Support at Home Costing Study

Study Report

Independent Health and Aged Care Pricing Authority

FINAL

21 March 2024

Building a better working world

RELEASE NOTICE

Ernst & Young ("EY") was engaged on the instructions of the Independent Health and Aged Care Pricing Authority ("Client") to conduct the Support at Home Costing Study ("Project"), in accordance with the engagement agreement dated 3 March 2023 ("the Engagement Agreement").

The results of EY's work, including the assumptions and qualifications made in preparing the report, are set out in EY's report dated 21 March 2024 ("Report"). You should read the Report in its entirety including any disclaimers and attachments. A reference to the Report includes any part of the Report. No further work has been undertaken by EY since the date of the Report to update it.

Unless otherwise agreed in writing with EY, any party accessing the Report or obtaining a copy of the Report ("Recipient") agrees that its access to the Report is provided by EY subject to the following terms:

1. The Report cannot be altered.

2. The Recipient acknowledges that the Report has been prepared for the Client and may not be disclosed to any other party or used by any other party or relied upon by any other party without the prior written consent of EY.

3. EY disclaims all liability in relation to any party other than the Client who seeks to rely upon the Report or any of its contents.

4. EY has acted in accordance with the instructions of the Client in conducting its work and preparing the Report, and, in doing so, has prepared the Report for the benefit of the Client, and has considered only the interests of the Client. EY has not been engaged to act, and has not acted, as advisor to any other party. Accordingly, EY makes no representations as to the appropriateness, accuracy or completeness of the Report for any other party's purposes.

5. No reliance may be placed upon the Report or any of its contents by any party other than the Client. A Recipient must make and rely on their own enquiries in relation to the issues to which the Report relates, the contents of the Report and all matters arising from or relating to or in any way connected with the Report or its contents.

6. EY have consented to the Report being published on the Independent Health and Aged Care Pricing Authority's website for informational purposes only. EY have not consented to distribution or disclosure of the Report beyond this.

7. No duty of care is owed by EY to any Recipient in respect of any use that the Recipient may make of the Report.

8. EY disclaims all liability, and takes no responsibility, for any document issued by any other party in connection with the Project.

9. A Recipient must not name EY in any report or document which will be publicly available or lodged or filed with any regulator without EY's prior written consent, which may be granted at EY's absolute discretion.

10. A Recipient:

    a. may not make any claim or demand or bring any action or proceedings against EY or any of its partners, principals, directors, officers or employees or any other Ernst & Young firm which is a member of the global network of Ernst & Young firms or any of their partners, principals, directors, officers or employees ("EY Parties")

arising from or connected with the contents of the Report or the provision of the Report to the recipient; and

b. must release and forever discharge the EY Parties from any such claim, demand, action or proceedings.

11. If a Recipient discloses the Report to a third party in breach of this notice, it will be liable for all claims, demands, actions, proceedings, costs, expenses, loss, damage and liability made or brought against or incurred by the EY Parties, arising from or connected with such disclosure.

12. If a Recipient wishes to rely upon the Report that party must inform EY and, if EY agrees, sign and return to EY a standard form of EY's reliance letter. A copy of the reliance letter can be obtained from EY. The Recipient's reliance upon the Report will be governed by the terms of that reliance letter.

Ernst & Young's liability is limited by a scheme approved under Professional Standards Legislation.

Acknowledgement

EY and the Independent Health and Aged Care Pricing Authority (IHACPA) would like to acknowledge and thank the in-home aged care providers who have participated in the Support at Home Costing Study. The time and effort invested by these providers is acknowledged and greatly appreciated. The insights and data that have been provided through their participation in the Study is an important first step for IHACPA to understand the costs associated with the delivery of in-home aged care services and will help support future pricing advice for Support at Home services.

Table of contents

Glossary

Term	Definition
ABN	Australian Business Number
ACFR	Aged Care Financial Report
ACPR	Aged Care Planning Region
AN-ACC	The Australian National Aged Care Classification
ATHM	Assistive technology and home modifications
CAPS	Continence Aids Payment Scheme
CHSP	Commonwealth Home Support Programme
DRS	Data Request Specification
EBA	Enterprise Bargaining Agreement
EY	Ernst & Young
FAQ	Frequently asked question
FTE	Full-time Equivalent
FY	Financial Year
GLM	Generalised Linear Model
HCP	Home Care Packages
IACWG	Interim Aged Care Working Group
IHACPA	Independent Health and Aged Care Pricing Authority
MMM	Modified Monash Model
NAPS	National Approved Provider System
NDIS	National Disability Insurance Scheme
NMBA	Nursing and Midwifery Board of Australia
NSAF	National Screening and Assessment Form
PBS	Pharmaceutical Benefits Scheme
Q&A	Question and Answer
QFR	Quarterly Financial Report
RA	Remoteness Area
SDMS	Secure Data Management System
STRC	Short-term Restorative Care
VBA	Visual Basic for Applications

1. Executive summary

1.1 Background

The Independent Health and Aged Care Pricing Authority (IHACPA) engaged Ernst & Young (EY) to perform the Support at Home Costing Study (the "Study") to support the future pricing advice that IHACPA will provide to the Minister for Health and Aged Care. This Report details the key findings and recommendations from the Study and outlines the insights from the development of the costed dataset.

At the time of reporting, help at home (or "in-home aged care") comprised three programs: (1) Commonwealth Home Support Programme (CHSP), (2) Home Care Packages (HCP), and (3) Short-term Restorative Care (STRC). The Department of Health and Aged Care was also in the process of reforming in-home aged care with the new Support at Home program, which will be implemented in two stages, from 1 July 2025.

The Study is an important foundational step in understanding the fully absorbed costs of the in-home aged care sector and was delivered within an evolving policy context. The Study was designed to be repeatable and is intended to be one of several that will be needed to fully understand cost. Given the evolving policy context, the constraints the sector faces, and the immaturity of existing data collections – improvements over time in the sector's systems and data will assist to support the ongoing collection of robust data that can be relied upon for future pricing advice.

1.2 Study approach

The Study aimed to: (1) build an understanding of the in-home aged care sector's existing cost structures and operations, (2) develop knowledge of the data infrastructure, business systems and programs used by providers to collect data (financial and service delivery), and (3) perform a data collection to prepare a costed dataset, building on existing data.

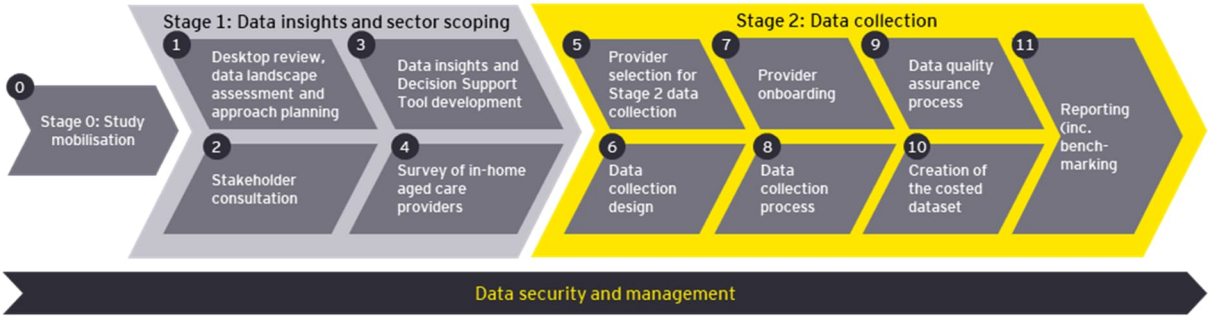
The Study was conducted between March 2023 and February 2024 and focused on in-home aged care costs for CHSP, HCP and STRC, in accordance with the policy arrangements during that period. The Study involved three stages of work (as outlined in Figure 1):

- Stage 0: Study mobilisation – Established the Study governance arrangements, confirmed the overall Study approach, developed a stakeholder engagement and communications plan, and established a risk register.

- Stage 1: Data insights and sector scoping – Developed a baseline understanding of the in-home aged care sector and insights from existing data sources, with the primary aim of informing the scope and design of the Stage 2 data collection. This included consultation with 20 in-home aged care providers and a survey of 111 providers. A Decision Support Tool was developed to be complementary to the Stage 2 data collection and can be used by IHACPA to support future pricing advice.

- Stage 2: Data collection and costed dataset – Data collection with a sample of in-home aged care providers was performed and a costed dataset prepared. This involved development of a Data Request Specification (DRS) template to collect cost, activity, and workforce data from providers. Data was provided over an eight-week period via IHACPA's secure data portal, with a total of 44 completed DRS responses received, relating to 48 providers. This data was processed and analysed to create the costed dataset.

Figure 1: Overview of the study approach



The Study scope and approach evolved over the Study period. This reflected that: (a) the Study was exploratory in nature and the lessons learnt from each activity were applied to the next, (b) the Study was being delivered within an evolving policy context, (c) there was limited existing data to develop a costed dataset, and (d) that relationships with the in-home aged care sector needed to be developed as part of the Study.

1.2.1 Stakeholder engagement and participation

Intensive engagement with providers was undertaken by the Study team, to both educate providers on the Study requirements and to obtain their participation in Study activities. In total, 152 in-home aged care providers participated in the Study across the Stage 1 consultations, the Stage 1 Provider Survey and the Stage 2 data collection.

While 90 providers initially confirmed their involvement in the Stage 2 data collection, data was received from 48 providers. The drop-off in provider participation was primarily due to the timing and timeframe of the Study (e.g., the data collection period coincided with mandatory Aged Care Financial Report (ACFR) and Quarterly Financial Report (QFR) reporting for all in-home aged care providers), with the competing priorities impacting provider capacity.

Nevertheless, the Stage 2 data collected had coverage across the different programs, organisation types, provider size, and geography (based on the Modified Monash Model (MMM) and jurisdiction). Out of the 48 providers that submitted data, 42 were CHSP providers, 40 were HCP providers, and 10 were STRC providers. These providers reflect 13 per cent, 16 per cent and 24 per cent of total Commonwealth funding for CHSP, HCP and STRC respectively, and provide care to 118,000 CHSP recipients, 44,000 HCP clients, and 2,000 STRC clients. However, there were some provider characteristics with a lower number of data points. This included providers operating in Northern Territory, South Australia, Tasmania, and in MMM7.

