailored data collection approach was implemented, allowing providers to choose the data submission method that was most achievable for them within the project timeline. The tiered approach was successful in reducing barriers to participation, evidenced by the low provider attrition rate of 14% between confirmation and costing, an improvement compared to recent cost collections.

Out of the 135 participating branches, 57 (42%) belonged to at least one target cohort. Despite representing less than half of all participants, they provided services to 50% (17,891) of the total clients associated with the participating branches. It is important to note that some branches belonged to multiple cohorts and may have been counted more than once.

Figure 13 - Participating branches belonging to target cohorts

| | Aboriginal and Torres Strait Islander peoples | People from CALD backgrounds | MM3-5 | MM6-7 |
|---|---|---|---|---|
| **Participating branches** *(percentage of total participating branches)* | 9 *(7%)* | 17 *(13%)* | 25 *(19%)* | 9 *(7%)* |
| **Total clients served by participating target branches** *(percentage of total participating clients)* | 988 *(3%)* | 11,871 *(33%)* | 4,822 *(14%)* | 253 *(<1%)* |

Based on client numbers, the coverage of the target cohorts within the SAHCC25 was generally consistent with the sector (see **Section 3.2** for details).

As indicated earlier, data collection and cost analysis were conducted at the branch level this year to determine whether any potential variations in costs could be identified between the target cohorts and other participants.

Despite the more granular data collection, inconsistent cost variation was observed across the SAHCC25 target cohorts when compared to the broader sector. While there was some evidence of higher unit costs in more rural areas for certain service categories, this evidence was not sufficiently consistent to constitute a definitive finding of the project.

A number of factors may have influenced the findings of the SAHCC25:

1. While there was reasonable coverage of the target cohorts based on their proportionate representation within the sector, the sample size by branches and number of clients of the

target cohort was still relatively small. Consequently, the findings were influenced by a few branches with high volumes of activity. A larger sample may reveal clearer cost variation trends between cohorts.

2. Some participants noted challenges in assigning HCP and STRC costs and activities to individual branches, as well as correlating these operational branches with National Approved Provider System (NAPS) service IDs. In cases where internal systems did not readily support data segmentation to this level, some providers employed methodologies which led to similar unit costs being assigned across multiple branches, dampening any cost variations that may have existed. This was more prevalent amongst larger providers.
3. The breadth of the criteria used to qualify target cohorts may have resulted in a reduced ability to distinguish variances in cost between target and non-target branches. Given that target cohorts are defined as branches with a client base of at least 50% Aboriginal and Torres Strait Islander peoples, or people from CALD backgrounds, or branches located in rural or remote areas (MM3-7), approximately 53% of all NAPS service IDs across the sector (representing 46% of clients) meet the criteria for inclusion in one or more target cohorts. Furthermore, since the thresholds for client characteristics were set at 50%, a substantial proportion of clients within a 'target' branch may not belong to the focus cohort, potentially distorting cost comparisons. This may be more evident in people from CALD backgrounds focused services, where defining the CALD status of a person by country of birth, as was done in the underlying dataset provided by the department, may not consistently reflect differences in care or support requirements.
4. While branches are typically assigned an MMM classification based on the registered location of the branch, some providers reported that branches are often situated in larger towns for operational efficiency, even when serving clients in rural or remote areas. As a result, the MMM classification may reflect the characteristics of the entire client base. Given that both target and non-target cohort branches serve a diverse client base, the opportunity to discern significant cost differences between these groups may be reduced.

These findings informed the recommendations outlined in **Section 6**.

## 4.2 Data considerations

Throughout the data collection process, it was evident that data for certain services or delivery streams (internal, agency, brokered) could not be collected easily or effectively due to misalignment between reporting practices in FY2023–24 and the reporting requirements of the incoming Support at Home service list.

These data considerations are detailed in **Table 8** below.

### Table 8 - Data considerations

<table>
<tr><th>Area</th><th>Details</th></tr>
<tr><td>Care management</td><td>During the FY2023–24 reporting period, care management fees were based on client package value rather than the number of hours of care management delivered. The introduction of care management as a defined hourly service took effect from 1 November 2025 with the introduction of the Support at Home program.<br><br>Due to this, most providers did not capture the hours of care provided by care management staff with the level of detail required for the SAHCC25.<br><br>Where this information was not available, total worked hours of the care management staff for the branch were collected along with an estimate of the percentage of worked hours that aligned to the new Support at Home program definitions and what would be considered billable under the Support at Home service list. Where possible, this assumption was determined and agreed with providers prior to progressing to costing. Where a provider was unable to contribute to the determination of a billable factor, an assumption of 70% of total worked hours was applied.<br><br>Even when providers had care management activity data, they often could not distinguish between clinical and non-clinical care management. Unless participants submitted data for these categories separately, costing was undertaken at the aggregate care management level without further breakdown.</td></tr>
<tr><td>Brokered services</td><td>The volume of brokered service activity was difficult for providers and the SAHCC25 project team to ascertain for the FY2023–24 reporting period. This was due to 2 non-exclusive reasons:<br>• A lack of detail included in the invoices of third-party providers, including visibility over the duration, or volume of units provided.<br>• Third-party services were commonly recorded as one appointment or order, regardless of the actual service duration or quantity delivered. This meant that capturing an accurate volume of activity and subsequently creating a unit cost per hour was not possible in many cases.<br><br>Where this information was not available and it was not possible to make appropriate assumptions as to the volume of activity provided, a unit cost was not calculated.<br><br>Adjustments to the data were required when the branch and subcategory was missing activity or labour cost information. Removing the costs for which there was no activity ensured the unit costs were not overstated and vice versa. This resulted in a reduction of approximately 6% of total collected costs, of which brokered allied health and meal delivery contributed a high proportion.</td></tr>
<tr><td>Transport</td><td>During the FY2023–24 period, transport activity was predominately captured as duration (hours) and distance (kilometres travelled). The Support at Home service list will require the capture of transport services as a per trip unit. In the case of many providers, historical reporting practices made it challenging to identify the number of trips. This was compounded by the fact that many providers did not report transport separately to other services delivered as part of the same booking. For example, if a client's booking included transport to the grocery store, assistance with shopping, and then transport home, all hours and kilometres were recorded as domestic assistance.<br><br>Where this information was not available and it was not possible to make appropriate assumptions as to the number of trips undertaken, a unit cost was not calculated.</td></tr>
<tr><td>Delineation of costs between funding programs</td><td>The SAHCC25 collected data exclusively for the HCP and STRC programs. For many providers, this meant extracting data for these programs from broader 'aged care' datasets that also included CHSP services. As these 3 programs often share a common workforce, de-coupling costs, payroll data and activity units for group services was difficult and at times, impossible. As a result, providers sometimes relied on allocation and apportionment methods, which reduced the reliability of the data provided.</td></tr>
</table>

| Area | Details |
| --- | --- |
| **Group activities** | There were several common challenges experienced in collecting data for group activities:<br>• **Inability to separate group and individual service costs:** some participants did not record group and individual services separately in their systems. For example, they could only report total costs for social support services.<br>• **Difficulty allocating group service costs to HCP and STRC:** some participants found it challenging to allocate group service costs specifically to HCP and STRC programs as opposed to other programs. For instance, if a staff member transported 2 HCP clients and 2 CHSP clients in the same vehicle, the associated costs were not clearly attributed in their systems.<br>• **Limited visibility of client numbers by funding program:** Some participants were unable to confidently report the number of HCP and STRC clients participating in group activities, separate from clients funded through other programs such as CHSP, the Department of Veterans' Affairs or the National Disability Insurance Scheme.<br>Each of these challenges introduced potential misalignment between cost and activity data, affecting the accuracy of unit cost calculations. |
| **Service level granularity** | As the Support at Home service list was not in effect during FY2023–24, it was acknowledged that providers would unlikely be able to report data separately for every subcategory. This was due to the common practice among providers of not distinguishing between similar services in their internal reporting. In such cases, data was collected at the broader service type or for a selection of subcategories.<br>Examples include:<br>• **Personal care** data was collected as a whole, rather than separately for assistance with self-care and activities of daily living, assistance with the self-administration of medication and continence management (non-clinical).<br>• **Domestic assistance** data was collected as a single category, rather than being broken down into general house cleaning, laundry services and shopping assistance.<br>• **Social support and community engagement** data was collected only for the subcategories of group social support, individual social support and digital education support, as it was not expected that providers could reliably distinguish the remaining subcategories. |

While these data considerations had to be factored into the data collection and costing processes, they did not materially impact the ability to complete SAHCC25.

# 5 Cost insights

## 5.1 Overview

This section examines the unit costs for different subcategories of Support at Home services and the unique characteristics of individual aged care provider branches to identify trends in collected unit cost data.

Throughout this section of the report, analysis results have been presented in the 3 main groups below. These groups were established to support the interpretation of the analysis and facilitate better comparison between similar services and those provided by comparable workforce types.

Figure 14 - Service groups for SAHCC25 cost insights

**Group 1:** all subcategories in the care management, nursing care, domestic assistance, personal care, respite and social support service types.

**Group 2:** all subcategories in the allied health and other therapeutic services (allied health) and the therapeutic services for independent living (therapeutic services) service types.

The reported data for allied health and other therapeutic services (in Group 2) was often unable to be split into the more granular service list subcategories. As such, Group 2 information shows an aggregation of all subcategories in the allied health and other therapeutic services service type alongside a breakout of the following services:

- Physiotherapist subcategory
- Occupational therapy subcategory
- Podiatry subcategory

**Group 3:** all subcategories in the home maintenance and repairs, transport and meals service types.

Results have been masked in this section of the report where there were fewer than 5 branches or 3 providers. These numbers were included in the cost output produced but are not displayed in the analysis below to ensure that participants cannot be identified. The results presented in this section are based on the unweighted costed outputs i.e. they have not been weighted to adjust between the SAHCC25 sample and the sector population.

Unless stated otherwise, all total and unit costs referenced include tax and have been adjusted to account for missing activity or labour cost data at the branch or subcategory level. For example, in many cases branches were unable to provide activity for external third-party delivered services even if costs were available. Removing the costs for which there was no activity ensures the unit costs are not overstated and vice versa where activity was provided for which there was no associated cost. This was also done for the few instances of missing internal labour costs and activity.

In all graphs presented in this report, “n” denotes the number of branches.

## 5.2 Total cost and activity volumes

The following section presents an overview of the total costs and total activity volumes for each service type based on the costed sample data. Note that transport and meal delivery have been reported on a different basis to all other service types as their activity volumes are respectively measured in number of trips and meals rather than in service hours.

Figure 15 - Total costs and total activity volumes by service type[12]

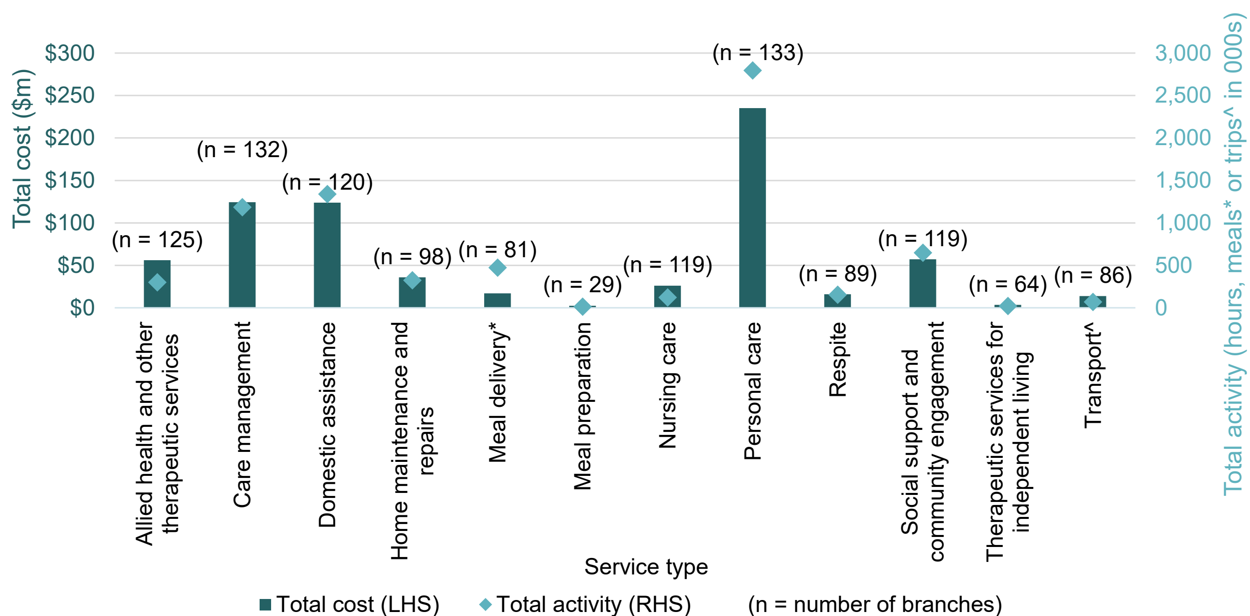



**Figure 15** illustrates the total costs (left axis) and total activity volumes (right axis) by service type. The number of branches for each service type with cost data has also been provided in the labels above.

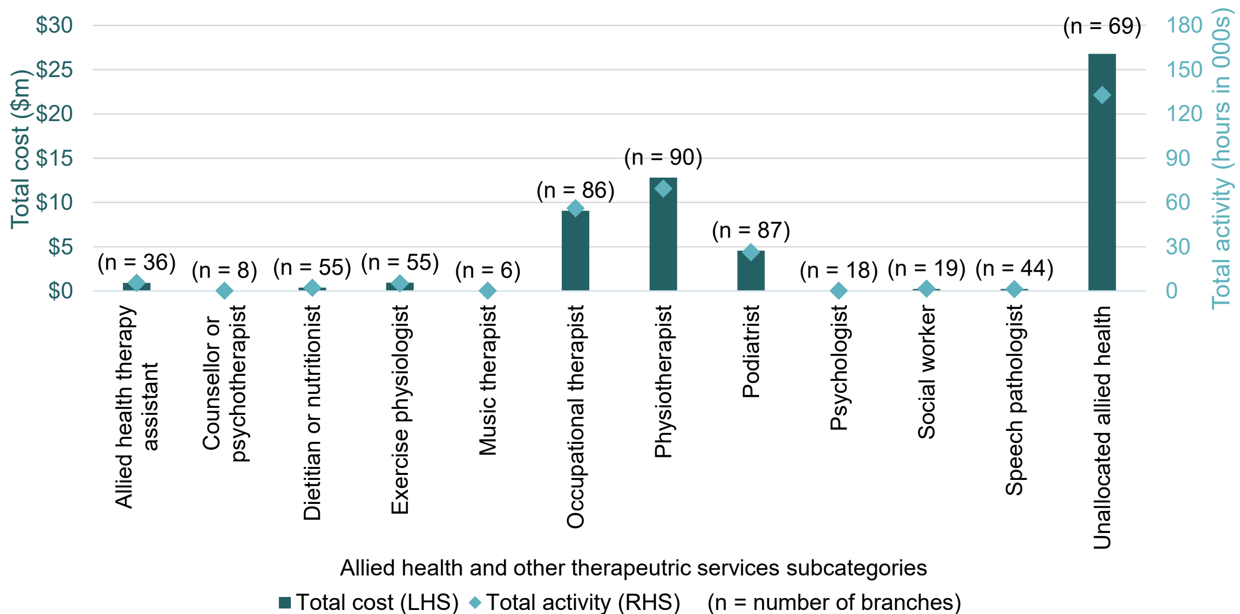
Approximately 70% of collected costs and activity units were reported across the 3 largest service types of personal care (33% of costs, 38% of activity), care management (17% of costs, 16% of activity) and domestic assistance (17% of costs, 18% of activity). As previously discussed, care management was not a standalone service for the 2023-24 financial year, though the proportion of costs submitted relating to care management is broadly consistent with the care management amounts claimable under home care packages (20% of the package value).

The remaining service types shown above individually each made up less than 10% of total costs and activity volumes but total to approximately 30% of total costs and activity volumes.

Overall, approximately 51% of all costs were internal costs while 49% of all costs were external third-party costs, though this varied by service subcategory. This is detailed further in **Section 5.6**.

[12] This figure includes total costs and activity without adjusting for where the branch and subcategory was missing activity or cost. This is an exception to the rest of this section and thus why the number of branches here may not match further figures in the report.

Figure 16 - Total costs and total activity volumes for allied health and other therapeutic services subcategories[13]




The allied health service type made up 8% of total cost for the SAHCC25 sample, but comprises of numerous service list subcategories, representing different services from different allied health professions. These have been presented in further detail in **Figure 16**, which illustrates the total costs (left axis) and total activity volumes (right axis) for each subcategory. The number of branches for each service type with cost data has also been provided in the labels above.

Throughout the SAHCC25 data collection phase, many providers experienced difficulty providing allied health data in the more granular service subcategory levels as current ACFRs do not require this granular split. Furthermore, allied health services are often outsourced to third parties, meaning it was challenging to collect data at the required level.

Hence, a large proportion of costs and activity were unable to be broken down and subsequently reported in the "unallocated" subcategory, making up 48% of allied health costs and 44% of allied health activity.

After the unallocated category, 3 allied health service list subcategories made up the majority of the remaining data, being physiotherapy (23% of costs, 23% of activity), occupational therapy (16% of costs, 19% of activity) and podiatry (8% of costs, 9% of activity).

Given that the remaining subcategories contributed to 5% of allied health costs and 5% of allied health activity volumes, the remainder of this section will focus on the 3 major subcategories of occupational therapy, physiotherapy and podiatry, and overall allied health as a service.