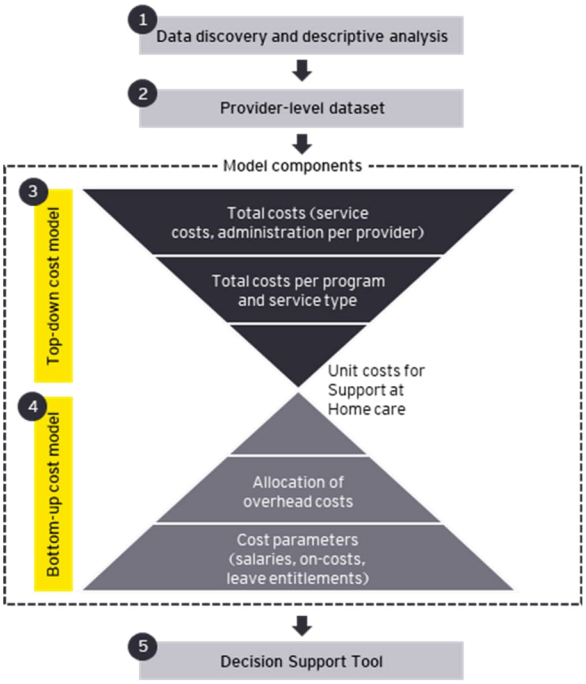
Despite these limitations of the Stage 2 data collection, the cost insights in this Report contribute to the evidence base in understanding costs for the Support at Home program and provide a solid foundation for future costing studies.

1.2.2 Data collection and analysis

Stage 1: Data insights and Decision Support Tool development

As outlined in Figure 2, several activities were undertaken in Stage 1 to provide an understanding of the availability, granularity, and limitations of existing data sources and thus inform the Stage 2 data collection and analysis. Key modelling artefacts from Stage 1 included a consolidated provider-level dataset (#2 in Figure 2) and a Decision Support Tool (#5 in Figure 2). The Decision Support Tool consolidated results from the top-down and bottom-up cost models, including the average cost for service types and subcategories, and the impact of different provider and client characteristics on costs.

Figure 2: Overview of data insights and Decision Support Tool activity



Stage 2: Data collection

For the Stage 2 data collection, the DRS template facilitated the collection of cost, activity, and workforce data from providers.

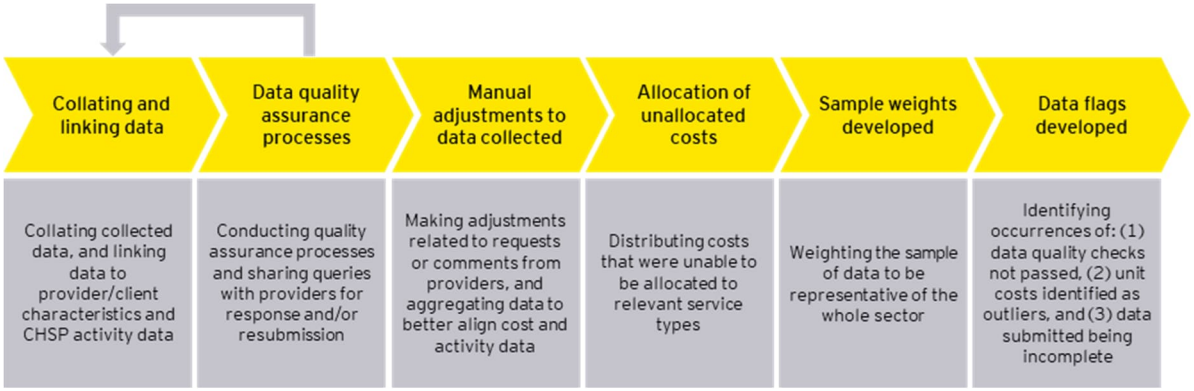
The cost data requested from providers was based on the existing *Financial Year (FY) 2021–22 HCP ACFR Income and Expenditure Statement*, with more granular data requested at a service type-level. The period chosen for the data collection was FY22, to align with existing completed and available ACFR data. The data requested from providers is shown in Table 1. The table cells denoted by (P) relate to the data that providers were asked to prioritise.

Table 1: Overview of data requested in the Stage 2 Data Collection using the DRS template

Program	Cost	Activity	Workforce
CHSP	Aged Care Planning Region-level costs by service type Time period: FY22 (P)	*No activity data required for CHSP only (because already available)*	*Workforce data was collected consistently across all programs*
HCP	Aged Care Planning Region-level costs by service type Time period: FY22 (P)	Aged Care Planning Region-level activity volumes by service type Time period: FY22 (P)	
		Aged Care Planning Region-level activity volumes by subcategory Time period: FY22	
STRC	Provider-level costs by service type Time period: FY22 (P)	Provider-level activity volumes by service type Time period: FY22 (P)	
		Provider-level activity volumes by subcategory Time period: FY22	
Across all programs	*Cost data was only collected at program level*	Provider-level activity volumes by time of the week delivered and service type, measured as a percentage breakdown of activity performed across days Time period: FY22	Staff Full-time Equivalent (FTE) within awards / Enterprise Bargaining Agreement (EBA) Time period: Determined by the provider

Figure 3 describes the steps that were undertaken in the creation of the costed dataset (a more detailed description of these components is included in the *Addendum to the Study Report: Costed Dataset Technical Documentation).*

Figure 3: Costed dataset development process



While data quality assurance processes helped to resolve unintended errors in the data provided, it was not possible to resolve all identified issues due to provider's system or timeframe challenges.

The *Addendum to the Study Report: Costed Dataset Technical Documentation* is provided separate to this Study Report. It provides additional technical detail on the data processes undertaken on the collected provider cost and activity data.

1.2.3 Data security and management

Maintaining data security was a key principle in the conduct of the Study. IHACPA's Secure Data Management System (SDMS) was utilised as part of strict data management protocols to enhance data security. A key feature of the SDMS was the secure data portal, which supported secure two-way data transfer in and out of the SDMS environment. All providers who participated in the Stage 2 data collection were required to obtain access to SDMS for secure two-way data transfer (i.e., for both receiving data collection templates and submitting data). The Study team worked closely with each provider to support adherence to the data protocols. As a result, there were no data breach incidents incurred during the conduct of this Study.

1.2.4 Study limitations

The key limitations which impact the interpretation of the Study results include:

- Representativeness of the sample: Due to the tight timeframes of the Study, there were a limited number of providers who participated in the Stage 2 data collection, which impacted the representativeness of the sample and limits the reliability of inferences made with the data collected.

- Data quality issues were identified: Whilst attempts were made to resolve data quality issues, they could not always be fully resolved due timing or limitations in the granularity of data held by providers. Known data quality issues included data that failed the quality assurance checks and outlier data points. In addition, the approach to allocating unallocated costs was based on a set of business rules, and the calculated unit costs were sensitive to the allocation approach adopted. There were some service types with additional limitations, arising from low number of observations collected.

- The Support at Home program is still under development at the time of this Report: Given the approaches used in the Study were based on draft policy, some results may not be relevant once policy is confirmed.

- The Study period was based on FY22: This period was chosen for the Study to align with existing completed and available ACFR data. Results presented in this Report have not been indexed, and do not reflect recent expense increases since FY22.

1.3 Study outputs

1.3.1 Costed dataset

The costed dataset collated the data collected from the sample of providers, along with other data sources to create a dataset that can be used to support future pricing advice for the Support at Home program. The costed dataset contained data on costs, activity volumes and unit costs for each service type in FY22 from 48 providers.

1.3.2 Benchmarking reports

In addition to this Report, benchmarking reports were developed for each provider who submitted data as part of the Stage 2 data collection. For each service type, these reports benchmarked each provider's unit costs against the distribution of unit costs across all participating providers.

1.4 Cost insights

The costs collected in this Study were broadly in line with observable price points and trends in the care and support sector. The median unit costs for service types measured in hourly units were highest for *allied health and other therapeutic services*, *specialised support services*, and *nursing care*. The median unit costs for service types measured in hourly units were lowest for *assistance with hoarding and squalor* and *care management*, however these results were likely to be influenced by low data availability and quality. Specifically, *care management* cost data capture was ambiguous and variable, both across and within in-home aged care programs, posing challenges in understanding the true cost.

The unit costs were also segmented and analysed by program (CHSP compared to HCP/STRC), rurality (areas where clients were mainly from MMM5-7 compared to areas where clients were mainly from MMM1-4) and provider size (providers with between 1-500 clients inclusive compared to providers with more than 500 clients). Unit costs for Support at Home services were typically higher in areas where clients were mainly from MMM5-7, compared to areas where clients were mainly from MMM1-4. However, the trends by program and provider size were not consistent across service type.

Collecting data by expense category supported an understanding of the cost compositions by service type. Labour costs were the largest cost bucket for all Support at Home service types and account for 40 per cent to 60 per cent of the total costs in most service types. The composition of labour types varied by service types – *specialised support services*, *assistance with hoarding and squalor* and *meal preparation* and *nursing care* service types were mainly staffed internally, whereas *home maintenance* and *meal delivery* service types utilised more external labour.

1.5 Study learnings and recommendations for future costing studies

This Study assists in better understanding the costs in the Support at Home sector, in what is an evolving policy landscape. It is a proof-of-concept for future costing studies and builds upon and extends the work performed in previous costing studies, capturing data at a more granular level i.e., by detailed expense categories and by service types. As such, there are learnings from this Study can be used to inform future costing studies.

1.5.1 Overarching Study learnings and recommendations

There were several overarching Study learnings and recommendations which are outlined below.

Table 2: Overarching study learnings and recommendations

Learning	Recommendation
1. Future costing studies can build upon this Study to fill in gaps and increase the representativeness of the sample.	1. IHACPA should conduct future costing studies to increase the representativeness of the costed dataset, particularly focusing on HCP and STRC initially. These future costing studies should seek to target gaps in the data collected in this Study, including STRC providers, providers operating in Northern Territory, South Australia, Tasmania, and in MMM7, and the *care management*, *assistance with hoarding and squalor*, *nutrition*, *specialised support services* and *meal preparation* service types.
2. To understand costs, there is a need to triangulate the current and future costing study results to other data inputs.	2. To gain an understanding of costs, IHACPA should consider the use of other data inputs, in addition to the outputs of this Study and future costing studies. These data inputs include price points in adjacent sectors and the outputs of complementary cost modelling.
3. It will be important to obtain feedback from providers who participated in this Study to inform the design, implementation, and timing of future costing studies.	3. IHACPA should conduct a survey for providers who participated in the Stage 2 data collection to obtain feedback on what went well and what could be improved on, to inform future costing studies.
4. Future data collections may need to be mandated and/or integrated with other data collection processes to increase provider participation and reduce provider burden.	4. In the long-term, IHACPA should explore opportunities to expand existing mandatory data collections, such as the ACFR/QFR and other routinely collected datasets held by the Department of Health and Aged Care, to capture service type-level cost and activity data.