## 5.3 Overall unit costs by subcategory

The sections below summarise the unit costs (including tax) and key observations for the 3 analysis groups defined earlier. The unit costs are expressed as a cost per hour of service with the exception of meal delivery and direct transport, where the units are the number of meals and trips respectively.

[13] This figure includes total costs and activity without adjusting for where the branch and subcategory was missing activity or cost. This is an exception to the rest of this section and thus why the number of branches here may not match further figures in the report.

### 5.3.1 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 17 - Unit costs for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

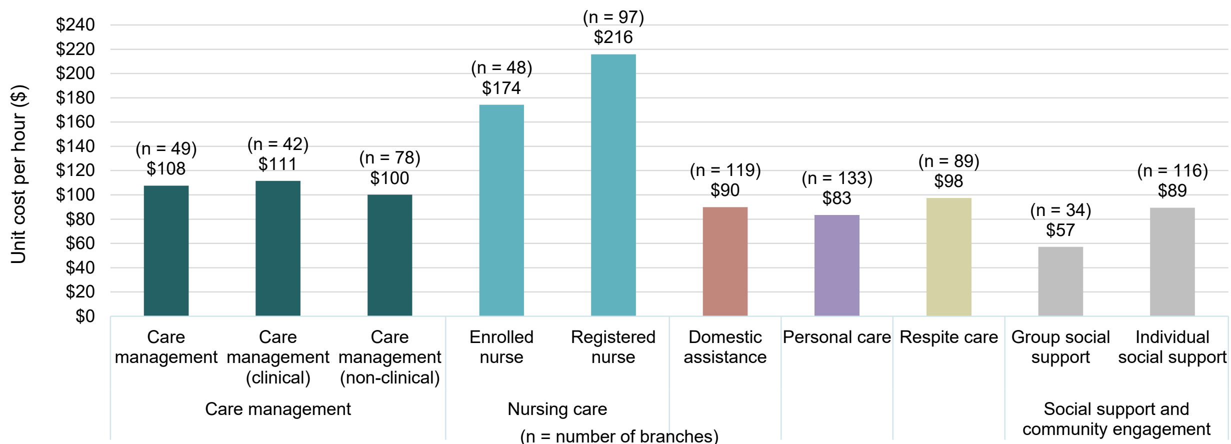



**Figure 17** shows the unit costs for subcategories in Group 1. Key observations included:

- Unit costs for nursing care were the highest in this group, with the average cost for registered nurses calculated at $216 per hour for the SAHCC25 sample. As expected, the unit cost for enrolled nurses was slightly lower at $174 per hour. It is noted that some providers had difficulty identifying whether brokered nursing services were provided by registered nurses or enrolled nurses. Nursing consumables also contributed to the unit cost for nursing services. It was observed during the cost collection that some providers had central ordering hubs, where consumable costs for all branches are allocated to a single branch or ACPR. This was not always possible to be allocated out to corresponding branches and, where appropriate, was adjusted or removed in consultation with the provider to align with participating branches.
- When accounting for all subcategories of care management, the unit costs were $104 per hour with a slight variation between reported clinical care management ($111 per hour) and non-clinical care management ($100 per hour).
- Domestic assistance, personal care and respite care all reported unit costs in the range of $83 per hour to $98 per hour. These subcategories all had a large volume of data from participating branches (89 branches or more) and the similar unit costs is not unreasonable given the services are typically delivered by the same home care workforce cohort.
- Individual social support also had a similar cost per hour at $89 hour, once again typically being delivered by the same workforce cohort as domestic assistance, personal care and respite. Costs for group social support was lower at $57 per hour, with the average cost reflecting the total number of participant activity hours submitted by participating branches which are higher for group services.
- Unit cost analysis was not presented for the following subcategories as they did not meet the required minimum data point thresholds:
  - Restorative care management
  - Nursing care: nursing assistant

- Social support and community engagement: assistance to maintain personal affairs, digital education and support, unallocated social support and community engagement.

### 5.3.2 Group 2: Allied health and therapeutic services

Figure 18 - Unit costs for Group 2: Allied health and therapeutic services

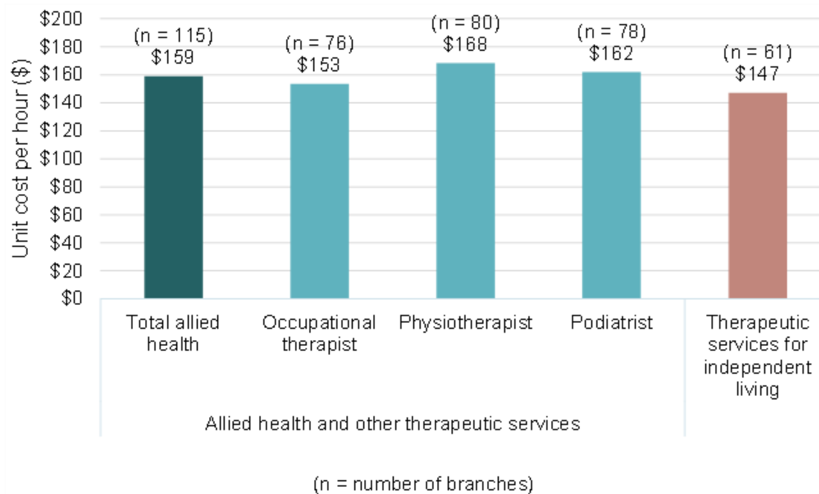



**Figure 18** displays the unit costs for subcategories in Group 2. As previously described, many of the individual allied health professions had low reported cost and activity volumes due to the difficulties providers experienced in being able to report at a more granular level. Hence, the reporting focuses on the largest 3 subcategories and for allied health and therapeutic services in aggregate. Further detail is provided in **Appendix E,** which displays the unit costs for all allied health and other therapeutic services subcategories for participating providers and branches subject to masking criteria.

Key observations for the unit cost in allied health and therapeutic services included:

- Total allied health had a unit cost of $159 per hour, slightly higher than the unit cost of $147 per hour for therapeutic services.
- The unit costs for the 3 major subcategories were similar to the aggregated allied health unit cost, ranging between $153 per hour to $168 per hour as shown in **Figure 18** above.
- A wide range of unit costs existed for other subcategories in allied health which were not below the masking criteria, ranging from $135 per hour for music therapy to $201 per hour for counselling or psychotherapy. Further detail on the unit costs for unmasked subcategories is presented in **Appendix F**.

### 5.3.3 Group 3: Home maintenance and repairs, transport and meals

Figure 19 - Unit costs for Group 3: Home maintenance and repairs, transport and meals

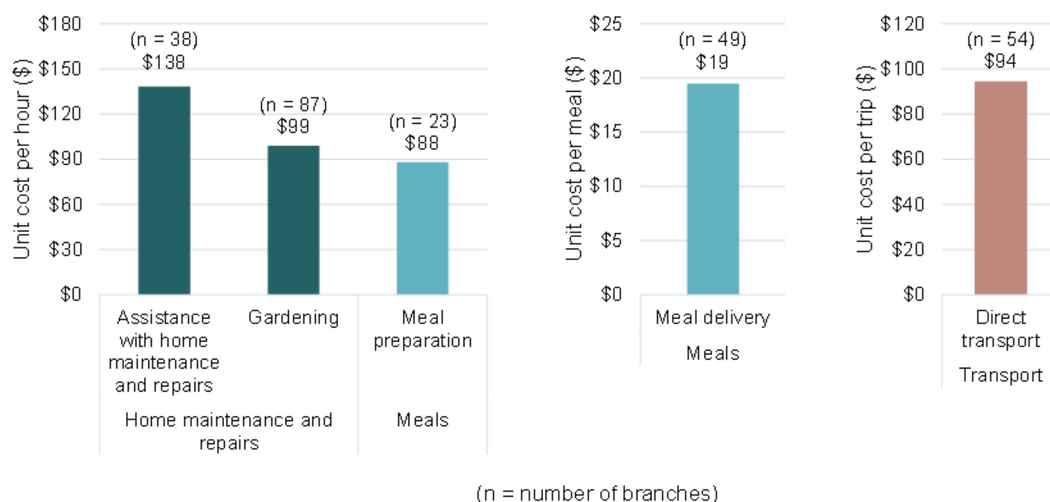



**Figure 19** displays the unit costs for subcategories in Group 3.

Key observations included:

- Home maintenance and repairs unit costs varied significantly between the service provided, with an average unit cost of $138 per hour for assistance with home maintenance and repairs, compared to $99 per hour for gardening. However, gardening constituted more than 90% of the total service units provided in this service type and was reported by 64% of the 135 participating branches.
- As previously discussed, a trip is the unit of activity for direct transport. Some branches provided information related to the number of hours and/or kilometres travelled, though these were not used in the calculation of unit costs. The average cost per trip for direct transport was $95, and it is noted that significant variation was observed for this service subcategory.
- In the meal service type, cost and activity data was collected for 2 subcategories:
  - Meal preparation was typically delivered internally by a similar cohort of the workforce that also provides domestic assistance services. The unit cost of $88 per hour was similar to the domestic assistance and personal care services in Group 1.
  - In contrast, meal delivery (of pre-prepared meals) was often externally delivered, with many providers relying on specialised third-party meal delivery providers. Activity collection for third party providers was a challenge across many service subcategories, but particularly for meal delivery where the unit of activity is a meal. Often the number of meals included in a single meal delivery activity information from providers was bundled in the invoicing received by these third-party providers and hence could not be used due to poor data quality. The unit cost for meal delivery was $19 per meal.

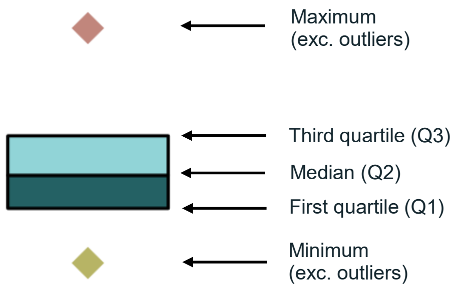
## 5.4 Distribution of unit costs by subcategory

### 5.4.1 Interpretation of a distribution of costs plot

Throughout the analysis below, distribution of unit cost charts have been used to present the variation in unit cost by subcategory for each participant. The use of this plot allows the quantification of the interquartile range (IQR), which represents the middle 50% of unit costs, as well as the minimum and maximum values (excluding outliers, which are not shown in the presentation to focus on the main data trends).

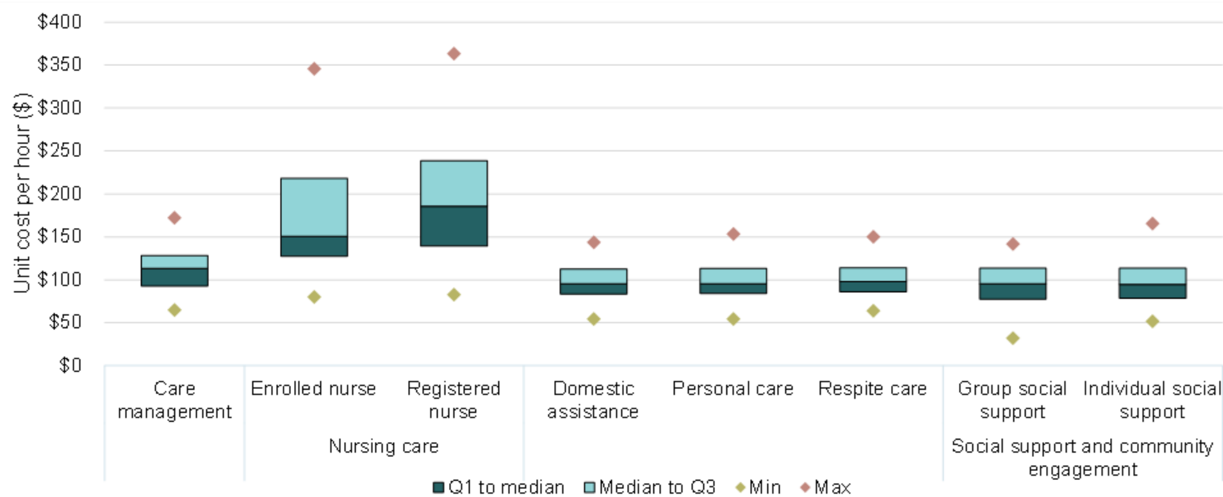
**Figure 20** below outlines how to interpret these plots. Outliers (defined as values above the 75th percentile (Q3) or below the 25th percentile (Q1) by more than 1.5*IQR) are excluded in the presentation of all graphs. The quartiles were calculated without considering the 0th and 100th percentiles to reduce outlier sensitivity. The minimum is the lowest value that was above the outlier lower bound, and the maximum is the highest value that was below the outlier upper bound.

Figure 20 - Interpretation of a distribution of costs plot




### 5.4.2 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 21 - Distribution of unit costs for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

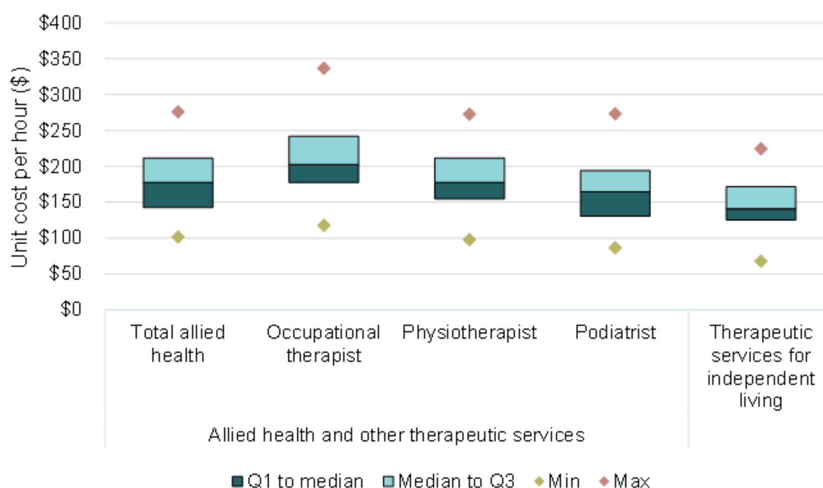


The plot in **Figure 21** shows the range of unit costs for each subcategory in Group 1. There is significant variation within each service type, as indicated by the range between the lower and upper quartiles and the distance between the minimum and maximum.

- For example, in Group 1, registered nurses and enrolled nurses showed particularly high volatility in their unit costs, with a broad IQR of $100 which is significantly higher than the other subcategories in Group 1. Additionally, for nursing services, the larger difference between Q3 and the median as well as the high maximum value indicates that the distribution is more skewed by high-cost observations.
- Other subcategories clustered more tightly around a similar range, as shown by the similar distributions for domestic assistance, personal care and respite care where the IQR ranged between $28 to $36. These services are typically delivered by the same workforce as previously discussed. However, there was still reasonable variation in unit costs which could have been driven by differences in provider operating models (internal vs external service delivery), branch location, or data quality issues such as untrimmed outliers.
- Individual social support and group social support had a similar median cost, although the average unit cost for group social support was lower than individual social support, which reflected a low unit cost for one provider delivering a large volume of group social support services.
- The IQR for care management unit costs was similar to social support and slightly higher than domestic assistance, personal care and respite care. As previously discussed, most providers did not capture the hours of care provided by care management staff with the level of detail required for the SAHCC25 and care management activity needed to be derived from workforce hours. As such, the level of variation in care management unit costs may change over time as activity is collected under Support at Home.

### 5.4.3 Group 2: Allied health and therapeutic services

Figure 22 - Distribution of unit costs for Group 2: Allied health and therapeutic services




The plot in **Figure 22** shows the range of unit costs for each subcategory in Group 2.

**Appendix E** displays further detail on the distribution of unit costs for all allied health and other therapeutic services subcategories from participating providers and branches subject to masking criteria.

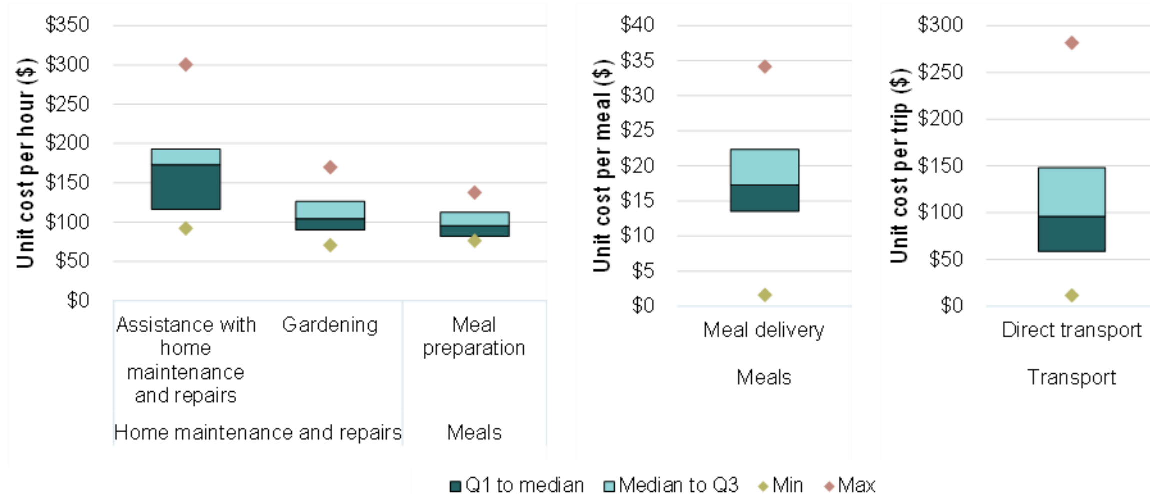
The IQR for the unit cost for total allied health ranged from $143 to $211, which is higher than ranges observed for most subcategories in Group 1 with the exception of nursing services. This is expected as, for many providers, granular allied health data by profession (as reflected by subcategories) was unable to be provided. Hence, the unit costs would reflect a mix of different subcategories.

Out of the 3 major subcategories:

- Occupational therapy was comparably higher than the other two subcategories despite having a lower unit cost overall. This was driven by a branch with large volumes of occupational therapy activity at a relatively lower unit cost. The IQR of observed unit costs ranged between $178 and $242 with large variation in the distribution of observed costs as shown by the distance between the min and max.
- Physiotherapy was lower (IQR of $155 to $212) and more aligned with total allied health.
- The median of podiatry unit costs was lower than the other two subcategories but with a similar level of variability to occupational therapy (IQR of $131 to $194).
- Therapeutic services for independent living had a lower overall unit cost compared to allied health and also exhibited less variation in cost as represented by a narrower plot.

### 5.4.4 Group 3: Home maintenance and repairs, transport and meals

Figure 23 - Distribution of unit costs for Group 3: Home maintenance and repairs, transport and meals




The plot in **Figure 23** shows the range of unit costs for each subcategory in Group 3. Key observations included:

- The direct transport service subcategory showed large variation in unit cost, with the IQR ranging from $58 to $148 per trip, as well as a large range between the minimum ($12) and maximum ($282). As trips can significantly range in distance travelled, it is not unexpected to see such wide cost variation, which is also shown in the higher maximum value ($282).

- Assistance with home maintenance and repairs similarly displayed a wide IQR ($116 to $193) and a high maximum ($300), showing the wide variability across different types of home repairs submitted by providers. The IQR for gardening was about half that of assistance with home maintenance and repairs ($36 vs $77), showing some variability albeit smaller.
- As the unit cost for meal delivery is on a per meal basis, the unit cost and IQR is significantly lower compared to other subcategories, with meals typically ranging from $14 to $22. Meal preparation is on a per hour basis and thus has a much wider IQR ($82 to $133) than meal delivery.

## 5.5 Unit costs by participant characteristics

The sections below analyse the unit costs by subcategory across participant characteristics of interest, particularly for the target cohorts (providers focusing on service delivery Aboriginal and Torres Strait Islander peoples, people from CALD backgrounds and rural/remote clients).

As with previous sections, masking was applied where there were fewer than 5 branches or 3 providers to ensure participants could not be identified.

### 5.5.1 Unit costs by participant cohort

A key focus area for SAHCC25 was ensuring that data was collected from providers who have not been able to participate in previous cost collections and those who provide care to underrepresented client cohorts.

The charts below provide comparisons between the unit costs at an aggregate level for the target and non-target cohorts, noting that the criteria to identify the target cohorts are not mutually exclusive and a participating branch may fit into more than one category.

Despite the more targeted collection approach, inconsistent variation was observed across the SAHCC25 target cohorts when compared to the broader sector. This could have been due to the small sample size and number of clients of the target cohort branches, and the challenges some participants found allocating costs at a branch level or to the in-scope HCP and STRC services.

#### 5.5.1.1 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 24 - Unit costs by participant cohort for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

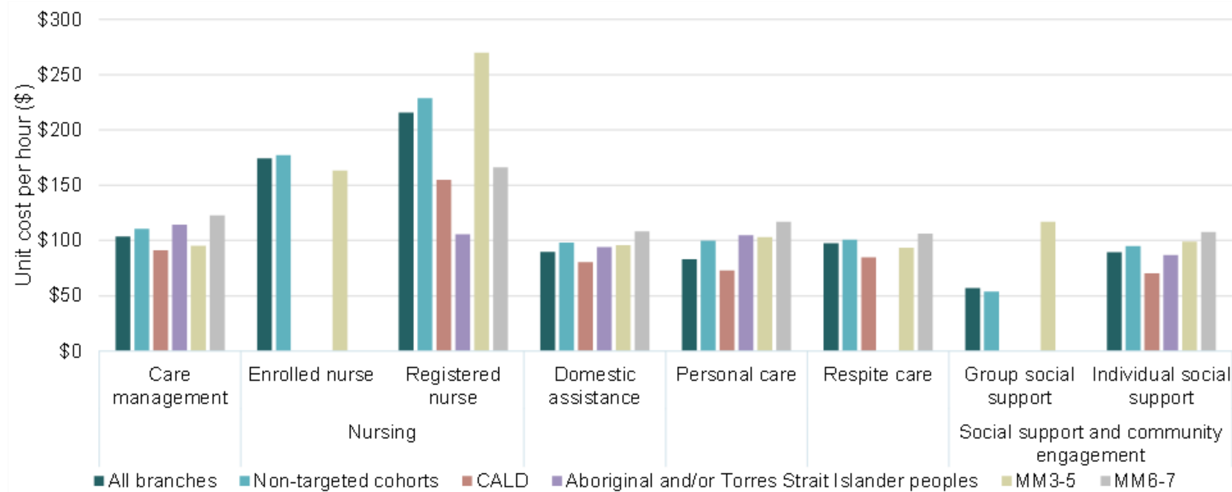



**Figure 24** displays the unit costs by branch characteristics for all subcategories in Group 1. Key observations included:

- Across most subcategories, unit costs were 2-9% higher for non-targeted cohorts when compared to the overall unit cost, with personal care having the highest differential (20% higher).
- On average, the unit cost for people from CALD backgrounds focused branches was lower than for the non-target cohorts, ranging from 32% lower for registered nurses to 16% lower for respite care. The sample size by branches and number of clients of the people from CALD backgrounds cohort was still relatively small and influenced by a few branches with high activity volumes.
- The unit cost for branches that met the criteria for Aboriginal and Torres Strait Islander peoples did not show a consistent trend when compared to the non-target cohort. The unit cost for care management and personal care was 3-5% higher than the non-target cohorts, whereas the unit cost for registered nurses was 54% lower than the non-target branches.
- Branches in the MM3-5 and MM6-7 categories mostly had higher unit costs when compared to all branches. When comparing these 2 MMM groups, where data was available, unit costs were higher for the MM6-7 branches, providing some evidence of higher costs of delivery for more rural areas. This was observed for care management, domestic assistance, personal care, respite care and individual social support. Reasons given by participants indicated that the additional costs related to extra travel and lower levels of activity due to lower client numbers resulted in higher average costs per delivered unit of activity.

#### 5.5.1.2 Group 2: Allied health and therapeutic services

Figure 25 - Unit costs by participant cohort for Group 2: Allied health and therapeutic services

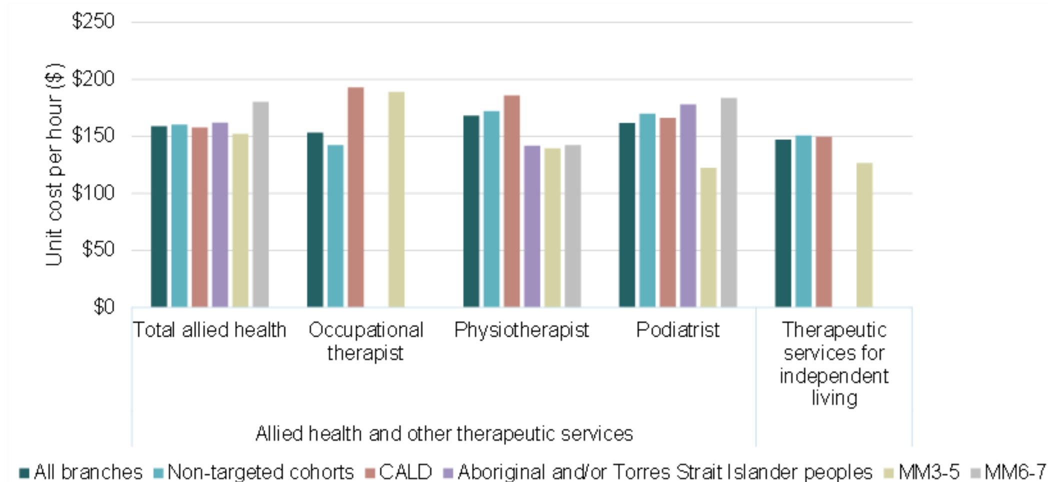



**Figure 25** displays the unit costs by branch characteristics for all subcategories in Group 2. Key observations included:

- Across both allied health and therapeutic services service types, unit costs were very similar between all branches and non-targeted cohorts when considered in aggregate.
- The findings were not as consistent when examining the unit costs for each of the 3 largest allied health subcategories separately:
  - Unit costs for non-target cohorts were approximately 7% lower for occupational therapy compared to the overall average whereas the unit costs were significantly higher for people with CALD backgrounds and remote (MM3-5) providers for this subcategory.
  - Conversely, the unit cost for non-target cohorts was approximately 5% higher than the overall average for podiatry, with the unit cost for MM3-5 branches being much lower.
  - Similarly, the unit cost for non-target cohorts was approximately 2% higher than the overall average for physiotherapy, with the unit cost for branches that met the criteria for Aboriginal and Torres Strait Islander peoples and rural and remote communities (MM3-5 and MM6-7) being much lower.
- Branches that met the criteria for Aboriginal and Torres Strait Islander peoples had an overall higher unit cost compared to all branches and the non-targeted cohorts for allied health overall.
- Contrastingly, unit costs for the people with CALD backgrounds cohort were typically similar to or higher than all branches and the non-targeted cohorts.
- The unit cost for rural and remote communities was quite varied compared to all branches. Similar to findings in Group 1, the unit cost for MM6-7 was consistently higher than MM3-5 for allied health services (where available).

#### 5.5.1.3 Group 3: Home maintenance and repairs, transport and meals

Figure 26 - Unit costs by participant cohort for Group 3: Home maintenance and repairs, transport and meals

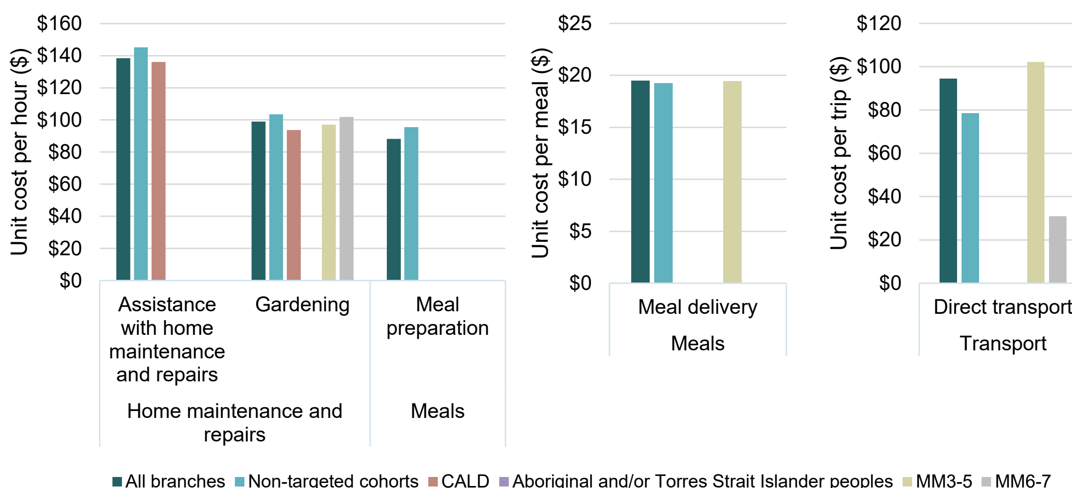



**Figure 26** displays the unit costs by branch characteristics for all sub-categories in Group 3. Unit costs for these subcategories were less consistent, with lower branch numbers in these categories leading to more volatility in the calculated unit costs and more masking applied.

Unlike for other subcategories, the limited volume of data for these services meant there was not a clear trend in the relationship between remoteness, targeted cohorts and unit cost.

- The unit cost for non-targeted cohorts was higher than all branches for assistance with home maintenance and repairs, gardening and meal preparation, though lower for direct transport. Meal delivery costs were broadly aligned.
- The unit cost for the people from CALD backgrounds cohort was lower than all branches and non-targeted cohorts for both subcategories under home maintenance and repairs.
- The unit costs for rural and remote branches were not consistently higher or lower than the average across all branches for these subcategories.

### 5.5.2 Unit costs by Modified Monash Model

The charts below illustrate unit costs by MMM area for each subcategory in each of the 3 groups. MMM areas provide insight into the difference in unit costs between branches in metropolitan (MM1-2), rural (MM3-5) and remote (MM6-7) communities.

In the data collected from aged care providers, 75% of branches were located in MM1-2, 19% of branches were in MM3-5, and 7% of branches were in MM6-7[14].

As previously observed, there is some evidence that unit costs are higher for more remote participants, though this was not consistent by subcategory.

[14] These figures do not sum to 100% due to rounding.

#### 5.5.2.1 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 27 - Unit costs by MMM for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

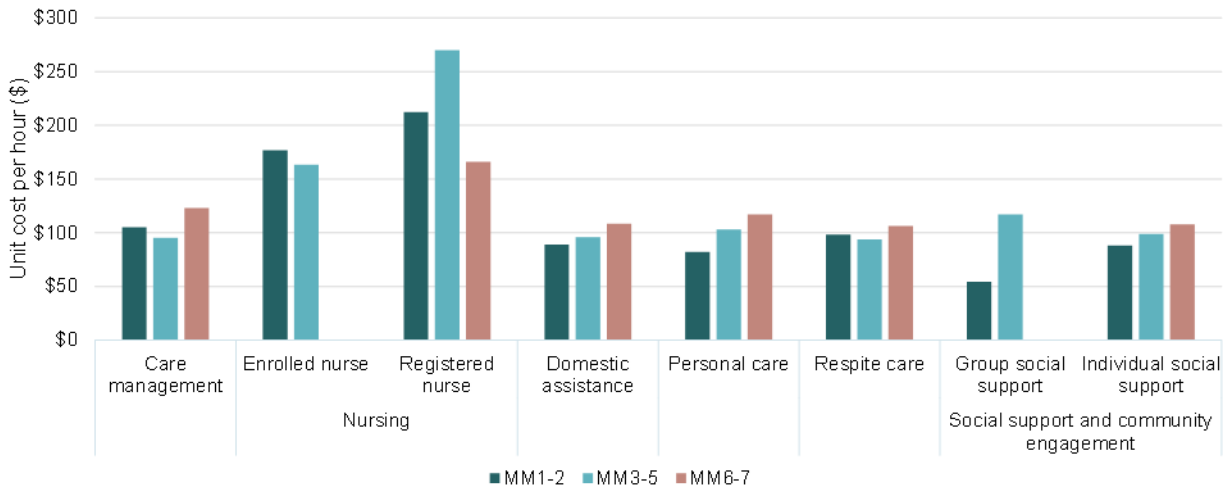



**Figure 27** illustrates the unit cost by MMM for Group 1 subcategories. Some key observations included:

- Typically, the unit cost for MM6-7 was higher than MM1-2 and MM3-5. This was the case for all service types except nursing.
- For subcategories where MM6-7 was highest, the difference in unit cost between MM6--7 and MM1-2 ranged from a difference of 8% for respite care ($106 for MM6-7 compared to $98 for MM1-2) up to 43% for personal care ($117 compared to $82).
- There was no clear correlation between unit cost and remoteness for nursing services. For the enrolled nurse subcategory, MM1-2 had a higher unit cost than for MM3-5, while for the registered nurse subcategory, MM3-5 had the highest unit cost.

#### 5.5.2.2 Group 2: Allied health and therapeutic services

Figure 28 - Unit costs by MMM for Group 2: Allied health and therapeutic services

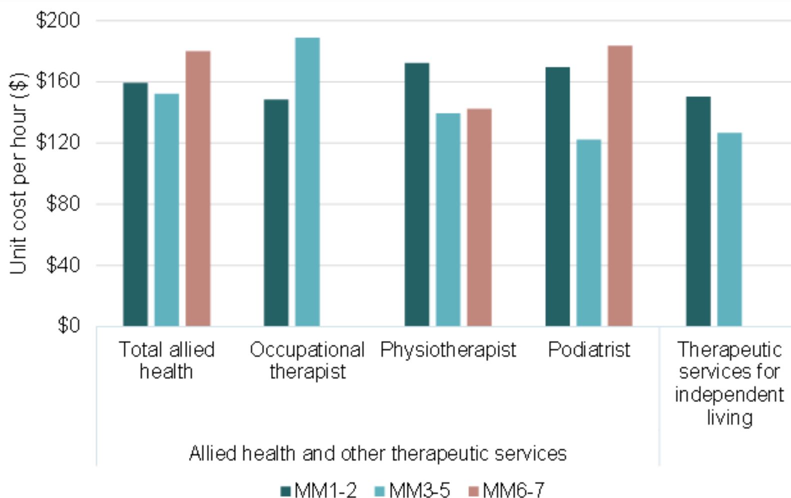


**Figure 28** illustrates the unit cost by MMM for allied health and therapeutic services.

In aggregate, the unit cost for allied health for MM6-7 branches was approximately 13% higher than MM1-2. This varied between allied health subcategories, with a small sample size for remote branches leading to volatility in unit costs and an inability to draw definitive conclusions.