1.5.2 Stakeholder engagement

Learnings and recommendations related to stakeholder engagement are outlined below.

Table 3: Stakeholder engagement learnings and recommendations

Learning	Recommendation
5. Broad sector engagement and education to providers on the study may have been beneficial in reducing the lead time to recruit and onboard providers and increase participation.	5. IHACPA should implement a sector engagement and education strategy that maintains the provider relationships established through this Study and to facilitate the establishment of new relationships, so that providers are kept informed and are engaged ahead of the commencement of future costing studies. 6. IHACPA should maintain a client relationship management tool of in-home aged care providers for future studies.
6. A resource-intensive and multifaceted approach was needed to attract provider participation in the Stage 2 data collection and to support to providers to improve data quality and obtain data within the Study timelines.	7. IHACPA should consider this Study as a guide for stakeholder support requirements during future costing studies (e.g., resourcing and time required) to increase provider participation, along with the number and quality of data submissions.

1.5.3 Data collection design and process

Learnings and recommendations related to the data collection design and process are outlined below.

Table 4: Data collection design and process learnings and recommendations

Learning	Recommendation
Data collected and the DRS template design	
7. Having access to the structure of the pricing advice that IHACPA provides to the Minister would have supported the data collection to be more tailored.	8. IHACPA should seek to align future costing studies to the finalised service list and the structure of the pricing advice that IHACPA provides to the Minister. This may include designing the costing study to capture more explicitly: costs and activity using the MMM/Remoteness Area (RA) classifications, subcategory-level costs, and provider, service and service delivery characteristics.
8. Discrepancies between CHSP administrative data and data on provider systems led to challenges in calculating unit costs.	9. To minimise the discrepancies between different data sources, in the short-term it is recommended that CHSP activity at a service type-level is collected within the costing studies. 10. IHACPA should inform the Department of Health and Aged Care about the identified data discrepancies and work with them to understand and resolve issues where possible, enhancing the quality of the data.
9. Providers experienced challenges with providing FY22 data in the Stage 2 data collection.	11. In conducting future costing studies, IHACPA should consider using more recent data, if possible. IHACPA should also analyse the costs obtained in future costing studies to understand the extent that current and future reforms impact costs to providers.
10. There were numerous approaches to allocating costs to service types that could have been used in the Study, each with their respective advantages and disadvantages.	12. Building on Recommendation 2, the provider survey could include questions that seek feedback from providers on their ease in allocating costs to service types themselves, and whether there are alternative approaches that could be used in the future.
11. Insights gained within this Study are useful for refining the cost allocation methodology and developing costing standards for the Support at Home program.	13. When the Support at Home program takes shape and the service list is finalised, IHACPA should develop a transparent cost allocation method and costing standards for the Support at Home program to improve the quality of data collected.
Data transfer	
12. The use of IHACPA's secure data portal was critical in maintaining data security, although onboarding providers to this data portal took longer than planned.	14. IHACPA should build in sufficient time to allow for new providers to be engaged and onboarded to the secure data portal, both at the outset and over the course of the data collection period. 15. IHACPA should consider allowing multiple relevant contacts per organisation to be identified and provided access to the secure data portal.
Quality assurance and data quality	
13. The process of sharing queries with providers and requesting resubmissions used in this Study can be refined for future studies.	16. For future costing studies, IHACPA should consider building in additional automated checks within the DRS template to reduce the extent of the data-related queries required during the quality assurance process.
14. Obtaining sign-off from providers on data submissions could increase the quality of data in the future.	17. IHACPA should obtain provider sign-off to increase data quality. This sign-off could be at the point of submission, and on the final data post quality assurance and allocation processes. This could be similar to an ACFR Declaration, which is signed by a member of the governing board.

1.5.4 Timing and timeframe of future studies

Learnings and recommendations related to the data collection design and process are outlined below.

Table 5: Timing and timeframe of future studies learnings and recommendations

Learning	Recommendation
15. Lengthening the period for data collection would have supported greater provider participation and improved data quality.	18. IHACPA should lengthen the period for data collection, beyond the eight-week period used for this Study, to increase provider participation and improve data quality.
16. Considering the suitability of the data collection timing for providers would have better supported provider participation.	19. IHACPA should take into account the timing of competing reporting priorities for future data collection requests, to increase provider participation.

2. Introduction

2.1 Purpose of this report

This Report details the key findings and recommendations from the Study and outlines the key cost insights from the development of the costed dataset. The findings have been derived from several data sources, including a desktop review and assessment of the existing data landscape, stakeholder consultations, a survey of the in-home aged care sector, the collection of provider cost, activity and workforce data, and data analyses.

The *Addendum to the Study Report: Costed Dataset Technical Documentation* is provided separate to this Study Report. It provides additional technical detail on the data processes undertaken on the collected provider cost and activity data.

2.2 Background and context to the study

Recommendations from the Royal Commission into Aged Care Quality and Safety included the establishment of an independent pricing authority for aged care services. To address this recommendation, IHACPA's role was expanded on 12 August 2022, to provide aged care costing and pricing advice to the Minister for Health and Aged Care. It is the Minister for Health and Aged Care who is responsible for determining the price for aged care services.

At the time of this Report, in-home aged care consisted of three programs: (1) CHSP, (2) HCP, and (3) STRC.

Meanwhile, the Department of Health and Aged Care was in the process of reforming in-home aged care with the Support at Home program. The Support at Home program is being developed in response to the Royal Commission and aims to consolidate the existing in-home aged care programs and simplify the assessment processes through a new single assessment system. The Support at Home program will replace the HCP and STRC programs from 1 July 2025. The CHSP will transition to the new program no earlier than 1 July 2027.[1]

During the period of this Study, the policy, design, and implementation details for the Support at Home program were still under development. This Study was based on the draft design of the program as of July 2023.

2.3 Objectives and scope of the study

IHACPA engaged EY to develop a costed dataset that would be used to support future pricing advice to the Minister for Health and Aged Care for the Support at Home program. The Study was conducted from March 2023 to February 2024.

The key objectives of the Study were to:

1. Build IHACPA's understanding of the in-home aged care sector's existing cost structure and operations.

2. Provide IHACPA with knowledge of how the existing data infrastructure, business systems and programs have been used to date by providers to collect data (financial and service delivery).

[1] Australian Government Department of Health and Aged Care, About the reforms to in-home aged care, https://www.health.gov.au/our-work/reforming-in-home-aged-care/about-the-reforms-to-in-home-aged-care#:~:text=We%20are%20reforming%20in%2Dhome,earlier%20than%201%20July%202027. [accessed 11/12/2023]

3. Perform a data collection to prepare a costed dataset to support pricing for Support at Home services, building on existing data and the findings that have been collated through the Department of Health and Aged Care and this Study.

The scope of the Study was understanding costs, in accordance with current policy arrangements, for the following in-home aged care programs: CHSP, HCP and STRC. The Study was limited in scope, with the following considerations noted below.

- Indicative service list: The Study was based on the service types and subcategories that are delivered to older people though the Home Care Package and Commonwealth Home Support Programme today ("indicative service list" – see Appendix A). Assistive technology and home modifications (ATHM) were not in scope service types for this Study.

- STRC: STRC can be provided in both the home and in a residential care setting. The costs in delivering STRC in a home setting was in scope for this Study, whilst costs relating to a residential care setting were not in scope.

2.4 Principles for the study

Several key principles have underpinned the Study approach and were consistently applied to the work conducted. These principles were identified to reflect that the Study was exploratory in nature, there was limited existing data, and relationships with the in-home aged care sector needed to be developed as part of the Study.

The principles for the Study included:

- Develop sector relationships: By engaging with in-home aged care providers in a meaningful, sustainable, and iterative way over the course of the Study.

- Data security and privacy was paramount: By having clearly documented agreed processes for managing data and utilising platforms which best support data security.

- Approach with pragmatism: By applying practical considerations and lessons learnt to the approach and methodology, considering the maturity of available data and readiness of the sector to provide it.

- Establish a strong baseline: Of knowledge, information and data about in-home aged care that can be built upon into the future and provides a clear way forward for future costing studies based on the lessons learnt from this Study.

The outputs of this Study were intended to be one of many inputs into the pricing advice that IHACPA develop for the Support at Home program. It is important that the outputs of this Study are collated and compared to other sources, such as the results of future costing studies, observable price points in the market (including adjacent sectors), and alternative modelling (including models using existing in-home aged care administrative data and bottom-up cost models). Refer to Section 6 for detail on the limitations of the costed dataset developed as part of the Study.

3. Approach to the study

This section describes how the Study was designed and conducted. This includes data management and security, stakeholder engagement, and the development of both the Decision Support Tool and the costed dataset.

3.1 Overview of the study approach

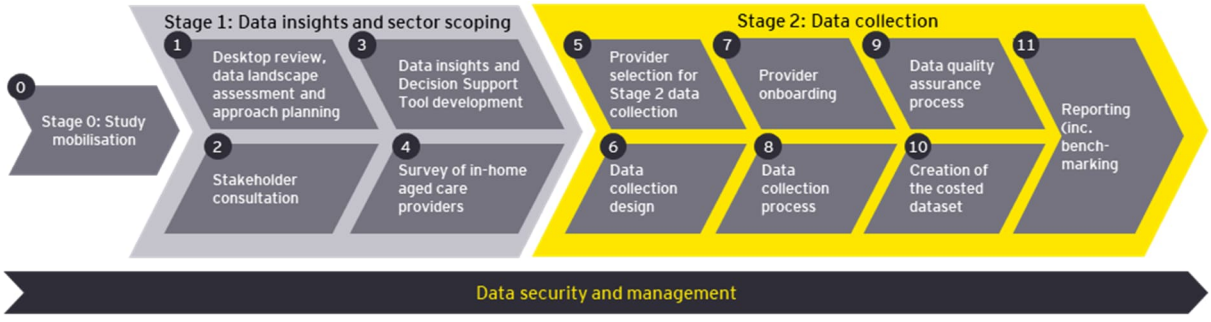
As shown in Figure 4, the Study was conducted across three stages of work. These stages are outlined below, and were underpinned by a robust data security and management plan:

- Stage 0: Study mobilisation (refer to Section 3.3) – Involved the setup of Study governance arrangements, the development of a stakeholder engagement and communication plan, and establishment of a risk register.

- Stage 1: Data insights and sector scoping (refer to Section 3.4) – A baseline understanding of the in-home aged care sector and insights from existing data sources were developed, with the primary aim of informing the scope and design of the Stage 2 data collection. This involved consultation with the sector to develop an understanding of their existing cost structures and operations, data infrastructure, and business systems and programs. Data insights were generated through analysis of existing available data. A Decision Support Tool, to be used complementary to the Stage 2 data collection, was developed and can be used by IHACPA to support future pricing advice.

- Stage 2: Data collection (refer to Section 3.5) – A data collection with a sample of in-home aged care providers was performed and a costed dataset prepared. This involved leveraging insights from Stage 1 to develop a DRS template to collect cost, activity, and workforce data from providers. Data was provided over an eight-week period via IHACPA's secure data portal. This data was processed and analysed to create the costed dataset.

Figure 4: Overview of the Study approach



3.2 Data security and management

IHACPA's SDMS was utilised throughout the Study as part of data management protocols to enhance data security. A key feature of the SDMS was the secure data portal, which supported secure two-way data transfer in and out of the SDMS environment. Data management protocols employed in this Study included:

- A SDMS protocol for the Study was developed to outline the data security processes that were required to be adhered to by the EY Study team in using the SDMS. This included responsibilities when using the SDMS and clear processes for importing to and exporting from the SDMS environment by EY.

- All sensitive data was maintained on SDMS, with analysis of sensitive data being undertaken within the SDMS environment. Any outputs of sensitive data were de-identified, aggregated and assessed for sensitivity by IHACPA's project team prior to approvals being granted to export out of the SDMS environment.

- All participating providers in the Stage 2 data collection were required to obtain access to SDMS to support secure two-way data transfer (i.e., receiving templates and submitting data). Only one representative from each provider organisation was granted access to SDMS.

- A data breach process and incident tracker were developed for the Study to define: (1) what constituted a data breach, and (2) the governance, responsibilities, and processes for managing any data breaches that may have occurred in the conduct of the Study. To note, there were no data breach incidents during the Study.

Data transferred securely via the secure data portal for the Study included:

- Providers submitting cost, activity, and workforce data as part of the Stage 2 data collection (refer to Section 3.5.2 for more details on the data specifications).

- Providers receiving clarification questions from the Study team regarding provider cost, activity, and workforce data (refer to Section 3.5.5 for more details).

- Exporting de-identified and aggregated costing and analysis outputs out of the SDMS environment.

3.3 Study mobilisation approach

3.3.1 Study governance

A project charter was developed to define the roles and responsibilities for the Study across EY and IHACPA, the joint governance structure, Study timeframes, and the agreed Study approach. It included key project management tools, such as a stakeholder engagement and risk management plan, as well as a quality assurance framework for the Study.

Weekly status update meetings were held with IHACPA to discuss progress against Study milestones and work products, to proactively manage the Study risks, and to discuss any emerging issues and decisions. Fortnightly meetings were also held with IHACPA's pricing team to discuss any project decisions related to the modelling and data analysis activities of the project. An iterative and co-design approach with IHACPA was adopted throughout the Study, so that the outputs of this Study were fit-for-purpose to support IHACPA's role in developing pricing advice for the Support at Home program.

A risk register was developed, maintained, and updated throughout the duration of the Study, to track and manage live and emerging risks and issues with IHACPA at the weekly status update meetings.

3.3.2 Stakeholder engagement and communications

A Stakeholder Engagement Plan was developed at the outset of the Study and updated prior to each stakeholder engagement activity (e.g., stakeholder consultations, the Provider Survey, and the Stage 2 data collection). The plan described the targeted stakeholder engagement approach for each activity, the sampling framework used to select providers (refer to Sections 3.4.2 and 3.4.4 for more details), and the communication and correspondence templates. A central email account was also established at the commencement of the Study to support a single point of contact for providers participating in the Study. The key stakeholder groups who participated in the Study included:

- In-home aged care providers (~700 contacted, 135 participated)

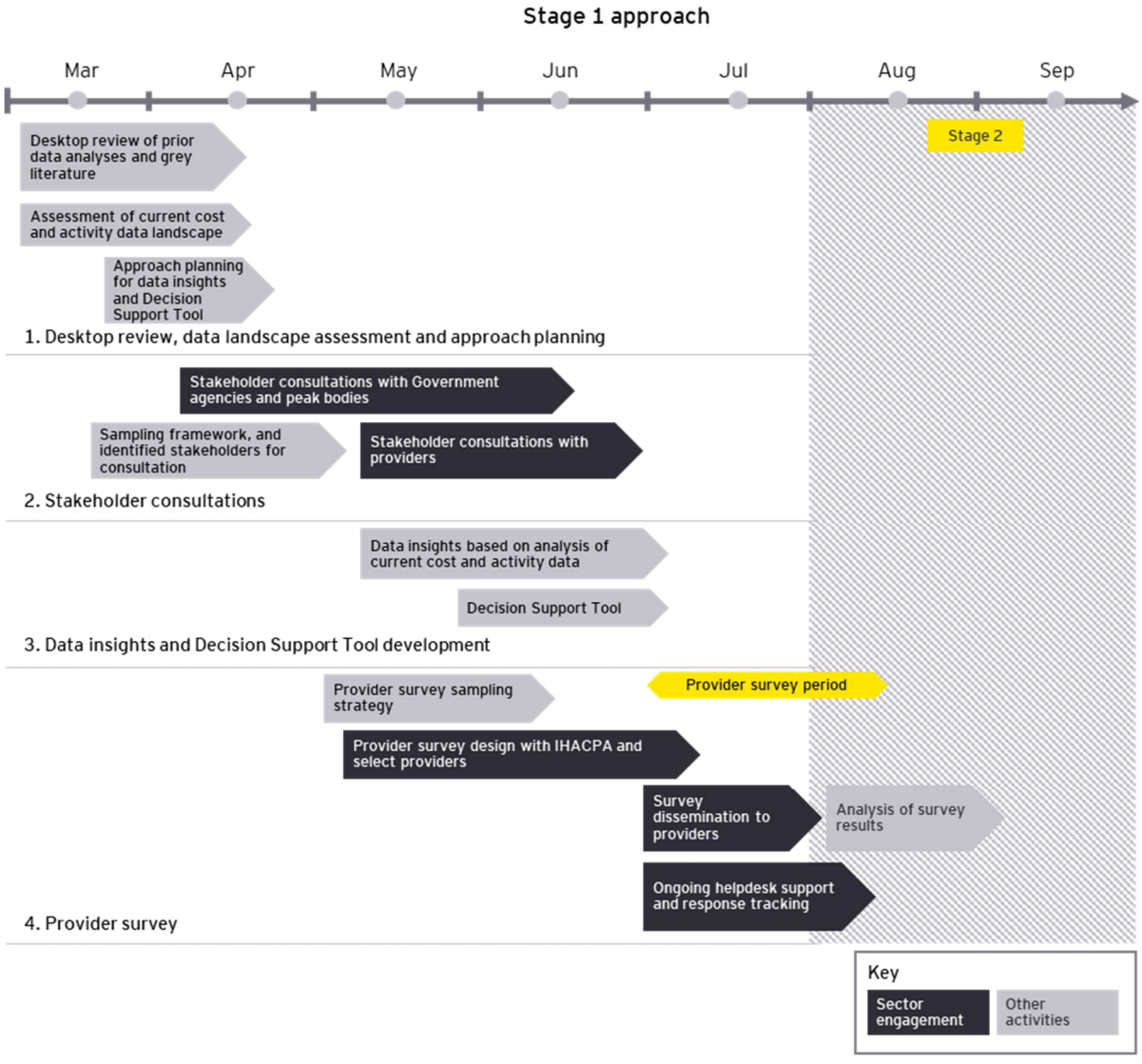
- Federal government departments
- Peak industry bodies
- Consumer advocacy groups.

In addition to the above, IHACPA engaged with the Interim Aged Care Working Group (IACWG) to obtain feedback on the design of the Study.

3.4 Stage 1 approach

A summary of the key Stage 1 activities and timeline is shown in Figure 5 below. Further details on each Stage 1 activity are described in the subsections below. The outputs of the Stage 1 activities contributed to the scoping and design of the Stage 2 data collection.

Figure 5: Summary of Stage 1 activities



3.4.1 Desktop review, data landscape assessment and approach planning

A desktop review was conducted which consisted of a review of relevant prior analyses and reports related to the Support at Home programs. This included research into a range of provider, client and service characteristics that may lead to differences in costs of services based on prior analyses. These provider, client and service characteristics were then shortlisted to be tested (where possible) as part of future data analyses.

The data landscape of the existing Support at Home programs was assessed to understand the availability, granularity and quality of service utilisation, the client- and provider-level data, and the financial data available for each program.

Using the findings from the desktop review and data landscape assessment, two approach planning workshops were conducted with IHACPA to discuss how meaningful data insights could be derived from existing in-home aged care data. This included discussing the approach to building an interactive Decision Support Tool, which provided data insights that were complementary to data collected within the Study. This is further described in Section 3.4.3.

3.4.2 Stakeholder consultation

Stakeholder consultations were conducted with in-home aged care providers (20 in total). In addition, Federal government departments, consumer advocacy groups, and peak industry bodies to provide a broader policy and sector perspective (7 in total) were also consulted.

The consultations aimed to understand: (1) the operational environment of providers, and (2) the implication of this for costs and how data on costs are collected, assigned to service delivery, and reported. In addition, stakeholder consultations sought feedback on the most appropriate approach to collect this information at a larger scale and further granularity, via a Provider Survey (refer to Section 3.4.4 for more details).

Stakeholders for consultation were agreed with IHACPA via the Stakeholder Engagement Plan and were identified by leveraging existing contacts from IHACPA, the Department of Health and Aged Care and EY's existing relationships with the in-home aged care sector. New providers were identified through EY's provider-level dataset (mentioned in Section 3.4.3). Providers selected aimed to reflect the different characteristics of providers, business models, cost structures, service types, geographic distribution, and specialisation.

Key findings from the stakeholder consultations assisted in building an understanding of provider systems and data collections, which informed the approach to the development of the DRS template to collect cost, activity, and workforce data from providers for Stage 2 (refer to Section 3.5.2 for more details).