#### 5.5.2.3 Group 3: Home maintenance and repairs, transport and meals

Figure 29 - Unit costs by MMM for Group 3: Home maintenance and repairs, transport and meals

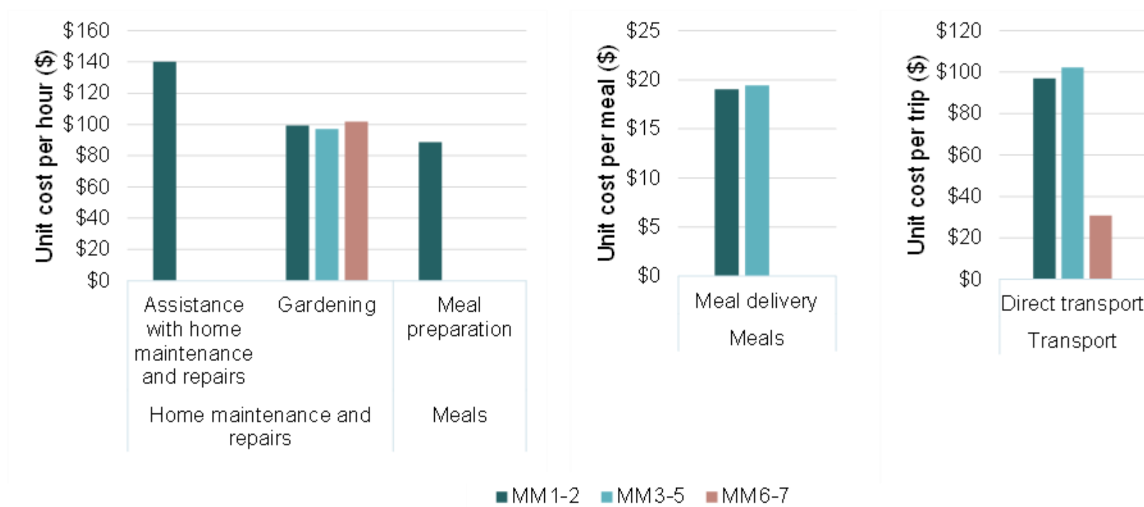



**Figure 29** illustrates the unit cost by MMM for Group 3 subcategories. Some key observations included:

- As with Group 2, there was no consistent relationship between the remoteness of the branch and the unit costs, with low branch volumes meaning many categories required masking.
- Unit costs for MM1-2 and MM3-5 branches were similar across most of the subcategories where there was sufficient volume.
- Data collected for these services provided by MM6-7 branches was sparse, resulting in volatility in the calculated unit costs particularly for direct transport.

### 5.5.3 Unit costs by branch size

This section analyses unit cost by number of clients per branch. In the sample:

- 53% of branches had 100 or fewer clients
- 36% of branches had 101 to 500 clients
- 3% of branches had 501 to 1,000 clients, and
- 8% of branches had more than 1,000 clients.

The charts below illustrate unit costs by branch size in each of the 3 groups.

#### 5.5.3.1 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 30 - Unit costs by branch size for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

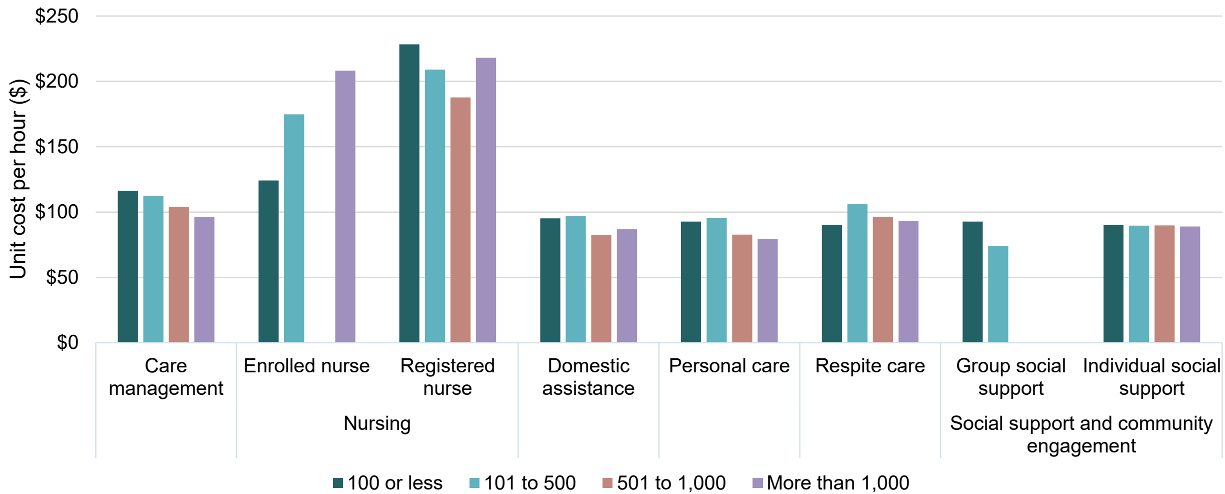



**Figure 30** illustrates the unit cost by branch size for Group 1 subcategories. Some key observations included:

- For care management, there was some evidence to suggest a smaller branch size correlated to a higher unit cost. This was also observed, though not as consistently, for respite, domestic assistance and personal care, where branches with fewer than 500 clients (with an exception for respite 100 or less) had a higher unit cost compared to branches with more than 500 clients.
- Enrolled nursing showed the opposite trend where the unit cost increased as branch size increased, though there were fewer large branches (more than 500 clients) where data was collected for enrolled nurses, leading to volatility in this subcategory.
- Individual social support showed no relationship between branch size and unit cost with all unit costs being similar regardless of size.
- Overall, there was no consistent relationship between branch size and unit cost for these subcategories.

#### 5.5.3.2 Group 2: Allied health and therapeutic services

Figure 31 - Unit costs by branch size for Group 2: Allied health and therapeutic services

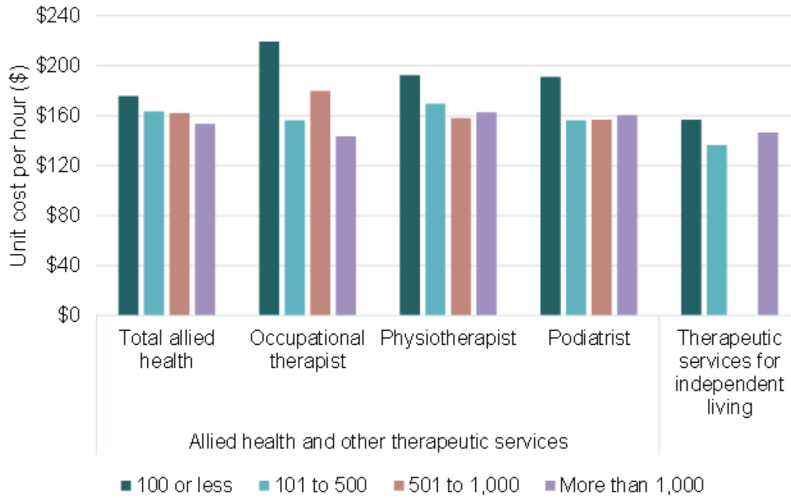



**Figure 31** illustrates the unit cost by branch size for Group 2 subcategories. Some key observations included:

- Overall, for allied health and therapeutic services, branches with 100 or less clients had the highest unit cost. This was similarly the case for the 3 largest allied health services i.e. occupational therapy, physiotherapy and podiatry.
- For branch sizes with more than 100 clients, there was no clear trend between branch size and unit cost.

#### 5.5.3.3 Group 3: Home maintenance and repairs, transport and meals

Figure 32 - Unit costs by branch size for Group 3: Home maintenance and repairs, transport and meals

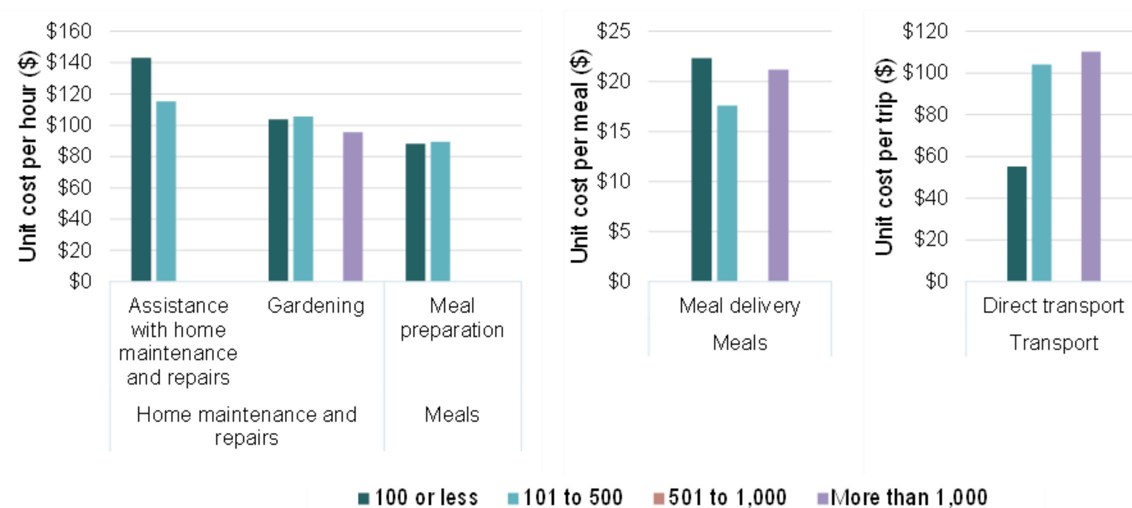


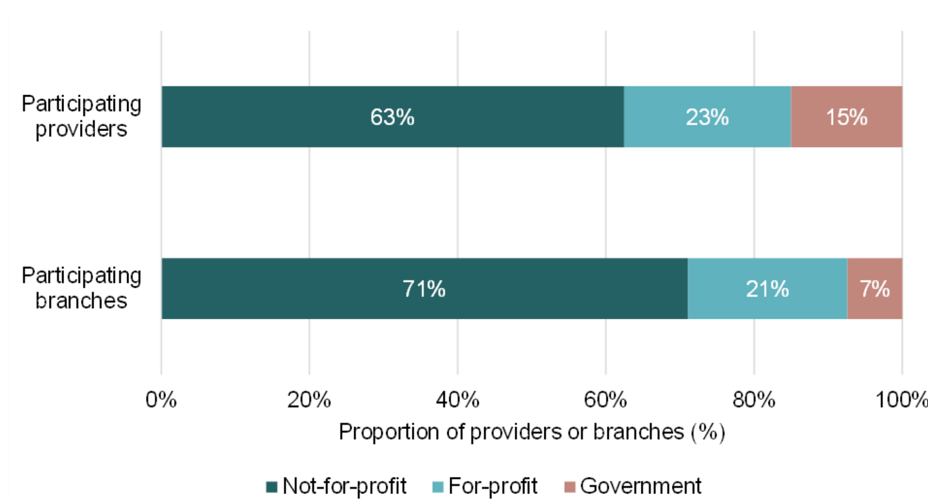
**Figure 32** illustrates the unit cost by branch size for Group 3 subcategories. Some key observations included:

- For transport, the unit cost per trip was higher for the larger branch sizes (101 or more compared to 100 or less clients).
- Assistance with home maintenance and repairs had a higher unit cost for branches with 100 or less clients, while gardening had a higher unit cost for branches with 500 or less clients.
- Overall, there was no consistent relationship between branch size and unit cost for these subcategories.

### 5.5.4 Unit costs by ownership

Ownership refers to whether a provider is a not-for-profit, for-profit or government organisation. **Figure 33** presents a breakdown participants based on provider ownership.

Figure 33 - Ownership of SAHCC25 participants




This indicates that on average, not-for-profit participating providers had a larger number of branches while government owned providers had fewer branches.

The charts below illustrate unit costs by ownership in each of the 3 groups.

#### 5.5.4.1 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 34 - Unit cost by organisation type for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

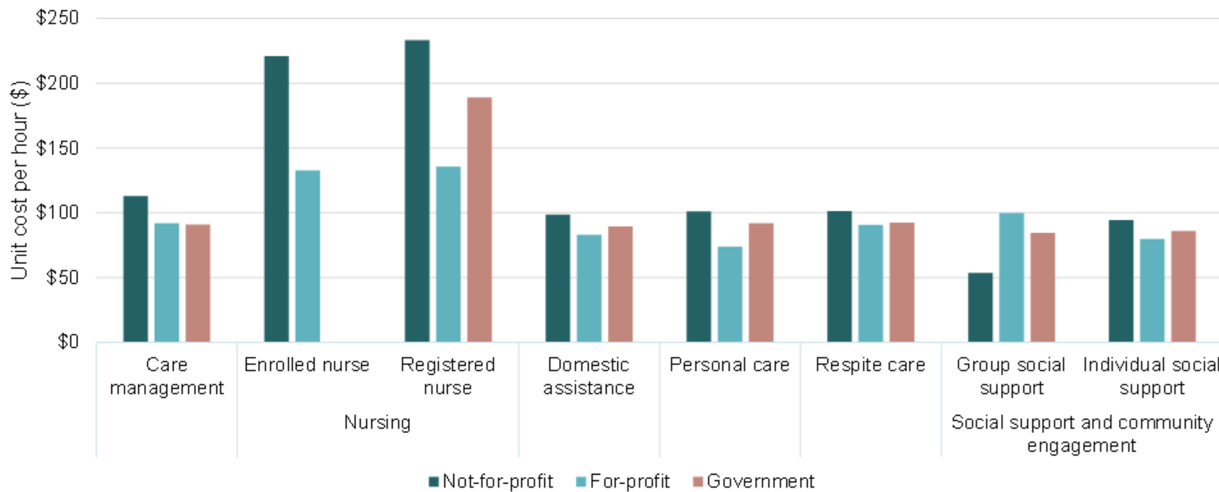



**Figure 34** illustrates the unit cost by organisation type for Group 1 subcategories. Some key observations included:

- For-profit organisations were typically observed to have a lower unit cost compared to not-for-profit organisations, although this varied by service subcategory. The exception to this was group social support, where the unit cost was the highest of the 3 categories.
- Government owned organisations also had a lower unit cost (between 9% to 19% lower) compared to not-for-profit providers for all subcategories except group social support.
- Registered nursing had the largest disparity in unit cost between the different ownership types, with the highest unit cost coming from not-for-profit providers at $233 per hour, compared to $136 for for-profit organisations (42% lower than not-for-profit) and $189 for government owned organisations (19% lower than not-for-profit).

### 5.5.4.2 Group 2: Allied health and therapeutic services

Figure 35 - Unit cost by organisation type for Group 2: Allied health and therapeutic services

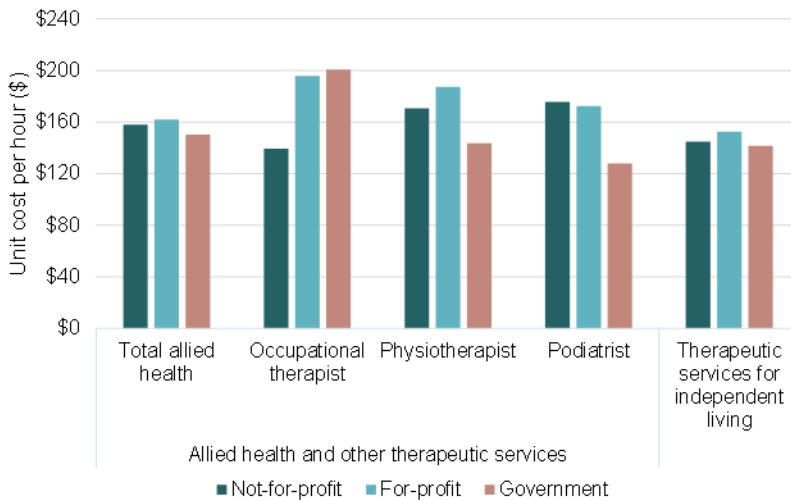



**Figure 35** illustrates the unit cost by organisation type for Group 2 subcategories. Some key observations included:

- Unlike Group 1, for-profit providers typically had the highest unit cost across allied health, with the exception of occupational therapy and podiatry where government and not-for-profit providers respectively had a slightly higher unit cost.
- Occupational therapy had the largest difference in unit cost with for-profit unit costs being 40% higher than not-for-profit unit costs.
- Government owned organisations typically had a lower unit cost than not-for-profit and for-profit organisations, except for occupational therapy where government organisations had the highest unit cost, 3% higher than the unit cost for for-profit branches.

### 5.5.4.3 Group 3: Home maintenance and repairs, transport and meals

Figure 36 - Unit cost by organisation type for Group 3: Home maintenance and repairs, transport and meals

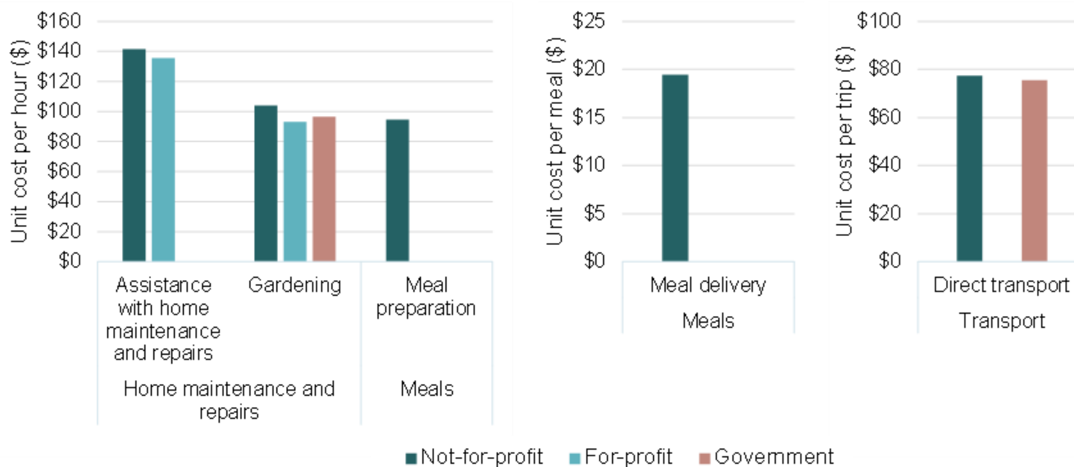


**Figure 36** illustrates the unit cost by organisation type for Group 3 subcategories. For the home maintenance and repairs service type, the unit cost for not-for-profit organisations was slightly higher than for-profit organisations (4% to 12%). Low data volumes in the other categories prevented further comparisons due to masking.

## 5.6 Proportion of costs by cost category

The sections below show the proportion of costs collected in the SAHCC25 including labour costs, other direct costs (e.g. consumables, motor vehicle expense), administration costs and tax.

As expected, most costs were related to direct labour costs (including care management salaries) which made up approximately 73% of the reported costs, with the majority of these related to staff costs for home care workers.

Administration costs made up approximately 23% of reported costs, with over 40% of administration costs relating to administration salaries and wages, followed by corporate recharge[15] (28%). Other direct costs, mainly consumables, made up 3% of reported costs.

All costs were further split into internal (related to employed staff and including agency) and external (third party brokered services) with the exception of tax. Excluding tax, approximately 53% of all costs were internal while 47% were external, though this varied by service subcategory as detailed further below.

The charts below illustrate the proportion of costs by cost bucket for each of the 3 groups. Percentages are shown on the charts for categories with 5% of costs or more.

### 5.6.1 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 37 - Proportion of costs by cost category for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

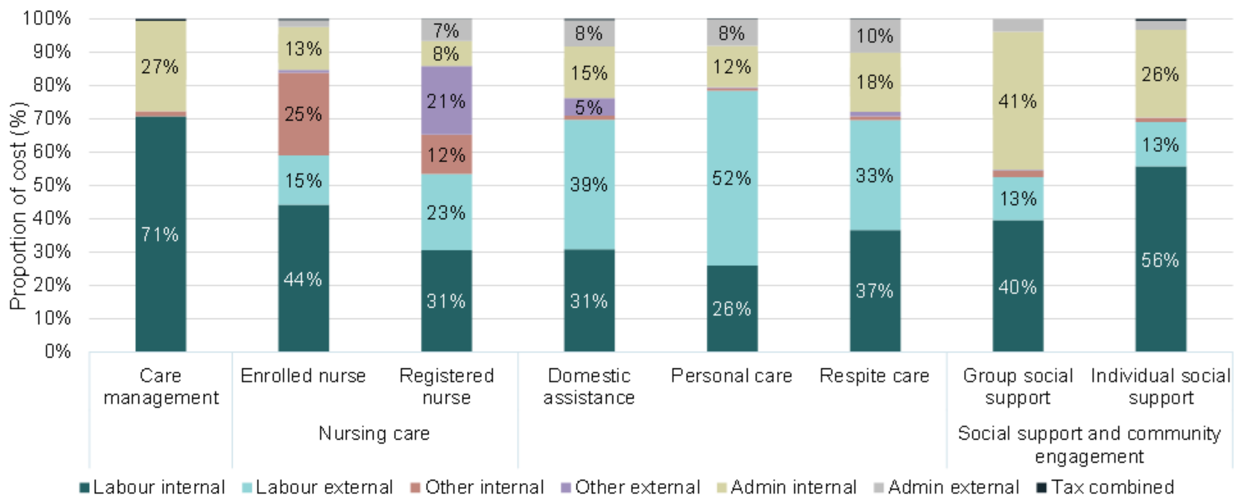



**Figure 37** displays the proportion of costs by cost bucket for Group 1.

- As expected, labour costs made up the majority of total costs, accounting for over 70% of total costs, though this varied by subcategory. The prevalence of different service delivery models (i.e. internally delivered versus external brokered) also varied by subcategory.

[15] Relevant to providers with multiple branches, corporate recharge is the share of central costs paid by the branch for corporate support services.

- Care management was delivered internally by all participants in the cost collection, which was in line with expectations given the nature of the responsibilities and care management activities required from providers.
- In contrast, for the domestic assistance, personal care and respite care subcategories, between 33% and 52% of costs were external labour costs, compared to between 26% to 37% reported as internal labour costs. This reflects the mix of service delivery models adopted by participants, which could be influenced by staffing levels and expertise, available infrastructure or client preferences (e.g. where clients request specific providers whom they have used before).
- For the nursing subcategories, other direct costs made up between 26% to 32% of costs. This primarily related to nursing consumables which were allocated to the nursing categories under the costing methodology.
- Administration costs were more significant than other direct costs and the proportion ranged from 14% of costs (registered nurse) to 45% of costs (group social support).
- Tax costs were not significant for the participants and made up less than 0.5% of the total cost in the subcategories referenced above.

### 5.6.2 Group 2: Allied health and therapeutic services

Figure 38 - Proportion of costs by cost category for Group 2: Allied health and therapeutic services

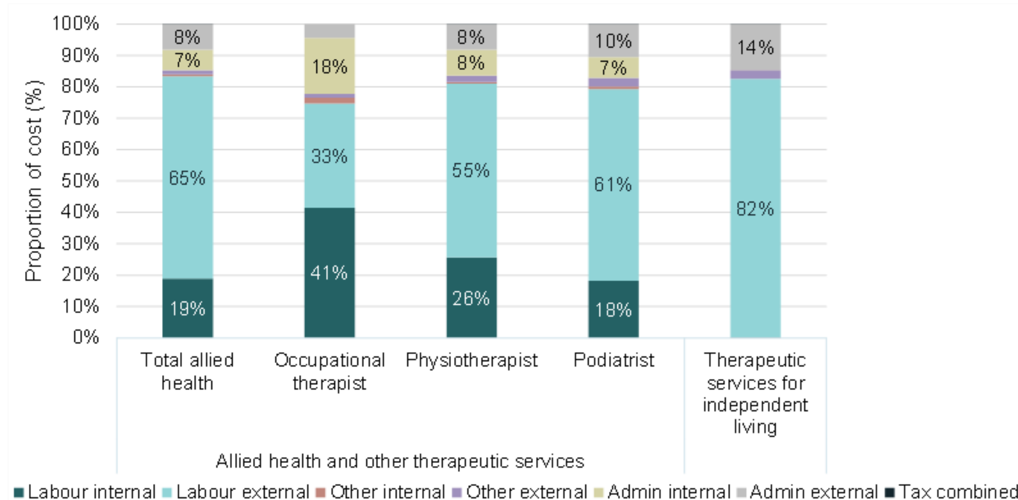



**Figure 38** displays the proportion of costs by cost bucket for Group 2.

- Similar to Group 1, more than 75% of total costs were related to labour costs. However, unlike Group 1, a significantly larger proportion of labour costs were external third-party labour costs, showing the higher prevalence of providers brokering these services for allied health. This aligns with expectations, as these services are provided by professionals who may be difficult to employ directly or not needed on a full-time basis due to client demand, thus prompting third-party engagement.
- There was some variation observed between the 3 major subcategories, with the proportion of external labour costs varying between 33% (occupational therapy) to 61% (podiatry) and internal labour costs varying between 18% (podiatry) to 41% (occupational therapy).

- Administration costs typically made up 10% to 20% of total costs, with occupational therapy having the highest proportion of admin costs at 22%. This is lower than the average proportion of administration costs in Group 1. However, workers compensation was not allocated to third-party delivered services which comprised a higher proportion of allied health and therapeutic services.
- All reported labour costs for therapeutic services for independent living were external third-party brokered, though this data for this service type was low in volume as previously shown in **Figure 15** and hence driven by a small number of participants.

### 5.6.3 Group 3: Home maintenance and repairs, transport and meals

Figure 39 - Proportion of costs by cost category for Group 3: Home maintenance and repairs, transport and meals

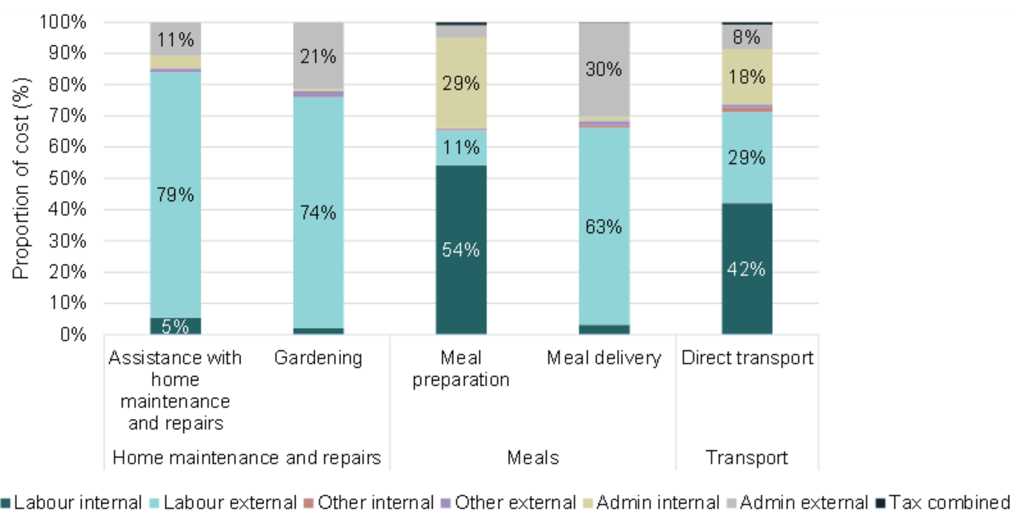



**Figure 39** displays the proportion of costs by cost bucket for Group 3.

- Similar to Groups 1 and 2, labour costs accounted for the majority of costs for these subcategories, making up more than 65% of total costs.
- For home maintenance and repairs, external labour costs made up approximately 76% of all costs, indicating that most providers relied on third parties to provide these services to their clients. This is in line with expectations, as these services require a specialised workforce who may be difficult to employ directly or may not be needed on a full-time basis due to client demand.
- This was also similar for meal delivery, where external third-party costs (mapped to direct labour costs) made up the majority of costs. This is in line with expectations, with many providers indicating that they relied on specialist meal delivery services such as Lite n' Easy to support their clients.
- In contrast, a higher proportion of labour costs for direct transport and meal preparation were related to internal labour costs. These subcategories were more in-line with the delivery models for personal care, domestic assistance and respite, as they are often delivered by the same workforce.
- Administration costs ranged between 22% to 33% of total costs for most subcategories in Group 3 except for assistance with home maintenance and repairs (15%). Meal delivery and meal preparation had the highest administration costs.

## 5.7 Shift type distribution

Data was also collected to understand when services were being provided. For the analysis presented below, the shift type refers to the time of day or day of week that the services were being provided.

For a provider, regular operating hours were between 8am to 6pm on weekdays. Services with hours outside of regular operating hours typically incur an extra cost to the provider due to higher labour costs.

Across all the data collected:

- 62% of service hours were provided during a provider's normal weekday operating hours.
- In addition, 31% of hours were unable to be definitively allocated. Unallocated hours occurred when limitations in the provider's systems meant the time of day was unable to be provided in supplied extracts. While these services were mostly confirmed to be provided on weekdays (based on the date alone), it was unknown as to whether this occurred during regular operating hours or afterhours, though it is likely that the majority of these hours would occur during regular operating hours.
- Of the remaining hours, 1% were reported to be on weekdays after business hours, 3% on Saturdays, 2% on Sundays and 1% on public holidays.

The charts below illustrate the proportion of costs by shift type for each of the 3 groups. Percentages are shown on the charts for categories with 5% of costs or more.

### 5.7.1 Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

Figure 40 - Proportion of hours by shift type for Group 1: Care management, nursing care, domestic assistance, personal care, respite and social support and community engagement

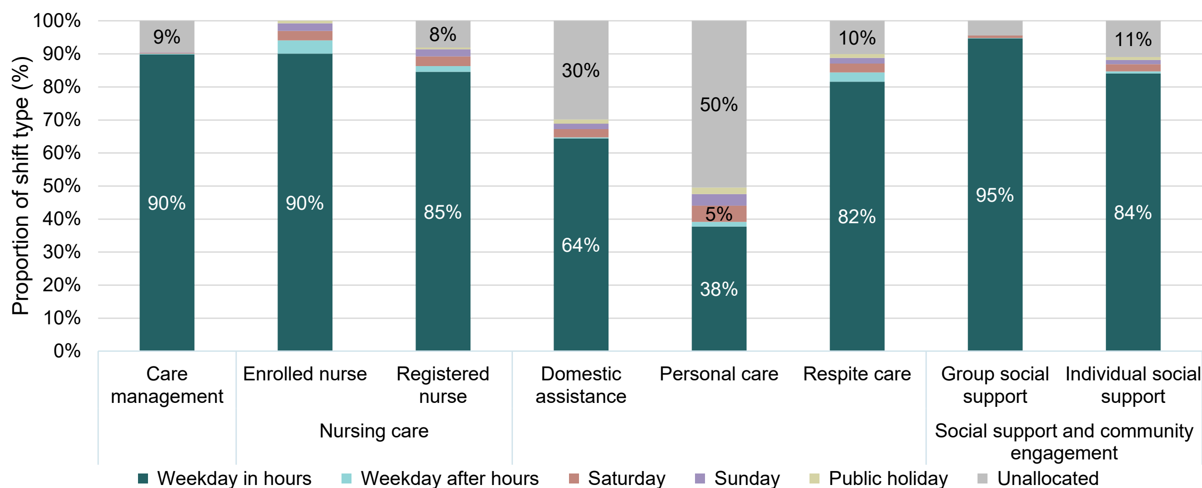


**Figure 40** displays the proportion of hours by shift type for Group 1. Generally, more than 60% of all service hours for Group 1 were provided during weekday regular operating hours, though if unallocated hours were also included, this was closer to 93% of all activity hours.

- Approximately 90% of hours (99% including unallocated) for care management were reported as weekday during business hours, which is in line with expectations as care management staff typically work business hour shifts and care management is typically not undertaken as a direct service outside of business hours.
- Group social support had the largest proportion of hours on weekday regular operating hours (95%), which is also expected given group services would typically be scheduled during the week.
- Personal care had the largest proportion of unallocated hours (50%), followed by domestic assistance (30%) and respite (10%). However, if these were once again assumed to be delivered in weekday business hours, then the proportion of activity delivered during business hours would range between 88% to 94%, similar to other categories in Group 1.
- Overall, less than 5% of service hours for each subcategory were provided on weekday after hours, Saturdays or Sundays, and less than 2% of service hours occurred on public holidays.

### 5.7.2 Group 2: Allied health and therapeutic services

Figure 41 - Proportion of hours by shift type for Group 2: Allied health and therapeutic services

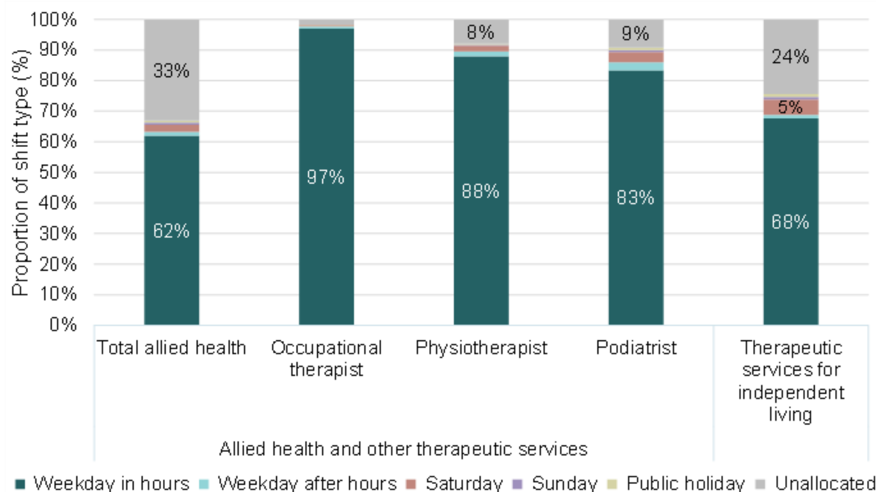



**Figure 41** displays the proportion of costs by Shift Type for Group 2.

- Similar to Group 1, the majority of activity was delivered during weekday business hours. 62% of allied health services and 68% of therapeutic services were provided during weekday regular operating hours, though this increases to 95% and 92% respectively if unallocated hours were included.
- This was also relatively consistent when examining the largest 3 allied health subcategories, with 93% to 99% of services being delivered during business hours (if unallocated hours were included).

- Overall, less than 5% of service hours for each subcategory were provided on Saturdays, and less than 3% of services hours were provided on weekday afterhours, Sundays and public holidays.

### 5.7.3 Group 3: Home maintenance and repairs, transport and meals

Figure 42 - Proportion of hours by shift type for Group 3: Home maintenance and repairs, transport and meals

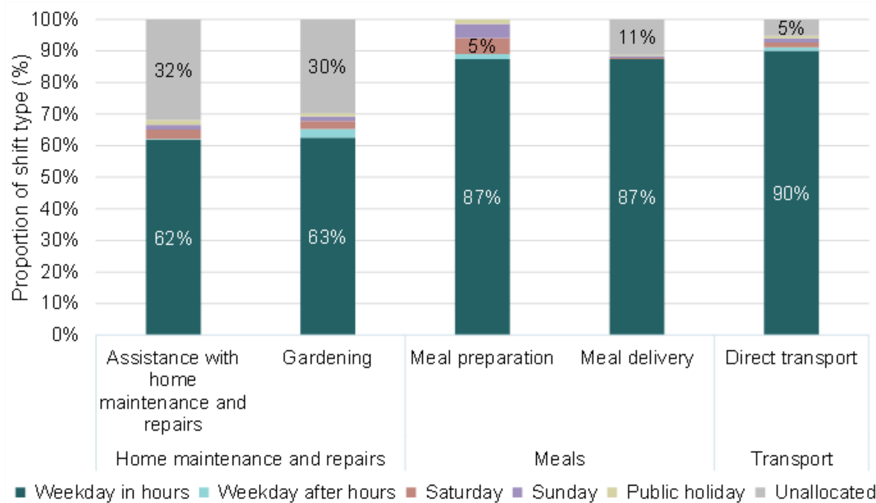



**Figure 42** displays the proportion of costs by shift type for Group 3. As with the previous groups, the majority of services (78%) were delivered during weekday business hours, increasing to 96% with the inclusion of unallocated hours.