3.4.3 Data insights and Decision Support Tool development

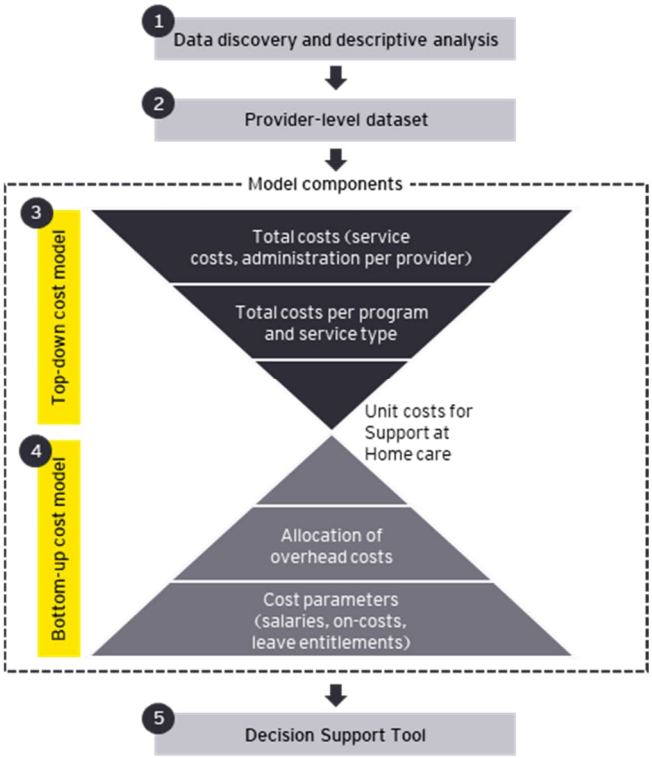
The key objectives of the data insights and Decision Support Tool development activities were to: (1) provide an understanding of the availability, granularity, and limitations of existing data sources for use in analysing unit costs by service type and subcategory, and (2) inform the data to be collected in Stage 2, which complemented the existing data collections and supplemented any data gaps. This activity is summarised in Figure 6 (refer to the next page).

The data insights activity consisted of data discovery and descriptive analysis of the existing available data for the current in-home aged care programs. Data gaps were identified, which limit the utility of the existing available data in solely informing unit costs for service types and subcategories within the Support at Home program. The key data gaps identified consisted of the following and were used to inform the data collected in Stage 2 (refer to Section 3.5.4 for details):

- For CHSP, whilst activity data by service type and subcategory are available for each client, CHSP providers are not currently required to report costs (by granular expense category) within the ACFR and QFR.
- For HCP, the availability of activity data is limited, as routinely collected administrative claims data do not contain activity at a service type-/subcategory-level.
- For STRC, cost data are captured through the ACFR and QFR but are less granular than expense data captured for HCP. Routinely collected administrative claims data do not contain activity at a service type-/subcategory-level, and only include the number of claim days per client.

The data insights activity also included developing a consolidated provider-level dataset across the three programs, containing data on provider characteristics (organisation type etc.), activity (number of claims, number of clients, number of sessions, etc.), client characteristics, outlet/service details (count of outlets/services, location of outlets/ services), and costs. The provider-level dataset leveraged data from a range of sources primarily received from the Department of Health and Aged Care, including:

Figure 6: Overview of data insights and Decision Support Tool activity



- CHSP data: Session-level data, client-level data, activity funding data from GovGPS, and acquittals financial reports.
- HCP data: Claim-level data, client-level data, Home Care Provider Survey and Stocktake data, ACFR and QFR.
- STRC data: Claim-level data, client-level data, and ACFR.
- Data across all programs: National Screening and Assessment Form (NSAF) data, publicly available GEN data extracts, list of providers with organisation type and program, National Approved Provider System (NAPS) and Australian Business Number (ABN) mapping.

This provider-level dataset was used as the basis for several subsequent activities, including the sampling for the survey (refer to Section 3.4.4) and the Stage 2 data collection (refer to Section 3.5), and the creation of the costed dataset (refer to Section 3.5.6). In addition, this provider-level dataset was a key input into the Decision Support Tool.

The Decision Support Tool was built as an interactive and reusable modelling artefact to support an understanding of the unit costs for Support at Home services. A modular approach was taken in developing the Decision Support Tool using a combination of methods to make the best use of existing data, integrating an analytical top-down and bottom-up approach to cost modelling. Specifically, the Decision Support Tool integrated:

- Top-down cost model: The aim of this model component was to estimate the unit cost of service types and subcategories using existing cost data for the current programs. This model attributed provider-level costs to units of each service type, using Generalised Linear Models (GLMs), where attribution to service type was not otherwise available. Several different top-down cost models were developed, using the disparate cost and activity data available across the programs. The low availability, granularity, and quality of data posed challenges in determining the true cost of delivery using this approach.

- Bottom-up cost model: This model built upon parameter inputs for direct and indirect costs to establish the unit cost for different service types. A key input to the bottom-up cost model was the Aged Care Wage Estimation Tool provided by the Department of Health and Aged Care. Some examples of these parameters included the relevant award rates, proportion of employees on EBAs, loadings for shift pay/location and staff utilisation assumptions. This approach to building up the costs provided an alternative to the top-down cost models and allows for additional granularity in wages and salaries.

This modelling artefact consolidated results from these cost models, including the average cost for service types and subcategories, and the impact of different provider and client characteristics on costs.

3.4.4 Survey of in-home aged care providers

A survey of a sample of in-home aged care providers (the "Provider Survey") was undertaken to: (1) build on the insights from stakeholder consultations (refer to Section 3.4.2), (2) scope cost data collection capabilities across a targeted sample of current in-home aged care providers, (3) understand the existing systems used for the collection of service and cost data by in-home care providers, and (4) inform the design and approach of the Stage 2 data collection.

A key objective of the Provider Survey was to identify organisations who would be suitable to participate in the Stage 2 data collection, based on the level of data granularity they currently captured. Specific questions on cost, activity and workforce data were asked to determine this.

The Provider Survey was targeted to 500 providers and aimed to reflect the different characteristics of providers, business models, cost structures, service types, geographic distribution, and specialisation. Providers were identified and engaged by leveraging contacts through EY's provider-level dataset (as mentioned in Section 3.4.3), existing IHACPA contacts, and through existing relationships with the in-home aged care sector.

The design of the Provider Survey was tested and refined with IHACPA and three providers. The survey was conducted through Swift Digital,[2] an IHACPA-endorsed online survey software platform.

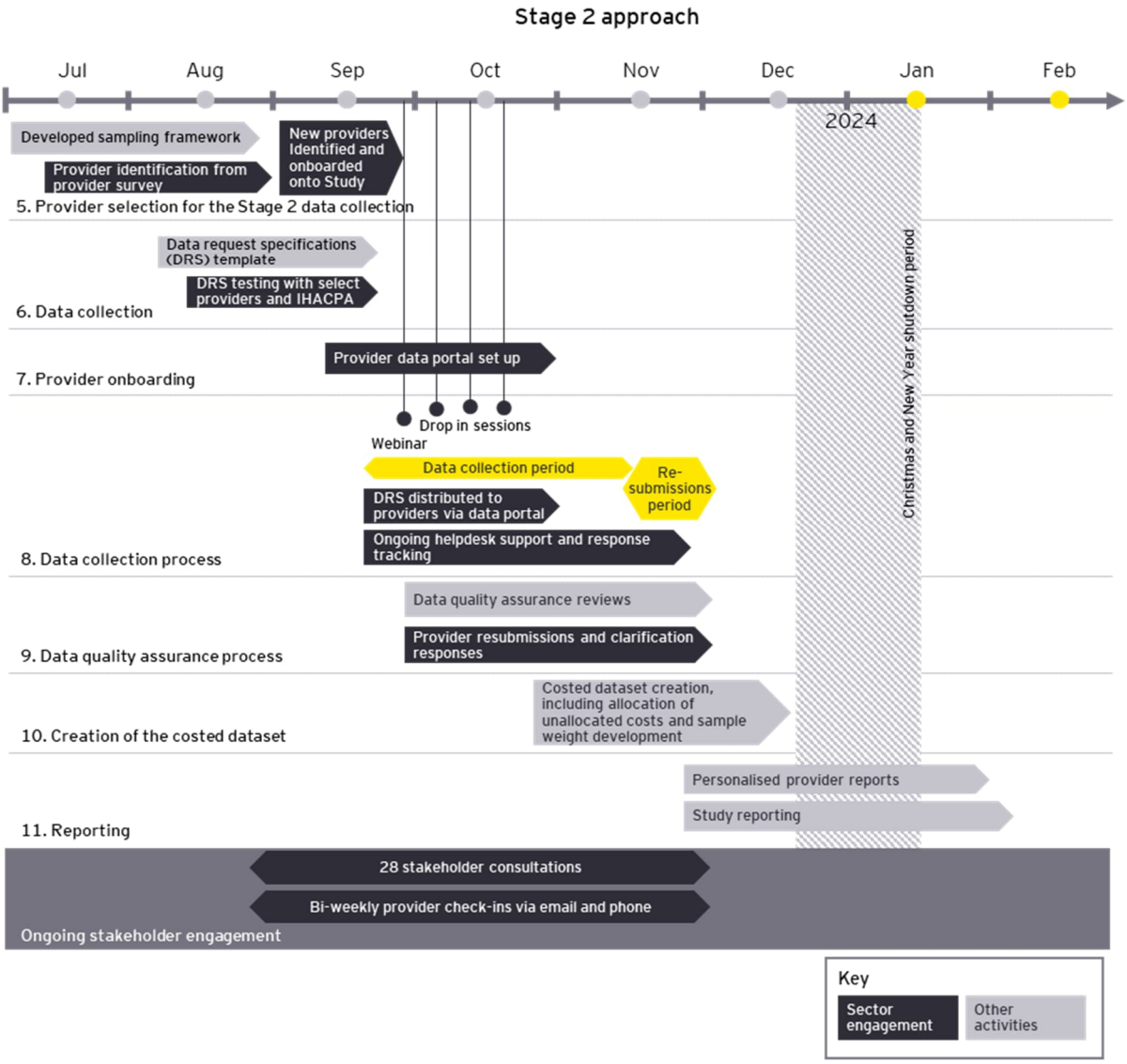
A total of 111 unique providers completed the survey and the insights obtained were a input into the development of the DRS in Stage 2 of the Study. In particular, providers shared insights around the feasibility of submitting cost and activity data at varying levels of granularity, which directly influenced the Stage 2 data collection design (refer to Section 3.5.2 for more details).

3.5 Stage 2 approach

The objective of Stage 2 was to perform a data collection with a sample of providers and prepare a costed dataset to support future pricing for Support at Home. A Stage 2 Data Collection Plan was developed to detail the approach to Stage 2, with the plan iterated and refined with IHACPA over the course of Stage 1. A summary of the key Stage 2 activities and timelines is summarised in Figure 7 on the following page. Further details on each Stage 2 activity are described in the subsections below.

[2] Swift Digital, https://swiftdigital.com.au/survey-software/

Figure 7: Summary of the Stage 2 approach



3.5.1 Provider selection for Stage 2 data collection

A Provider Engagement Plan was developed to detail the approach for attracting provider participation for Stage 2. This approach was co-designed between EY and IHACPA through several workshops. The approach to provider selection for the Stage 2 data collection (the "data collection") leveraged the Provider Survey contacts who had indicated an interest to participate and met data granularity criteria. Eligibility for participation in the data collection was based on the capability of providers to provide cost and activity data at a service type granularity.

Based on the level of Provider Survey participation, a target sample size of 84 was agreed with IHACPA for the Stage 2 data collection, with the sample aiming to reflect the different characteristics of providers, business models, cost structures, service types, geographic distribution, and specialisation.

From the 111 providers who participated in the Provider Survey, 100 providers were identified as eligible for participation in the data collection. However, only 51 of those 100 providers had indicated an interest to participate. Hence, a further 278 new providers were identified and engaged to secure the remaining 33 providers to meet the target sample size. Multiple avenues were employed to identify new providers, including engaging with providers at IHACPA's 2023 conference, IHACPA's previous study contacts, EY's consolidated provider-level dataset (mentioned in Section 3.4.3), and EY's existing relationships with the aged care sector.

All 278 new providers were engaged via an initial email to communicate the key objectives for the data collection and the benefits of participation. Follow-up phone calls were then performed within 2-3 business days of the initial email being sent, to further explain the objectives of the data collection and answer any queries providers may have regarding the data collection. Reconciliation of provider responses were then conducted, and non-responders within 3 business days were subject to an additional call to confirm participation in the data collection.

Following the stakeholder engagement efforts, a total of 90 providers confirmed their participation in the Stage 2 data collection.

3.5.2 Data collection design

A DRS template was developed to facilitate the collection of cost, activity, and workforce data from providers as part of the Stage 2 data collection. The granularity of this DRS template was informed by the responses to the Provider Survey.

Data requested via the DRS template

The cost data requested was based on the existing *FY22 HCP ACFR Income and Expenditure Statement* template*,* with more granular data requested at a service type-level. Providers were requested to allocate costs to the service types that they provided, using the following allocation methods in order of preference:

1. Actual allocation: Calculate using actual expenses at a service type-level.

2. Proportionate allocation: Allocate expenses in a way that indicates the proportional cause and effect relationship using an appropriate cost driver's relative value unit (e.g., number of care staff, to determine education and training cost allocations).

3. General allocation: Allocate expenses generally to distribute costs (e.g., averaging corporate overhead based on client revenue).

Where providers were not able to allocate an expense or proportion of expense using the above methods, they reported these expenses under "Value unable to be allocated to service type".

The DRS also sought activity data by service type, measured in the units shown in the indicative service list. Activity data for CHSP was not requested from providers in the DRS as this data was an administrative dataset held by the Department of Health and Aged Care, and the Study team were provided access to this dataset.

To capture additional granularity by geography, CHSP cost data and HCP cost/activity data were requested at an Aged Care Planning Region-level. STRC cost/activity data were requested at a provider-level. This design decision was informed by the Provider Survey and aimed to balance the additional detail received against provider effort to compile this data.

In addition, the DRS template included sections to capture supplementary data sources, consisting of: (1) activity data by subcategory, measured in the units shown in the indicative service list, (2) activity by time of the week, and (3) workforce data.

An overview of the data requested from providers is presented below in Table 6. Table cells denoted by (P) relate to the highest priority data requested from providers, should providers be unable to submit all data within the data collection timeframe.

The period chosen for the data collection was FY22, to align with existing completed and available ACFR data.

Table 6: Overview of data requested by program

Program	Cost	Activity	Workforce
CHSP	Aged Care Planning Region-level costs by service type Time period: FY22 (P)	*No activity data required for CHSP only (because already available)*	*Workforce data was collected consistently across all programs*
HCP	Aged Care Planning Region-level costs by service type Time period: FY22 (P)	Aged Care Planning Region-level activity volumes by service type Time period: FY22 (P)	
		Aged Care Planning Region-level activity volumes by subcategory Time period: FY22	
STRC	Provider-level costs by service type Time period: FY22 (P)	Provider-level activity volumes by service type Time period: FY22 (P)	
		Provider-level activity volumes by subcategory Time period: FY22	
Across all programs	*Cost data was only collected at program level*	Provider-level activity volumes by time of the week delivered and service type, measured as a percentage breakdown of activity performed across days Time period: FY22	Staff Full-time Equivalent (FTE) within awards / Enterprise Bargaining Agreement (EBA) Time period: Determined by the provider

Format and design of the DRS template

The DRS template was developed in a Microsoft Visual Basic for Applications (VBA)-enabled Excel format. VBA was used to automate aspects of the DRS, tailoring the template to the programs, service types and Aged Care Planning Regions relevant to each provider. This was designed to improve the ease for providers in completing the template. A copy of the DRS template was developed in standard Microsoft Excel format, and shared with providers who were not able to use VBA.

Checks and data validation were embedded into the DRS template to limit providers in submitting data that did not match the intended format. These included restricting costs and activity to non-negative numbers and restricting percentages to fall between 0 per cent and 100 per cent (inclusive). All blank cells were locked down with password protection to limit respondents from submitting sensitive information in these cells. For providers of HCP and STRC, cost data was requested to be reconciled back to the providers' ACFR FY22 submission. Where the data did not reconcile, the DRS requested commentary on the reasons for the differences between the two sources.

Refinement of the DRS template with IHACPA and select providers

The design of the DRS template factored in key insights from the Provider Survey. The DRS template was tested and refined with IHACPA through three workshops. Stakeholder consultations were also held with three providers to seek feedback on the feasibility of the template and timeframe required for completion. This helped to refine the template and assess whether the template was fit-for-purpose and best met provider needs.

3.5.3 Provider onboarding

As outlined in Section 3.2, IHACPA's SDMS was utilised to facilitate the Stage 2 data collection to reduce the risk of a data breach occurring, with all 90 confirmed providers required to be set up and onboarded onto IHACPA's SDMS. To assist with this process, all 90 providers were sent an initial email to communicate the rationale for utilising IHACPA's SDMS for the data collection, and to collect contact details for one representative per organisation for access to IHACPA's SDMS. Follow-up phone calls were also conducted to non-responders after three business days. Access to IHACPA's SDMS supported providers to securely submit their organisation's DRS template which contained sensitive information.

Each provider was assigned an anonymised ID, such that no identifiable provider information was included within the completed DRS template. This served as an additional layer of security in case data was shared via email or other incorrect channels. No data breaches were identified during this Study.

3.5.4 Data collection process

The data collection period spanned six weeks, with an extension of an additional two weeks to receive resubmissions from providers. Additional detail on resubmissions is provided in Section 3.5.5.

At the commencement of the eight-week data collection period, the DRS template was distributed to all participating providers via IHACPA's secure data portal. This included providing a DRS manual to support providers in completing the template and instructions on how to upload the template onto IHACPA's secure data portal.

Training and stakeholder engagement

In preparation for the commencement of the data collection, a webinar and weekly drop-in sessions were held with participating providers to outline the Study (Appendix B). This provided a step-by-step of how the data collection would occur and included a question and answer (Q&A) session. The webinar was recorded and shared with participating providers, along with a weekly updated frequently asked questions (FAQ) document.

Provider DRS template submissions were proactively monitored, and providers were followed up via email and telephone on at least a biweekly basis. This supported the Study team to check on progress and answer any queries from providers on a regular basis across the data collection period. Stakeholder consultations (18) were conducted with providers who had requested a submission extension, to walk-through their organisation's DRS submission and answer any queries regarding the DRS template.

A helpdesk function was established to facilitate providers to submit email queries regarding the DRS template and process. All queries to the helpdesk and via the stakeholder consultations were documented, and questions and responses were shared with all participating participants via an updated FAQ document on a weekly basis.

Completed DRS template responses

Of the 90 confirmed participants, a total of 44 completed DRS responses were received, relating to 48 providers.[3] The characteristics of these providers are provided in Section 4. The significant drop-off in provider participation was due to multiple factors, including the timing and timeframe of the Study, and provider capacity and capability due to competing priorities. For instance, the data collection period coincided with mandatory ACFR and QFR reporting for all providers within the in-home aged care sector, which impacted Study participation. A total of completed responses relating to 48 providers represent a strong foundation for future costing studies. These Study learnings are captured in detail in Section 7.

3.5.5 Data quality assurance processes

Data quality assurance reviews on DRS submissions were performed on an ongoing basis throughout the data collection period and continued for an additional two-weeks following the completion of the data collection period.

Data quality checks

The primary data quality checks conducted were for the following occurrences where:

- The initial derived unit costs (before allocation) for a service type were outside an expected range.
- The provider was identified as delivering a specific program and did not provide cost and activity data for the program.
- Only cost or activity data, but not both, was provided for a program.
- Either cost or activity data, but not both, was provided for some service types.
- There were significant differences between the total cost data provided through the DRS per program, compared to other sources (within 10 per cent of the provider's total expenses recorded within the ACFR FY22 data for HCP and STRC, and within 20 per cent of the total amount of CHSP acquittals for FY22).
- Negative cost or activity values were provided through the DRS.
- There were inconsistencies between total activity volumes at a service type and subcategory-level submitted by the provider.

Clarification questions and requests for resubmission

The data quality assurance process included engaging with providers to seek clarification or resubmission of provided data, if required. Clarification questions were sent to providers via IHACPA's secure data portal. The quality assurance processes also included additional follow-up queries, and phone or video call consultations with providers to discuss queries.

While the quality assurance process helped to resolve unintended errors in the data provided, this process was not able to resolve all issues identified. This was due to factors such as limited data granularity available within the provider's systems, or data issues that were unable to be resolved by providers within the time available for data collection.

[3] There were two DRS submissions that related to three entities each respectively.