- Overall, less than 5% of service hours for each subcategory were provided during weekday afterhours, Saturdays or Sundays, and less than 1% of service hours were provided during public holidays.
- Meal preparation had the largest proportion of hours on Saturday (5%), Sunday (4%) and public holidays (1%), while gardening had the largest proportion of hours on weekday after hours (3%).

# 6 Recommendations for future cost collections

Drawing on insights from SAHCC25 and previous cost collections, a set of recommendations has been developed to support the ongoing improvement of future cost collection efforts for Support at Home sector. These recommendations are detailed below.

## Recommendation 1

**Future cost collections should aim to collect data at the most granular level possible where accuracy can be achieved, enabling any potential cost variation to be identified throughout the sector. Target cohorts should continue to be a focus for cost collections.**

**Recommended actions:**

Collect data at the most granular level possible where accuracy can be achieved.

Place continued emphasis on increasing participation from the target SAHCC25 cohorts.

IHACPA has completed 3 Support at Home cost collections: 2 focused on Aged Care Planning Region (ACPR)[16] and provider level data, and the SAHCC25, which gathered data by individual branch to better capture cost variations across different client cohorts.

Despite the more targeted collection approach, inconsistent cost variation in the service subcategories was observed across the SAHCC25 target cohorts when compared to the broader sector.

This could have been due to the relatively small sample size and client base within the target cohort branches, rendering the outcomes more susceptible to the influence of a few branches exhibiting high levels of activity. Additionally, some participants encountered challenges in allocating costs at the branch level or assigning them accurately to the in-scope HCP and STRC services.

The outcomes may also have been influenced by the criteria used to classify branches as serving Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds, which required that at least 50% of clients belonged to the respective cohort. Under these definitions, a considerable proportion of clients within a 'target' branch may have fallen outside the focus cohort, potentially skewing cost comparisons.

[16] 2018 Aged Care Planning Region maps | Australian Government Department of Health, Disability and Ageing

It is recommended that future cost collections continue aiming to capture data at the most granular level possible, where accuracy can be achieved, while making some changes to the data collection approach:

1. Engagement with providers should actively seek to include operational team members, in addition to financial team members, as they may better understand the alignment of their operational reporting structure to NAPS service IDs and therefore improve the quality and ease of data submission.
2. Consider whether the criteria used to identify branches serving Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds should be adjusted to require a higher proportion of clients to meet the target demographic. Any change to the current 50% threshold must consider that increasing this requirement will reduce the number of participants qualifying within the broader population. For example, based on available data from the department, increasing the threshold to 75% would lead to a 34% reduction in the number of NAPS service IDs classified as focusing on Aboriginal and Torres Strait Islander peoples (down to 62) and a 56% reduction in the number classified as having a focus on people from CALD backgrounds (down to 258)..
3. The timing of cost collections should be moved (see recommendation 4) to reduce competing priorities of critical provider team members, allowing them more time to dedicate to producing meaningful data in the required format.

IHACPA should continue to place emphasis on increasing participation from the SAHCC25 target cohorts.

## Recommendation 2

**Future cost collections should continue to offer a flexible data collection approach.**

**Recommended actions:**

Maintain flexibility in provider engagement and data collection approaches for future cost collections.

In previous Support at Home cost collections, all providers were required to submit their data via a structured template. Throughout the SAHCC25, providers were able to submit data for each branch using a flexible, 3-tiered approach to providers and their branches.

While Tier 1 involved the use of structured templates, Tiers 2 and 3 allowed participants to submit data in alternative formats (e.g. raw data extracts), with the SAHCC25 project team providing additional support to identify the required information and, where necessary, transform it into the desired format.

The tiered collection approach decreased barriers to participation through offering a submission process that suited their capability and capacity to provide the required data. This resulted in the participation of 23 providers (57.5% of SAHCC25 participants) who had previously not been a part

of an IHACPA Support at Home cost collection, as well as only a 14% provider attrition rate between participation confirmation and costing, which was lower than previous cost collections.

**Table 9** shows the breakdown of the tiers used by the 40 participating providers for the collection of each data type. Payroll data was not collected from all providers as it was not always required or easily available.

Table 9 - Provider collection tier breakdown

| Collection tier | Financial | Activity | Payroll |
|---|---|---|---|
| **Tier 1** | 36 | 22 | 24 |
| **Tier 2** | 1 | 16 | 4 |
| **Tier 3** | 3 | 2 | 1 |

It is recommended that future cost collections continue to offer flexibility in their provider engagement and data collection approach.

## Recommendation 3

**HCP, STRC and CHSP data should be collected for future cost collections.**

**Recommended actions:**

Capture aggregate data for all service programs in scope for Support at Home, including HCP, STRC, and CHSP, despite CHSP's introduction into the Support at Home program occurring no earlier than 1 July 2027.

The SAHCC25 collected data for HCP and STRC programs only. For providers, this often involved pulling out these programs from a larger dataset that also included CHSP services. As these three programs often share a workforce, this made de-coupling costs, payroll data and activity units for group services difficult and at times, impossible, resulting in allocation and apportionment methods being used and reducing the reliability of the data provided.

It is recommended that the SAHCC26 captures aggregate data for all service programs in-scope for Support at Home, including HCP, STRC and CHSP. This approach will streamline the data collection process for participants by removing the need to disaggregate data to a level of granularity that often does not align with internal reporting systems. As a result, fewer assumptions will be required to prepare the data in the required format, which should enhance the overall accuracy and consistency of the information provided. Since all data ultimately informs a single set of Support at Home pricing, and with CHSP scheduled to transition into the Support at Home program no later than 1 July 2027, there is benefit to IHACPA starting to capture CHSP information as part of future cost collections for Support at Home.

## Recommendation 4

**The timing of future cost collections should be scheduled to avoid significant reporting periods within the sector.**

**Recommended actions:**

Schedule the SAHCC26 engagement and data collection between February and July 2026 to avoid other Support at Home reporting obligations.

The SAHCC25 provider engagement and data collection periods ran from May to September. This period overlapped with key dates within the sector including:

- Preparation for Support at Home (originally scheduled for July 1)
- End of financial year reporting
- QFR reporting
- Annual audit and reporting

Each of these activities required efforts from the same key personnel that were critical to participation in the SAHCC25. Future cost collections should be scheduled to minimise overlap with these activities. At the time of writing this report, forecast key dates for calendar year 2026 are presented in **Table 10** below.

Table 10 - Key dates in the Support at Home sector during 2026

| Activity | Due date(s) |
| --- | --- |
| **QFR reporting due** | Q2 25/26: 14th February 2026<br>Q3 25/26: 5th May 2026<br>Q4 25/26: 4th August 2026<br>Q1 26/27: 4th November 2026 |
| **End of financial year** | 30 June 2026 with year-end finance activities occurring in July and August 2026 |
| **ACFR reporting** | Approximate due date: 31st October 2026 |
| **Annual audit and reporting** | Approximate due date: 31st October 2026 |

It is recommended that the SAHCC26 project commence the stakeholder engagement and data collection periods as early as February 2026 to minimise the overlap with competing sector activities as shown in **Figure 43** below. Additionally, this approach ensures the data for collection is for the most recent full financial year.

Figure 43 - Recommended SAHCC26 timeline

| | 2025 | | 2026 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec |
| QFR reporting | | | | | | | | | | | | | | |
| End of financial year | Support at Home transition & December holiday period | | | | Recommended SAHCC26 engagement and data collection period | | | | | | | | | |
| ACFR reporting | | | | | | | | | | | | | | |
| Annual audit and reporting | | | | | | | | | | | | | | |

## Recommendation 5

**A diverse cohort of third-party allied health and meal delivery providers should be engaged to provide additional information and support the data collection.**

**Recommended actions:**

Engage with a range of third-party allied health providers and meal delivery services to understand their pricing structures (e.g. price per hour or meal), thereby improving understanding of unit costs for Support at Home branches.

An inclusion criterion for participation in the SAHCC25 was that participants needed to be a provider of HCP or STRC services. This led to the exclusion of several interested third-party allied health providers.

Throughout the collection, capturing accurate activity volume proved especially difficult for providers using third party allied health and meal delivery services. This was largely due to the way third-party invoices were captured within provider financial systems.

Using the reported SAHCC25 costs, approximately 73% of allied health services and approximately 93% of meal delivery were brokered. Despite the high volume of costs, where activity could not be provided, no unit costs were able to be included in the cost output.

It is recommended that future cost collections engage with a range of third-party allied health providers and meal delivery services to understand their price per hour of consultation and price per meal, thereby understanding of the cost per unit for Support at Home branches.

## Recommendation 6

**Emerging data sources that align with the commencement of Support at Home should be considered to support targeted reviews into areas where further insights are required.**

**Recommended actions:**

Conduct a comprehensive yearly cost collection while also implementing smaller supplementary collections for target services.

Include the collection of indirect hours for allied health and nursing services in the SAHCC26.

Conduct a targeted collection for care management costs and activity no earlier than 6 months into the Support at Home program.

The landscape of the Support at Home sector continues to change rapidly. Recent examples of this include:

1. Allied health and nursing services expanded to include indirect activities that can be billed.
2. Care management introduced as a defined service with definitions on what can be billed.

This continuously changing profile creates difficulties in capturing cost data that will remain relevant for the period that the pricing advice will inform as it means that some services are being costed using data from periods in which they did not yet exist, leaving the current data collection approach ineffective for these services.

It is recommended that IHACPA consider conducting smaller supplementary reviews to better inform their understanding of costs and activities for these newly introduced services. This could include the exploration of whether activity data can be sourced from Services Australia to complement a small, targeted review.

Table 11 - Target areas for supplementary reviews

| Target area | Justification |
| --- | --- |
| **Allied health and nursing face-to-face and indirect time** | The introduction of indirect reporting as a billable service occurred in November 2025. However, in reported data for FY2024-25, providers were not required to capture or report indirect time for allied health and nursing services separately to face-to-face services. |
| **Care management** | The introduction of care management as a defined service type that attracts an hourly price took effect on 1 November 2025. From conversations with providers during the SAHCC25 collection, it is expected that data quality for care management activity units will increase dramatically from this date. The data collection approach for the SAHCC25 was an estimate of these services and may not reflect the actual activities once they are captured and reported. |

## Recommendation 7

**IHACPA should continue to work with the department and the sector to understand availability of different data sources and the impact of Support at Home changes to future cost collections.**

**Recommended actions:**

Continue working with the department to monitor the Support at Home data capture landscape, identify opportunities to streamline data collection from centralised sources, and explore how these sources might support future cost collections.

Leverage the Aged Care Network (ACN) to understand changes to the data landscape during Support at Home transition period.

Over the next 12-24 months, the in-home aged care landscape will undergo significant change which will impact the data that providers are required to capture and submit following go-live of the Support at Home program on 1 November 2025. This includes new claiming processes from 5 November 2025, where providers can begin submitting invoices for services delivered under the Support at Home program, changes to reporting requirements for future QFRs and ACFR and the future inclusion of CHSP.

It is recommended that IHACPA continue to work with the department to monitor the Support at Home data capture landscape to recognise opportunities in streamlining data-collection from centralised data sources and how these might be used to support future cost collections.

Between the go-live of the Support at Home program and the end of FY2025–26, IHACPA should aim to develop further understanding of the data available, as well as the impacts of recent changes in the sector and incorporate these in the design of future cost collections.

In August 2025, IHACPA established the ACN to supplement and enhance existing formal consultative processes for our residential and in-home aged care work programs. The ACN enables IHACPA to receive timely and in-depth feedback on specific issues arising from our work program for example, cost collections, pricing frameworks and public consultations. The ACN membership includes government and non-government organisations and peak bodies, as well as individuals with the relevant experience and expertise. Additionally, members were appointed based on their experience and subject matter expertise in providing services to underrepresented cohorts defined as having special needs under the *Aged Care Act 2024* (Cth).

It is recommended that IHACPA leverage the ACN to understand changes to the data landscape during the Support at Home program transition period and to test and validate ideas on how data could be collected and utilised.

# 7 Participant feedback

## 7.1 SAHCC25 feedback

Following the conclusion of the SAHCC25 data collection, an anonymous feedback survey was created and distributed to the participating providers. The survey aimed to understand how to improve cost collections within the Support at Home sector moving forward and understand provider experiences with the data collection approach used.

No feedback was available for inclusion at the time of writing this report.

## 7.2 Insights from participants

Throughout the SAHCC25, participants offered anecdotal insights into various aspects of the Support at Home sector. These insights are detailed in **Table 12** below:

Table 12 - SAHCC25 participant anecdotal insights

| Provider insight | Description |
| --- | --- |
| | **Potential cost variation for the target cohort** |
| 1. Providers incur additional costs delivering services to people from CALD backgrounds. | Providers reported that delivering services to people from CALD backgrounds increased costs in 2 ways:<br>1. There is an impact on staff productivity when scheduling as it requires the coordination of client appointments to be based around the cultural and/or linguistic characteristics of specific workers, rather than efficient service delivery. As a result, staff members with the specific characteristics or abilities (e.g. ability to speak a particular language) may end up spending more time travelling between clients that are located further away from each other to ensure culturally appropriate care delivery.<br>2. The coordination and use of translators led to increased administrative effort and care management hours for non-English speaking clients. |
| 2. Maintaining optimal staffing levels is difficult in rural and remote branches | Rural and remote branches have reported challenges in maintaining optimal staffing levels due to the necessity of employing permanent staff to deliver essential services. These regions typically lack access to a pool of casual workers, limiting staffing flexibility. Consequently, when service demand fluctuates, particularly during periods of reduced demand, these branches are often overstaffed, with limited options to adjust workforce levels accordingly. |
| 3. The MMM classification of a branch may not match the MMM classification of the clients they serve | Some providers reported providing services to clients in more remote MMM classifications than their branch assignment indicates (e.g. a MM5 branch providing services to a large volume of MM6 clients). This was particularly common in MM3-5 and MM6-7 branches, as their central operating hub was often established in more central towns with larger populations. |
| | **Challenges in providing data for the SAHCC25** |
| 4. Providing accurate activity data is difficult for brokered services | Many providers reported difficulty in providing the required activity data for brokered services. While there were different issues reported, the most common challenges were:<br>1. Providers did not capture the number of brokered services delivered. While invoices were paid, there were no central records of the number of services |

| | |
|---|---|
| | attached to each invoice. For example, providers often had the cost per order for meal delivery services, but not the total number of meals that were included in the order.<br>2. Providers captured some level of activity data, but the way they captured this information did not align with Support at Home service list units (hours, meals, or trips). For example, many allied health appointments were recorded as a type of appointment (initial, subsequent, short, long) and did not have a corresponding duration. |
| 5. Measuring transport services by trip is seen as impractical by providers | Many providers reported that using a 'cost per trip' approach in the Support at Home Service List is not practical due to the potential variation in distance and time per trip. Providers voiced that defined kilometre ranges may be a more practical approach to transport as a service. |
| **Impact of the new Support at Home program** | |
| 6. The Support at Home service list is seen as restrictive by some providers | Some providers offer services to HCP and STRC clients that do not align to the incoming Support at Home service list. Examples of these services include but are not limited to inactive sleepovers, hydrotherapy, and Pilates. Providers remain unclear on how to claim for these services and many stated that it will need to become an out-of-pocket expense for clients if there is no clear guidance on how to claim these as defined services. |
| 7. There is nervousness about new, unknown costs that will be incurred through the Support at Home program | Multiple providers reported that there are future costs not captured in the SAHCC25 data collection period of FY2023–24 that are expected to impact Support at Home providers. These include regulatory expenses (e.g. audit fees) and administrative burdens (e.g. invoicing), stemming from the complexity of the new Support at Home service list.<br><br>A smaller number of providers reported that some clients expressed concerns about being worse off under the Support at Home program and potential pricing changes, either due to increased financial contributions or reduced service provision, such as fewer care management hours, under the new model. |
| **State and/or Territory specific considerations** | |
| 8. Queensland branches | The Queensland QLeave scheme has introduced the ability to transfer long service leave between organisations within the aged care industry. This introduces a higher workforce cost base for new employees who may reach their qualifying long service leave tenure earlier than previous years. According to one participating provider, this has affected workforce retention in aged care providers, leading to additional costs in agency staffing and inefficiencies associated with onboarding. |

# Appendix A – Support at Home service list

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| **Clinical supports**<br>Specialised services to maintain or regain functional and/or cognitive capabilities. Services must be delivered directly, or be supervised, by university qualified or accredited health professionals trained in the use of evidence-based prevention, diagnosis, treatment and management practices to deliver safe and quality care to older people. | Nursing care | • Registered nurse<br>• Enrolled nurse<br>• Nursing assistant<br>• Nursing care consumables<br>• Providers may apply for the supplementary Oxygen Supplement for Aged Care through Services Australia for eligible participants. | • Community based nursing care to meet clinical care needs such as:<br>  ○ assessing, treating and monitoring clinical conditions<br>  ○ administration of medications<br>  ○ wound care, continence management (clinical) and management of skin integrity<br>  ○ education<br>  ○ specialist service linkage | • Subsidised through other programs:<br>  ○ services more appropriately funded through other systems (e.g., health or specialist palliative care) |
| | Allied health and other therapeutic services | • Aboriginal and Torres Strait Islander health practitioner<br>• Aboriginal and Torres Strait Islander health worker<br>• Allied health therapy assistant<br>• Counsellor or psychotherapist | • Assistance for an older person to regain or maintain physical, functional and cognitive abilities which support them to remain safe and independent at home.<br>• Assistance may include a range of clinical interventions, expertise, care and treatment, | • Subsidised through other programs:<br>  ○ other government programs must be exhausted in first instance if already in place (e.g., Chronic Disease Management Plan, Mental Health Plan) |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| | | • Dietitian or nutritionist<br>• Exercise physiologist<br>• Music therapist<br>• Occupational therapist<br>• Physiotherapist<br>• Podiatrist<br>• Psychologist<br>• Social worker<br>• Speech pathologist | education including techniques for self-management, and advice and supervision to improve capacity.<br>• Treatment programs should aim to provide the older person the skills and knowledge to manage their own condition and promote independent recovery where appropriate.<br>• Interventions can be provided:<br>○ in person or via telehealth<br>○ individually or in a group-based format (e.g. clinically supervised group exercise classes).<br>• A treatment program may be delivered directly or implemented by an allied health assistant or aged care worker under the supervision of the health professional where safe and appropriate to do so.<br>• Prescribing and follow-up support for Assistive | ○ services more appropriately funded through the primary health care system (e.g., ambulance and hospital costs, medical diagnosis and treatment, medicine dispensing, psychiatry, dental care)<br>○ management of conditions unrelated to age/disability related decline (e.g., acute mental health) |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| | | | Technology and Home Modifications | |
| | Nutrition | • Prescribed nutrition Providers may apply for the supplementary Enteral Feeding for Aged Care Supplement through Services Australia for eligible participants. | • Prescribed supplementary dietary products (enteral and oral) and aids required for conditions related to functional decline or impairment. | • General expenses: ○ Products that are not prescribed for age related needs (e.g., weight loss) |
| | Care management | • Home support care management | • Activities that ensure aged care services contribute to the overall wellbeing of an older person (e.g., care planning; service coordination; monitoring, review and evaluation; advocacy; and support and education). • Care partners will hold clinical qualifications or be supervised by a clinician dependent on consumer complexity. | • Administrative costs funded through prices on services. |
| | Restorative care management | • Home support restorative care management | • Restorative care partners provide specialist coordination services for older people undergoing the time-limited Restorative Care Pathway. • Care partners will hold clinical qualifications. | • Administrative costs funded through prices on services. |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| **Independence**<br>Support delivered to older people to help them manage activities of daily living and the loss of skills required to live independently. | Personal care | • Assistance with self-care and activities of daily living<br>• Assistance with the self-administration of medication<br>• Continence management (non-clinical) | • Attendant care to meet essential and on-going needs (e.g., mobility, eating, hygiene).<br>• Support with self-administration of medication activities (e.g., arrange for a pharmacist to prepare Webster packs).<br>• Attendant care to manage continence needs (e.g., support to access advice/funding, assistance changing aids) | • General expenses:<br>  ○ professional services that would usually be paid for (e.g., waxing, hairdressing).<br>• Subsidised through other programs:<br>  ○ services more appropriately funded through the health system (e.g., pharmaceuticals, dose administration aids). |
| | Social support and community engagement | • Group social support<br>• Individual social support<br>• Accompanied activities<br>• Cultural support<br>• Digital education and support<br>• Assistance to maintain personal affairs<br>• Expenses to maintain personal affairs | • Services that support a person's need for social connection and participation in community life. Support may include:<br>  ○ service and activity identification and linkage<br>  ○ assistance to participate in social interactions (in-person or online)<br>  ○ visiting services, telephone and web-based check-in services<br>  ○ accompanied activities (e.g., support to attend appointments). | • General expenses:<br>  ○ costs to participate in an activity (e.g., tickets, accommodation, membership fees.)<br>  ○ the purchase of smart devices for the purpose of online engagement<br>  ○ service fees (e.g., funeral plans, accountant fees).<br>• Subsidised through other programs: |

| Participant contribution category | Service type | Services | In scope | Out of scope |
| --- | --- | --- | --- | --- |
| | | | • Support to engage in cultural activities for people with diverse backgrounds and life experiences. This includes older Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and lesbian, gay, bisexual, transgender and/or intersex people. Support may include:<br>○ assistance to access translating and interpreting services and translation of information into the older person's chosen language<br>○ referral pathways to advocacy or community organisations<br>○ assistance in attending cultural and community events.<br>• Access to training or direct assistance in the use of technologies to improve digital literacy where the | ○ the delivery of digital education where the need can be met through the Be Connected program delivered through the Department of Social Services. |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| | | | support aids independence and participation (e.g., paying bills online, accessing telehealth services, connecting with digital social programs).<br>• Internet and/or phone bills where the older person is at risk of, or is homeless, and support is needed to maintain connection to services | |
| | Therapeutic services for independent living | • Acupuncturist<br>• Chiropractor<br>• Diversional therapist<br>• Remedial masseuse<br>• Art therapist<br>• Osteopath | • Assistance (e.g., treatment, education, advice) provided by university qualified or accredited health professionals using evidence-based techniques to manage social, mental and physical wellbeing in support of the older person remaining safe and independent at home.<br>• Treatment programs should aim to provide the older person the skills and knowledge to manage their own condition and promote independent | • Subsidised through other programs:<br>○ other government programs must be exhausted in first instance if already in place (e.g., Chronic Disease Management Plan)<br>○ services more appropriately funded through the primary health care system (e.g., ambulance and hospital costs, medical diagnosis and treatment, medicine dispensing, |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| | | | recovery where appropriate.<br>• Interventions can be provided:<br>  ○ in-person or via telehealth<br>  ○ individually or in a group-based format (e.g., diversional therapist led recreation program).<br>• A treatment program may be delivered directly or implemented by an allied health assistant or aged care worker under the supervision of the health professional, where safe and appropriate to do so.<br>• Remedial massage may only be delivered by an accredited therapist, where included in a prescribed allied health treatment plan to address functional decline.<br>• Engagement of a diversional therapist to design and/or facilitate recreation programs that promote social, | psychiatry, dental care)<br>  ○ management of conditions unrelated to age/disability related decline (e.g., acute mental health)<br>  ○ services from a Chinese Medicine Practitioner, such as herbal medicine dispensing, are out of scope for aged care (see description for acupuncture exception).<br>• General expenses:<br>  ○ massage for relaxation<br>  ○ costs to participate in recreation programs (e.g., tickets, accommodation, membership fees, supplies to participate like craft materials). |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| | | | psychological and physical well-being for older people who live with age or disability related impairments that will benefit from a tailored program to enable and maintain participation. | |
| | Respite | • Respite care | • Supervision and assistance of an older person by a person other than their usual informal carer, delivered on an individual or group basis, in the home or community. | • Subsidised through other programs:<br>○ residential respite is funded through the Australian National Aged Care Classification funding model (AN-ACC). |
| | Transport | • Direct transport (driver and car provided)<br>• Indirect transport (taxi or rideshare service vouchers) | • Group and individual transport assistance to connect an older person with their usual activities. | • General expenses:<br>○ purchase of an individual's car and an individual's vehicle running costs<br>○ licence costs<br>○ professional transit services (e.g., public transport, flight, ferry)<br>○ claiming transport costs where state-based or local government travel assistance programs are available |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| | | | | ○ travel for holidays. |
| | Assistive technology and home modifications | • Assistive technology<br>• Home modifications | • Assistive technology and home modifications by the Assistive Technology and Home Modifications Scheme list, including wrap-around services, maintenance, and repair. | |
| **Everyday living**<br>Support to assist older people to keep their home in a liveable state in order to enable them to stay independent in their homes. | Domestic assistance | • General house cleaning<br>• Laundry services<br>• Shopping assistance | • Essential light cleaning (e.g., mopping, vacuuming, washing dishes).<br>• Launder and iron clothing.<br>• Accompanied or unaccompanied shopping. | • General expenses:<br>○ professional cleaning services that would usually be paid for (e.g., pest control, carpet cleaning, dry cleaning)<br>○ pet care<br>○ cost of groceries and other purchased items. |
| | Home maintenance and repairs | • Gardening<br>• Assistance with home maintenance and repairs<br>• Expenses for home maintenance and repairs | • Essential light gardening (e.g., lawn mowing, pruning and yard clearance for safe access).<br>• Essential minor repairs and maintenance where the activity is something the person used to be able to do themselves or where required to maintain safety (e.g., clean gutters, | • General expenses:<br>○ professional gardening services that would usually be paid for such (e.g., tree removal, landscaping, farm or water feature maintenance).<br>○ gardening services that relate to visual |

| Participant contribution category | Service type | Services | In scope | Out of scope |
|---|---|---|---|---|
| | | | replace lightbulbs and repair broken door handle). | appeal rather than safety/accessibility (e.g., installation and maintaining plants, garden beds and compost).<br>○ professional maintenance and repair services that would usually be paid for (e.g., professional pest extermination, installing cabinetry, replacing carpets due to usual wear and tear) except if there is an imminent age-related safety risk (e.g., repairing uneven flooring that poses a falls risk or section of carpet damaged by a wheelchair)<br>○ services that are responsibility of other parties (e.g., landlords, government housing authorities, generally covered by private insurance). |

| Participant contribution category | Service type | Services | In scope | Out of scope |
| --- | --- | --- | --- | --- |
| | Meals | • Meal preparation<br>• Meal delivery | • Support to prepare meals in the home.<br>• Pre-prepared meals. | • General expenses:<br>○ cost of ingredients<br>○ takeaway food delivery<br>○ meal delivery for other members of the household. |

# Appendix B – Information session slides

## Purpose and overview

**What is the cost collection and why is it being undertaken?**

- The purpose of this project is to collect cost data from providers to support the Independent Health and Aged Care Pricing Authority (IHACPA) in developing pricing advice for Support at Home (SAH) services, for the Minister for Health, Disability and Ageing.
- Short Term Restorative Care (STRC) and Home Care Packages (HCP) are both in scope for this cost collection, however the Commonwealth Home Support Programme (CHSP) has been excluded due to the Australian Governments staged approach to introduce CHSP into the SAH program no earlier than 1 July 2027.
- This is the third year IHACPA have undertaken a cost collection for SAH services. The Support at Home Cost Collection 2025 (SAHCC25) will build on the work undertaken in previous years, with a particular focus on collecting data from providers who were previously unable to participate, as well as from underrepresented cohorts, including:
  - Aboriginal and Torres Strait Islander Peoples
  - Rural and Remote Populations
  - Culturally and Linguistically Diverse Populations
- SAHCC25 will involve the collection of data at the service branch level (where available) for the year 1 July 2023 to 30 June 2024 (FY24).

2

## Plan for today

**The purpose of this session is to provide you with an understanding of what participation looks like. We will cover the following:**

1. **Focus of SAHCC25** – capturing data from underrepresented cohorts
2. **Type of data required** – summary of the data participants will be asked to provide
3. **Tailored data collection approach** – overview of how the data will be collected and the support that will be provided
4. **Timelines** – project timelines relevant to participants
5. **Data collection and transfer rules** – data privacy and security protocols for the SAHCC25
6. **Benefits of participation** – why this is beneficial for you

There will also be time at the end to ask questions to IHACPA and the project team.

3

# Focus of the SAHCC 2025

**The objective is to collect cost and activity data from a range of HCP and STRC providers at the service delivery branch level.**

- A service branch is identified using the NAPS ServiceID and is defined as *"the place of business of the registered provider through which funded aged care services are delivered to an individual"*.
- IHACPA are aiming to maximise representation from the following cohorts:
  - Aboriginal and Torres Strait Islander Peoples
  - Rural and Remote Populations (based on Modified Monash Model (MMM) classifications)
  - Culturally and Linguistically Diverse Populations
- Additional assistance will be provided to participants this year, acknowledging that previous collection methods may have posed challenges for some cohorts.
- Prior participants and providers that do not specifically target these cohorts are still eligible to participate in the cost collection.
- We will work with you to identify which of your service branches would be best placed to participate.

4

# Required data

**Participants will be asked to provide financial, activity and workforce data to enable the calculation of unit costs for each item on the Support at Home service list.**

This information will be requested at the branch level. Where this is not easily available, we will work with you to determine the best approach.

| Type of data | Description |
|---|---|
| Financial data | Costs incurred by the branch to deliver SAH services. This includes costs related to:<br>• Employed workforce<br>• Agency staff<br>• Sub-contractors and brokered client service cost<br>• Administrative costs and other overheads |
| Activity data | The types and volume of services delivered for the relevant branch at the service list level. |
| Workforce data | Workforce data may be required to supplement the financial and activity data, depending on the granularity of the information provided. This may include:<br>• Aggregated information on workforce hours and wages at the role level<br>• Mapping of which roles deliver each service |

5

# Tiered approach to participation

**The data collection approach for each participant, and the support provided, will be tailored to their individual capability and capacity to provide the required information.**

A 'tier' will be allocated to each type of data. The tiers are not rigid and service branches may have different tiers for each data type.

**Tier 1: Structured templates**

For participants with capability and capacity to deliver granular data in a pre-determined format.

- Participants will be provided a **data collection template** for completion at the **service branch level**.
- The format will be similar the to ACFR and QFR submissions, with additional granularity on some cost items (e.g. Allied Health).

**Tier 2: Data extracts**

For participants with capability but not capability or capacity to complete the data collection template.

- Participants will provide data extracts from their internal systems (dependent on data type).
- We will undertake the required data preparation and transformation, in consultation with the provider.

**Tier 3: Discover and support**

For providers that are unable to complete the templates or extract usable data.

- We will work with you to see what information can be provided.
- We will design a tailored, hands-on support approach based on your specific circumstances.

6

# SAHCC25 Onboarding

Your **dedicated SAHCC25 team member** will work with your nominated representative to understand the level of:

- Capability (dependent on systems and data availability) and;
- Capacity (dependent on key contact availability).

A **60-minute onboarding call** will be scheduled with your nominated contact. This meeting will be used to understand the challenges that may arise in the collection of the required cost data, and tailor an approach to address these.

*Example questions and question themes:*

***Organisation***

- What care streams does your organisation service? HCP, STRC, CHSP, NDIA, private, etc.
- How many clients does this branch look after?

***Financial data***

- Do you complete the ACFR? If so, is the data submitted at the same level as the branch?
- If you have multiple branches per ACPR, can you split these costs accurately down to an Outlet level?

***Activity data***

- What systems do you use to manage the following service delivery?
- How readily is data extracted from this system?

***Workforce data***

- What systems do you use to manage payroll?
- How readily is data extracted from this system?

# SAHCC25 Project timeline

| Topic | Timing | Indicative effort for providers |
|---|---|---|
| **Initial engagement** | June – early July | 1 day across this period. |
| **Data collection** | July – August | We will agree a timeline that suits you within this period.<br>The level of effort required will range from 2-3 days to ~2 weeks within a 4-week period depending on capability and capacity. |
| **Analysis and reporting** | October – December | No provider involvement required. |

| Key | |
|---|---|
| Indicative provider milestone | ◆ |
| Provider involvement available period | (dashed box) |
| Example provider effort requirement | (green bar) |
| Project team task | (blue bar) |

The below chart is an illustrative example of a single providers required time-commitments. This may vary depending on the level of support required.

# Data collection and transfer rules

Data security and compliance are extremely important to IHACPA and the SAHCC25 project and stringent process are in place to ensure the privacy and security of data for this project is upheld. The responsibility for the maintaining privacy and security of the data belongs to everyone – including participants.

## Data privacy – do not send personal information

No personally identifiable information will be collected for SAHCC25. As a participant, it is critical that you **do not provide any identifiable information** relating to clients or staff members, including but not limited to:

- Names
- Employee IDs
- Addresses
- Phone numbers
- Dates of birth
- Tax File Numbers
- AC-IDs

## Data security – do not send data via emails

Data will only be securely transferred through the **IHACPA Data Transfer Portal**. As a participant, it is critical that your organisation follows the data transfer rules and processes for the duration of the SAHCC25 and **do not email any data** to the SAHCC25 project team or IHACPA.

Further details of the approved data transfer process will be provided in the SAHCC25 information pack upon onboarding.

All data submitted to SAHCC25 project will be stored securely on IHACPA's Secure Data Management System (SDMS). This data will not be visible to anyone other than IHACPA and the SAHCC25 project team.

# Benefits of participation

At the end of the cost collection process, participants will receive:

1. **Finalised costed outputs** for your participating service branches, offering insights into your own data.
2. A **customised benchmarking report** relative to other cost collection participants (de-identified).
3. This work **supports the development of accurate pricing guidance** for in-home aged care based on actual service delivery costs.
4. IHACPA have listened to the SAH sector and are addressing the barriers to participation by providing **more dedicated support than previous studies.**
5. A key focus of the SAHCC25 project is to identify the cost variances for the targeted cohorts. If the service branches within your organisation cater to these cohorts, it is imperative that you participate to **ensure your costs are accurately represented in the pricing advice.**

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10

# Next steps

Following this session, we will send you an email with this presentation and a more detailed information pack. The email will also include a **participation confirmation form for completion**.

1. Please read this email and respond with any questions you may have.
2. Please have your nominated key contact **sign and return** the participation confirmation form via email (electronic signatures are accepted).