Where providers were unable to allocate costs to service types, the provider's input into the allocation method to be adopted for each expense category was sought. For cases where providers had unallocated costs and had provided activity data in units other than hours (i.e., for the service types: *nutrition*, *meal delivery*, and *transport*), providers were asked for an approximate conversion rate of the units provided, to hours, to inform the allocation by activity.

Overall, of the 48 providers (who submitted 44 unique DRS responses), queries were asked of 42 providers. Email responses or resubmissions were received from 36 providers. Consultations with seven providers were conducted to further discuss and clarify queries.

Refer to the *Addendum to the Study Report: Costed Dataset Technical Documentation* for additional detail on the data quality assurance processes conducted.

3.5.6 Creation of the costed dataset

This section provides an overview of how the costed dataset was created from data collected as part of the Study. The process is also summarised in Figure 8. A more detailed description of each component is included in the *Addendum to the Study Report: Costed Dataset Technical Documentation.*

Figure 8: Costed dataset development process

Collating and linking data

The participating providers submitted cost, activity, and workforce data to IHACPA using the DRS template over the specified time periods of interest. In addition, some providers utilised an alternate format for the provision of their data (either in addition to or instead of data provided in the DRS), which were required to be transformed to be consistent with the DRS.

Data collected from the sample of providers were collated and linked to the provider-level dataset (refer to Section 3.4.3) to include provider and client characteristics within the dataset. In addition, the data was linked to the CHSP activity data provided by the Department of Health and Aged Care.

Data quality assurance processes

As described in Section 3.5.5, data quality assurance processes were conducted on the submitted data and, where required, queries were shared with providers for their response and/or resubmission. Resubmitted data was collated and linked to other data sources, as described in the step above.

Manual adjustments to data collected

Some manual adjustments were made to the data collected. These adjustments consisted of actioning requests or comments from providers to adjust their submitted data and aggregating data to better align cost and activity data where data quality issues were encountered.

Allocation of unallocated costs

In the DRS template submissions, providers were given the option to input costs to "Value unable to be allocated to service type" bucket if they were not able to allocate costs directly to service types. To account for all costs in unit cost calculations, unallocated costs were distributed to relevant service types by provider, program, expense category and Aged Care Planning Region (ACPR) when available. The results of the allocation are sensitive to the assumptions and business rules used.

In general, any unallocated costs were allocated between service types based on volume of activity. This general method assumes that these unallocated costs should be equally spread across all service types, effectively increasing the unit costs uniformly across all service types. However, there are several expense categories that are more likely to be related to particular service types than others, and therefore a number of exceptions have been applied to this general approach. These exceptions apply to the following expense categories: care management costs, allied health and nursing staff costs, transport services costs, and client capital purchases and home modification costs. A discussion of these expense categories and the business rules applied is detailed within the *Addendum to the Study Report: Costed Dataset Technical Documentation*. We assessed the impact of the allocation approach on unit costs, and it does not appear to be a material driver of the results presented in this Report.

Sample weights development

The sample weights included in the costed dataset were developed to weight the sample of data to be representative of the whole sector. Sample weights were developed at a provider-level only. This process has two key objectives: (1) align the sample of providers with the sector as closely as possible, and (2) reduce the size and influence of the sample weight.

Data flags development

While no observations were removed or excluded from the costed dataset, data flags were developed to identify observations where: (1) data quality checks described in Section 3.5.5 were not passed, (2) unit costs calculated were identified as outliers, and (3) data submitted was relating only a proportion of the services provided (i.e., the data was incomplete).

3.5.7 Reporting

In addition to developing this Study Report, benchmarking reports were developed and provided to each provider who submitted data as part of the data collection process. For each service type, these reports benchmarked each provider's unit costs against the distribution of unit costs across all participating providers.

4. Provider characteristics

This section provides an overview of the characteristics of the providers who participated in the provider data collection components of this Study, including the Stage 2 data collection.

Summary of findings

- Across the provider data collection components of this Study (i.e., provider consultations, Provider Survey and Stage 2 data collection), 135 providers were engaged, with coverage across the programs, organisation types, provider size, and geography (based on the MMM and jurisdiction).
- In Stage 1, 121 providers, across a range of diverse characteristics, were engaged through the provider consultations and Provider Survey.
- In Stage 2, data was collected across all characteristics from 48 providers. Out of these providers, 42 were CHSP providers, 40 were HCP providers, and 10 were STRC providers. These providers reflect 13 per cent, 16 per cent and 24 per cent of total Commonwealth funding for CHSP, HCP and STRC respectively. However, there were some provider characteristics with lower number of data points, in particular providers operating in Northern Territory, South Australia, Tasmania, and in MMM7.

135 providers participated in the Study data collection activities, including the Stage 1 provider consultations, the Stage 1 Provider Survey, and the Stage 2 data collection. Table 7 provides a summary of the characteristics of these participating providers.

Note that data has been suppressed at a threshold of five providers, denoted by *. Two cells with a value of greater than five providers have also been suppressed to prevent re-identification, denoted by **.

Table 7: Number of providers by provider characteristics across the components of the Study

Provider characteristics		Number of providers in the sector[4]	Stage 1		Stage 2
			Number of providers consulted in Stage 1	Number of providers who submitted a Provider Survey	Number of providers who submitted data in data collection
Program[5]	CHSP	1,432	24	83	42
	HCP	871	20	81	40
	STRC	61	6	10	10
Organisation type[6]	For-profit	372	*	35	8
	Not-for-profit	1,005	**	71	35
	Government	326	NA	9	5

[4] Note that at the time of writing, there were 1,785 providers in the sector.

[5] Note that providers may be counted more than once for this characteristic, i.e., they may operate in more than one program. Therefore, the sum of the number of providers across the programs exceeds the total number of providers.

[6] 82 providers (5 per cent) have missing organisation type mostly because of limited provider characteristics from the CHSP datasets and ACFR HCP data. These are not included in the figures shown.

Provider characteristics		Number of providers in the sector[4]	Stage 1		Stage 2
			Number of providers consulted in Stage 1	Number of providers who submitted a Provider Survey	Number of providers who submitted data in data collection
Provider size	1-500 clients inclusive	1,157	*	60	14
	More than 500 clients	521	**	55	34
MMM[7,8]	MMM1	982	24	84	38
	MMM2	220	10	18	15
	MMM3	248	10	24	18
	MMM4	196	8	16	11
	MMM5	278	7	19	9
	MMM6	71	*	8	6
	MMM7	69	*	*	*
Jurisdiction[7]	ACT	44	*	7	5
	New South Wales	552	13	46	22
	Northern Territory	39	*	*	*
	Queensland	377	10	25	12
	South Australia	164	5	12	*
	Tasmania	69	*	8	*
	Victoria	440	10	34	22
	Western Australia	125	6	16	6

The data collection components of the Study had coverage across the various provider characteristics. In Stage 1, diverse provider perspectives from 121 providers were obtained across different programs, organisation types, provider size, regional and remote geographies, and jurisdictions. This was important to understand the heterogeneity of the sector.

In the Stage 2 data collection, there were 90 providers who confirmed participation in the data collection. After accounting for providers dropping out, data was ultimately received from 48 providers and spanned across all the characteristics shown in Table 7. Data was collected from 42 CHSP providers, 40 HCP providers, and 10 STRC providers, with 34 of the providers delivering services under more than one of these programs. There were some provider characteristics with a larger sample size, such as not-for-profit providers, providers who have a service/outlet in MMM1, and providers that operate in New South Wales or Victoria. However, a key limitation was the low number of data points for some characteristics – providers operating in the Northern Territory, South Australia, Tasmania, and in MMM7.

Table 8 provides an overview of the representativeness of providers that submitted cost and activity data in the Stage 2 data collection, compared to all FY22 Support at Home providers.[9]

[7] Note that providers may be counted more than once for these characteristics, i.e., they may operate in more than one MMM/jurisdiction. Therefore, the sum of number of providers by each characteristic exceeds the total number of providers.

[8] MMM of a provider is represented by the MMM of its services/outlets.

[9] Note that while these figures have adjusted for where a provider did not provide any data for a program that they provide, these figures have not been adjusted for providers that have submitted partial data (e.g., missing ACPRs or service types) within a program in their submission.

Table 8: Representativeness of providers in the sample, as percentage of clients and percentage of funding

Program	Percentage of clients represented by providers with submitted cost and activity data	Percentage of funding represented by providers with submitted cost and activity data[10]
CHSP	14%	13%
HCP	17%	16%
STRC	24%	24%

Although there were only 3 per cent of CHSP providers, 5 per cent HCP and 16 per cent of providers that contributed data within the Stage 2 data collection (refer to Table 7), these providers reflect a reasonable proportion of the sector when measured by percentage of clients and percentage of funding by program.

Despite the non-representativeness of the sample (which is offset to an extent using the sample weight methodology summarised in Section 3.5.6), these cost insights contribute to the evidence base in understanding costs for the Support at Home program and provide a solid foundation for future costing studies.

[10] CHSP funding data was based on grant income from the Acquittals Activity data, whereas HCP and STRC funding data was based on HCP claims and STRC claims data. Note that negative values in HCP claims from subsidy reductions and unspent amount upon recipient departure were not removed for this analysis.

5. Cost insights

This section provides cost insights using the data collected through Stage 2 of the Study.

Summary of findings

The costs collected in this Study were broadly in line with observable price points and trends in the care and support sector. The key trends observed include:

- Median unit costs for service types measured in hourly units were the highest for *allied health and other therapeutic services* at $122 per hour, followed by *specialised support services* at $113 per hour and *nursing care* at $101 per hour.
- Median unit costs for service types measured in hourly units were lowest for *assistance with hoarding and squalor* at $41 per hour,[11] and *care management* at $58 per hour.[12]
- *Domestic assistance* and *personal care* encompassed the largest portions of expenditure, accounting for 26 per cent and 18 per cent of the total costs respectively. The median unit cost was $74 per hour for *domestic assistance* and $82 per hour for *personal care*.
- Transport and meal delivery, which are presented on a per trip and per service basis, had median unit costs of $44 per trip and $12 per service respectively.
- Unit costs for Support at Home services were typically higher in areas where clients were mainly from MMM5-7, compared to areas where clients were mainly from MMM1-4.
- The trends by program (CHSP compared to HCP/STRC) and provider size (providers with between 1-500 clients inclusive compared to providers with more than 500 clients) were not consistent across service type.