For all correspondence regarding the SAHCC25. Please use the below contact details:

- **Email:** *sahcc2025@scyne.com.au*
- **CC:** *agedcarecosting@ihacpa.gov.au*

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11

# Appendix C – Target participant characteristics

## C.1 Qualifying targeted cohort branches

The SAHCC25 used criteria defined in the *Specialisation Verification Framework* published by the department to determine when a branch qualified as being a specialised provider of services to Aboriginal and Torres Strait Islander clients. The same approach was taken to identify branches specialising in provided services to Culturally and Linguistically Diverse populations. This was consistent with IHACPA's approach in previous Support at Home cost collections.

The criteria are detailed below:

**Aboriginal and Torres Strait Islander Peoples:**

*At least 50% of aged care recipients identify as Aboriginal and Torres Strait Islander peoples.*

**Culturally and Linguistically Diverse Peoples:**

*At least 50% of the clients that receive services from this branch identify as having a Culturally and Linguistically Diverse background.*

The SAHCC25 considered both rural and remote branch representation in the final sample. These branches have been grouped into 2 separate categories for reporting purposes:

**Rural Populations:**

*If the services that are provided by this branch are administered within a qualifying MMM:*

*MM3 – Large rural town*

*MM4 – Medium rural town*

*MM5 – Small rural town*

**Remote Populations:**

*If the services that are provided by this branch are administered within a qualifying MMM:*

*MM6 – Remote community*

*MM7 – Very remote community*

## C.2 Considerations for participation

In addition to SAHCC25 targeted cohorts, the participation framework considered a range of broader branch characteristics. These characteristics are detailed in **Table 13** below:

Table 13 - Branch characteristics

| Sample Characteristics | Considerations |
|---|---|
| Branch remoteness | The MMM for remoteness was considered to ensure a mix of metro, rural and remote branches.<br>The SAHCC25 sample aimed to include rural and remote services branches (MM3-7). |
| Diverse populations – package recipients | The sample prioritised the involvement of a mix of branches identified as providing services to:<br>• Aboriginal and Torres Strait Islander peoples<br>• People from Culturally and Linguistically Diverse (CALD) backgrounds. |
| Ownership structure | Different ownership models varied in the branch and staffing models. The sample considered a mix of government (state and local), not-for-profit, and for-profit branches. |
| Branch location (State/Territory) | The sample considered a mix of branches from different States and Territories. |
| Number of clients (size) | The 'size' of a branch was determined by the number of clients served:<br>• 100 or less<br>• 101 to 500<br>• 501 to 1000<br>• 1001 or more<br>The sample considered a mix of branches by size. |

In considering the characteristics above, it was not intended that the SAHCC25 sample would be statistically representative of the sector based on all these dimensions given the greater focus on the target SAHCC25 cohorts.

# Appendix D – Confidence intervals

The measures included in **Table 14** are defined below:

- **Service type:** A major grouping of care/support services under the Support at Home service list
- **Subcategory:** A more defined service offering within a service type
- **Number of branches:** The number of branches with data contributing to the SAHCC25 sample and used to calculate the mean cost
- **Unit cost:** The average cost per unit for the service subcategory – in most cases, the unit of activity is an hour, with the exception of meal delivery (meals) and direct transport (trips)
- **Standard error:** The standard error of the SAHCC25 sample observations

The lower and upper bound defines the 95% confidence interval, which is the range in which the true unit cost would fall with a 95% probability, given repeated sampling.

A weighted confidence interval has been determined, using the volume of activity as the weighting variable to reflect the size of each branch.

These confidence intervals have been performed on the full costed dataset, without any data trimming applied.

Table 14 - SAHCC25 confidence intervals

| Service type | Subcategory | Number of branches | Unit cost | Standard error | 95% CI Lower bound | 95% CI Upper bound |
|---|---|---|---|---|---|---|
| Nursing care | Registered nurse | 97 | $215.92 | $17.37 | $181.87 | $249.97 |
| | Enrolled nurse | 48 | $174.27 | $27.72 | $119.94 | $228.61 |
| | Nursing assistant* | 2 | * | * | * | * |
| Allied health and other therapeutic services | Allied health therapy assistant | 26 | $158.65 | $20.76 | $117.96 | $199.34 |
| | Counsellor or psychotherapist | 7 | $201.21 | $35.30 | $132.01 | $270.41 |
| | Dietitian or nutritionist | 51 | $163.65 | $13.96 | $136.29 | $191.02 |
| | Exercise physiologist | 49 | $165.07 | $8.98 | $147.46 | $182.67 |
| | Music therapist | 6 | $134.67 | $8.22 | $118.57 | $150.78 |
| | Occupational therapist | 76 | $153.41 | $18.16 | $117.83 | $189.00 |
| | Physiotherapist | 80 | $168.29 | $9.11 | $150.43 | $186.15 |
| | Podiatrist | 78 | $161.88 | $13.73 | $134.96 | $188.80 |
| | Psychologist | 15 | $168.09 | $16.54 | $135.66 | $200.51 |
| | Social worker | 19 | $159.16 | $13.73 | $132.26 | $186.07 |
| | Speech pathologist | 41 | $184.15 | $12.79 | $159.08 | $209.21 |
| | Unallocated allied health and other therapeutic services | 47 | $155.19 | $7.19 | $141.09 | $169.29 |
| Care management | Care management (clinical) | 42 | $111.50 | $11.46 | $89.03 | $133.97 |
| | Care management (non-clinical) | 78 | $100.08 | $6.16 | $88.00 | $112.16 |
| | Care management | 49 | $107.66 | $6.29 | $95.34 | $119.98 |
| Restorative care management | Restorative care management* | 3 | * | * | * | * |

| Service type | Subcategory | Number of branches | Unit cost | Standard error | 95% CI Lower bound | 95% CI Upper bound |
|---|---|---|---|---|---|---|
| Personal care | Personal care | 133 | $83.29 | $5.29 | $72.93 | $93.66 |
| Social support and community engagement | Group social support | 34 | $57.15 | $19.63 | $18.67 | $95.63 |
| | Individual social support | 116 | $89.46 | $3.26 | $83.08 | $95.84 |
| | Digital education and support* | 4 | * | * | * | * |
| | Assistance to maintain personal affairs* | 2 | * | * | * | * |
| Therapeutic services for independent living | Acupuncturist | 12 | $149.60 | $10.35 | $129.32 | $169.88 |
| | Chiropractor | 31 | $125.74 | $15.92 | $94.53 | $156.95 |
| | Diversional therapist* | 3 | * | * | * | * |
| | Remedial masseuse | 54 | $149.62 | $8.24 | $133.46 | $165.78 |
| | Art therapist | 6 | $107.69 | $23.32 | $62.00 | $153.39 |
| | Osteopath | 17 | $141.53 | $14.99 | $112.16 | $170.90 |
| Respite | Respite care | 89 | $97.50 | $3.92 | $89.81 | $105.19 |
| Transport | Direct transport (driver and car provided) | 54 | $94.47 | $22.68 | $50.02 | $138.91 |
| Domestic assistance | Domestic assistance | 119 | $89.90 | $3.35 | $83.34 | $96.47 |
| Home maintenance and repairs | Gardening | 87 | $98.96 | $3.44 | $92.22 | $105.69 |
| | Assistance with home maintenance and repairs | 38 | $138.38 | $18.35 | $102.42 | $174.35 |
| Meals | Meal preparation | 23 | $88.20 | $4.95 | $78.49 | $97.91 |
| Meals | Meal delivery | 49 | $19.48 | $2.29 | $15.00 | $23.96 |

* Results have been masked in this section of the report where there were fewer than 5 branches or 3 providers contributing to the data.

# Appendix E – Detailed reporting of allied health and therapeutic service subcategories

**Figure 44** and **Figure 45** below display the unit costs for all allied health and other therapeutic services subcategories for participating providers and branches subject to masking criteria.

Figure 44 - Unit costs for allied health service subcategories

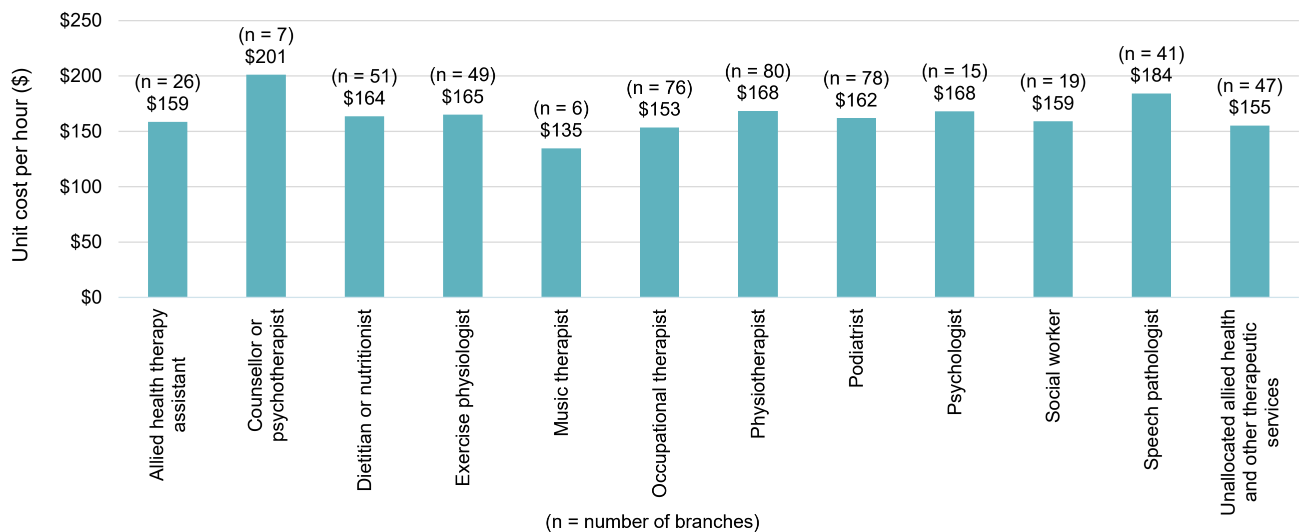



Figure 45 - Unit costs for therapeutic services subcategories

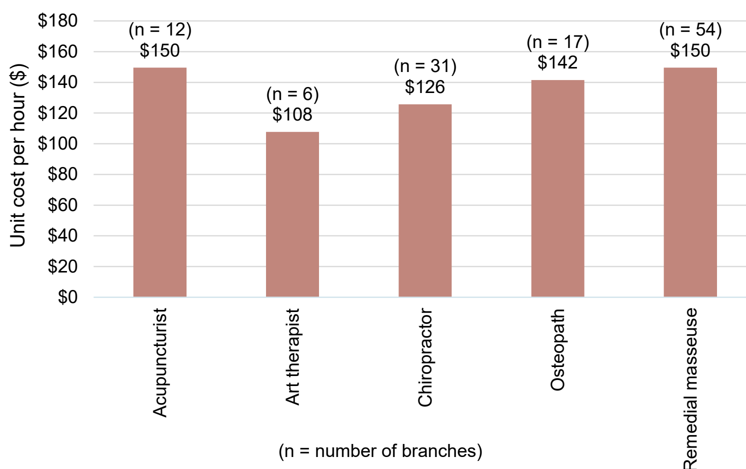
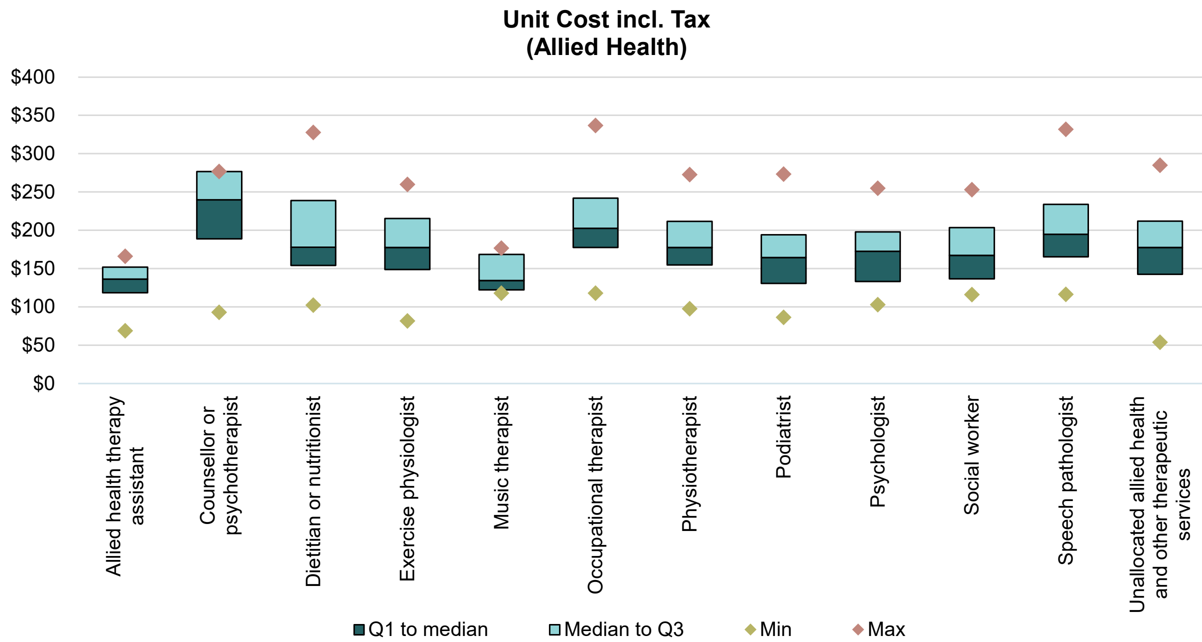
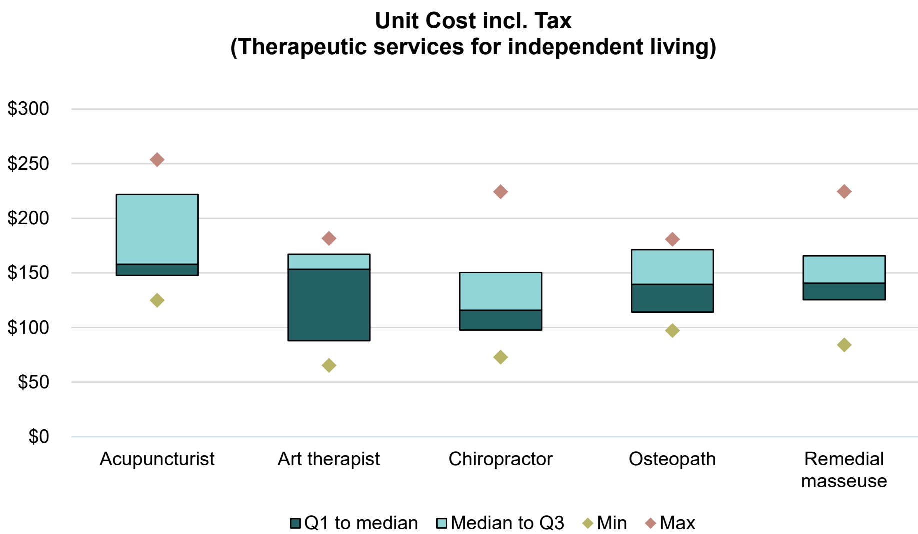


**Figure 46** and **Figure 47** below display the distribution of unit costs for all allied health and other therapeutic services subcategories for participating providers and branches subject to masking criteria.

## Figure 46 - Distribution of unit costs allied health service subcategories




## Figure 47 - Distribution of unit costs for therapeutic services subcategories



# Appendix F – Unit costs for all subcategories

| Service type | Sub-category | Number of branches | Unit cost |
| --- | --- | --- | --- |
| Nursing care | Enrolled nurse | 48 | $174 |
| | Nursing assistant | 2 | * |
| | Registered nurse | 97 | $216 |
| Allied health and other therapeutic services | Allied health therapy assistant | 26 | $159 |
| | Counsellor or psychotherapist | 7 | $201 |
| | Dietitian or nutritionist | 51 | $164 |
| | Exercise physiologist | 49 | $165 |
| | Music therapist | 6 | $135 |
| | Occupational therapist | 76 | $153 |
| | Physiotherapist | 80 | $168 |
| | Podiatrist | 78 | $162 |
| | Psychologist | 15 | $168 |
| | Social worker | 19 | $159 |
| | Speech pathologist | 41 | $184 |
| | Unallocated allied health | 47 | $155 |
| Care management | Care management | 49 | $108 |
| | Care management (clinical) | 42 | $111 |
| | Care management (non-clinical) | 78 | $100 |
| Restorative care management | Restorative care management | 3 | * |
| Personal care | Personal care | 133 | $83 |
| Social support and community engagement | Assistance to maintain personal affairs | 2 | * |
| | Digital education and support | 4 | * |
| | Group social support | 34 | $57 |
| | Individual social support | 116 | $89 |
| | Unallocated social support and community engagement | 1 | * |
| Therapeutic services for independent living | Acupuncturist | 12 | $150 |
| | Art therapist | 6 | $108 |
| | Chiropractor | 31 | $126 |
| | Diversional therapist | 3 | * |
| | Osteopath | 17 | $142 |
| | Remedial masseuse | 54 | $150 |
| Respite | Respite care | 89 | $98 |
| Transport | Direct transport (driver and car provided) | 54 | $94 |
| Domestic assistance | Domestic assistance | 119 | $90 |
| Home maintenance and repairs | Assistance with home maintenance and repairs | 38 | $138 |
| | Gardening | 87 | $99 |
| Meals | Meal delivery | 49 | $19 |
| | Meal preparation | 23 | $88 |

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