Collecting data by expense category supported an understanding of the cost compositions by service type. This included:

- Labour costs were the largest cost bucket for all Support at Home service types and account for 40 per cent to 60 per cent of the total costs in most service types.
- The composition of labour types varied by service types. *Specialised support services*, *assistance with hoarding and squalor* and *meal preparation* and *nursing care* service types were mainly staffed internally, whereas *home maintenance* and *meal delivery* service types utilised more external labour. Agency care staff labour only accounted for a maximum of 3 per cent of total labour costs across all service types.

[11] This could be driven by a relatively low number of observations for the assistance with *hoarding and squalor service* type.

[12] From information provided by stakeholders during Stage 1 and Stage 2, data for the *care management service* type is variable both within and across programs. This is likely to impact the robustness of the unit costs for this service type. This is further detailed in Limitation 3 in Section 6.

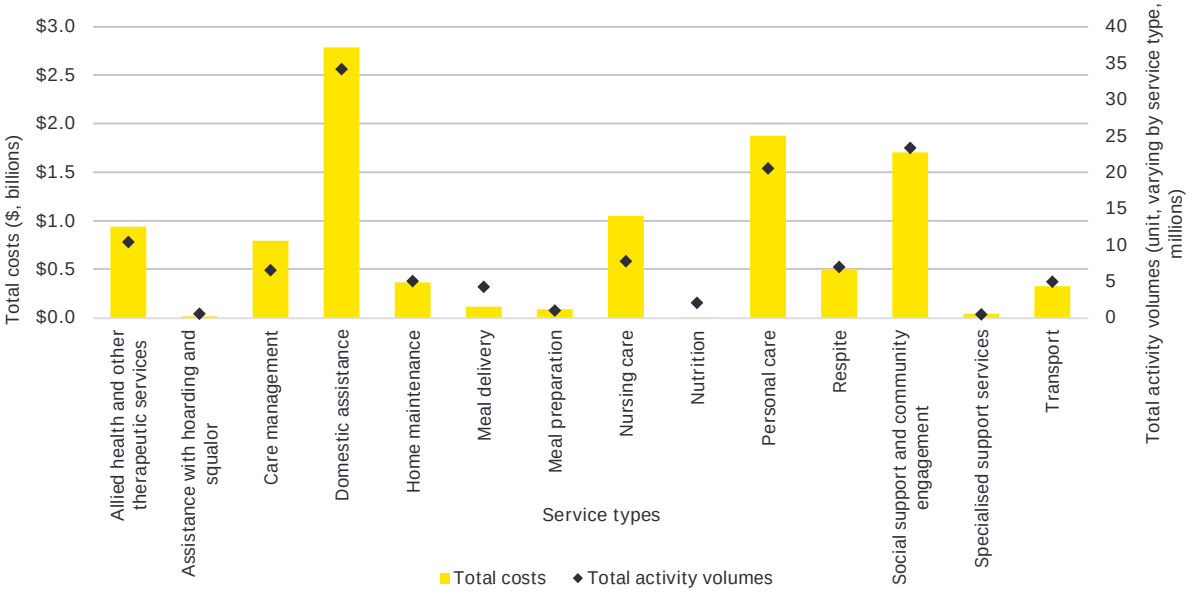
5.1 Total costs and activity volumes across the sector

This section provides an overview of the total costs and activity volumes for Support at Home services.

While the indicative service list categorised Support at Home services into 14 service types, the proportion of total costs and activity volumes varied significantly between these service types. Figure 9 provides a comparison of total costs and activity volumes by service type, based on the data collected in Stage 2 (weighted using the sample weights):

- Total costs and total activity volumes followed a similar trend, generally the higher the activity volumes, the higher the total costs for all service types.
- *Domestic assistance* was by far the largest service type by total costs at $2.8 billion (26 per cent of total costs across service types), followed by *personal care* at $1.9 billion (18 per cent), *social support and community engagement* at $1.7 billion (16 per cent) and *nursing care* at $1.1 billion (10 per cent). All remaining service types were relatively small as they each contributed to less than 10 per cent of the total costs.

Figure 9: Total costs and activity volumes by service type based on weighted sample data



5.2 Unit costs across the sector

This section compares the unit costs by service type between programs, rurality, and provider size.

5.2.1 How to interpret the box plots

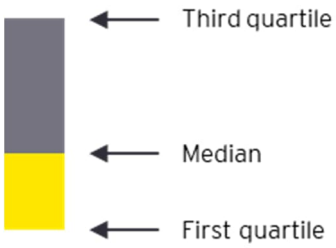
This section and Section 5.3 present unit costs from the data collected in Stage 2, represented using box plots, with outliers not shown to reduce the identifiability of data.[13] In each of the charts included in these sections:

- The lower end of the box represents the first quartile unit cost. 25 per cent of providers/provider ACPRs had a unit cost equal to or below this value.

[13] Note that outliers in the costed dataset were not removed from the unit cost distributions to retain sufficient sample size at a service type-level, as a limited number of providers submitted data for some service types.

- The line within the box represents the median unit cost. 50 per cent of the providers/provider ACPRs had a unit cost equal to or below this value.
- The upper end of the box represents the third quartile unit cost. 75 per cent of the providers/provider ACPRs had a unit cost equal to or below this value.
- The box represents the range in which the middle 50 per cent (from 25 per cent to 75 per cent) of the provider unit costs were distributed across, also known as the interquartile range.

Figure 10: Interpretation of results



Unit costs referred to in this section were weighted using provider characteristics to represent total unit cost distributions at a sector-level. Unit costs for providers with no cost and/or activity data for any service types were not able to be derived, and hence were not included in these figures. Providers with zero or no unit costs for any service types were not included in the unit cost distributions. The unit costs represent FY22 figures. The medians of charts presented in Section 5.2 are provided in a tabular format within Appendix C.

Unit cost distributions were suppressed if less than five providers supplied both cost and activity data for a given service type.

In interpreting these figures, the reader should understand the limitations of the data collected in Stage 2 (refer to Section 6 for details) and the approach taken to derive unit costs within the creation of the costed dataset (refer to Section 3.5.6 and the *Addendum to the Study Report: Costed Dataset Technical Documentation* for details).

5.2.2 Comparison between different service types

Total unit cost distributions across CHSP, HCP and STRC for each service type are shown in Figure 11. The key insights are as follows:

- Comparing the weighted median unit cost across service types, *allied health and therapeutic services* had the highest unit cost at $122 per hour, followed by *specialised support services* at $113 and *nursing care* at $101 per hour. This was likely driven by the higher labour costs for health professionals and nurses.
- The *allied health and therapeutic services* unit cost was influenced by the mix of subcategories within this service type. Based on the available information on subcategories[14], the most common subcategories were physiotherapist, occupational therapist, podiatry, and allied health assistant. Given the lower wages for allied health assistants, it is likely that the high volume of activity (relative to other subcategories) provided by allied health assistants may have slightly dampened the unit cost across the service type.
- The lowest median unit cost was for *assistance with hoarding and squalor* at $41 per hour (which could be driven by a relatively low number of observations for this service type), followed by *care management* at $58 per hour and *respite* at $67 per hour. From information provided by stakeholders during Stage 1 and Stage 2, data for the *care management* service type is variable both within and across programs. This is likely to impact the robustness of the unit costs for this service type and is further detailed in Limitation 3 in Section 6.

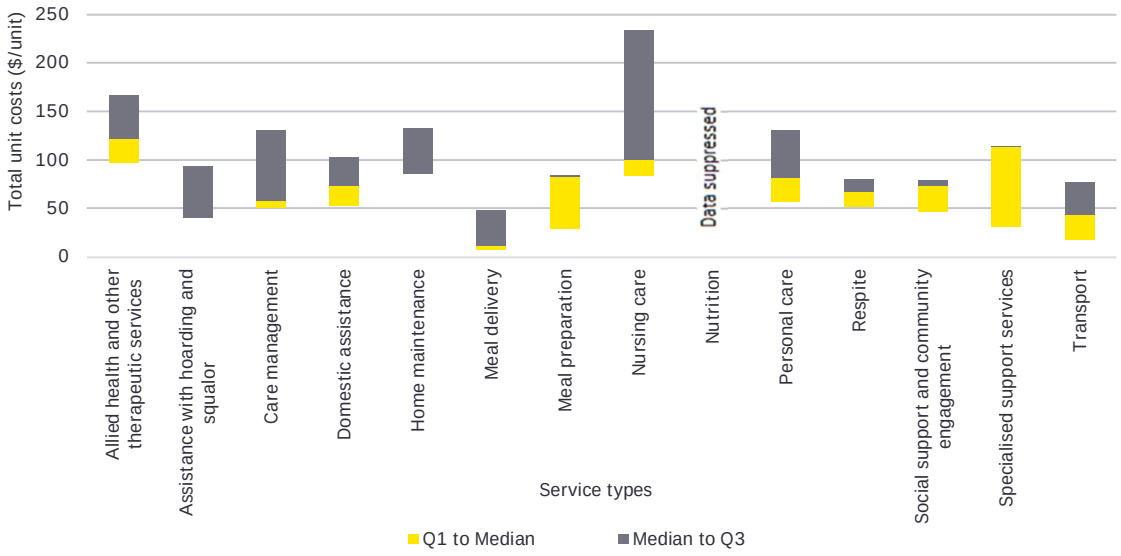
[14] This includes the subcategory-level activity data collected in the Stage 2 data collection, and sub-type data in the CHSP sessions data provided by the Department of Health and Aged Care. For the former, the subcategory data was not considered high priority during the data collection, where approximately half of the providers that provided allied health and other therapeutic services in FY22 also submitted subcategory data for this service type.

- *Transport* and *meal delivery*, which are presented on a per trip and per service basis, had median unit costs of $44 per trip and $12 per service respectively.

- There was a large spread of unit costs for several service types (represented by the distance between the first and the third quartiles – the interquartile range). The interquartile range (hereafter "spread") for most service types was around $40 to $80. *Nursing care* had the largest spread of $150 (between $84 and $234) representing large differences in the unit costs between providers, likely driven by varying resource mix across providers. The *Specialised support services* service type also had a notably large spread, possibly driven by the wide range of advisory and support services that are included in this service type.

- The spread of unit costs was also impacted by the number of observations for a service type and by sample weights. *Assistance with hoarding and squalor* and *specialised support services* had a smaller number of observations, resulting in a large spread between the first and third quartiles.

Figure 11: Distribution of weighted total unit costs by service type



5.2.3 Comparison between programs

Unit cost insights by program are presented in Figure 12. As only a limited number of providers supplied both cost and activity data for STRC, weighted total unit cost distributions for HCP and STRC were analysed in aggregate and compared against CHSP total unit costs.

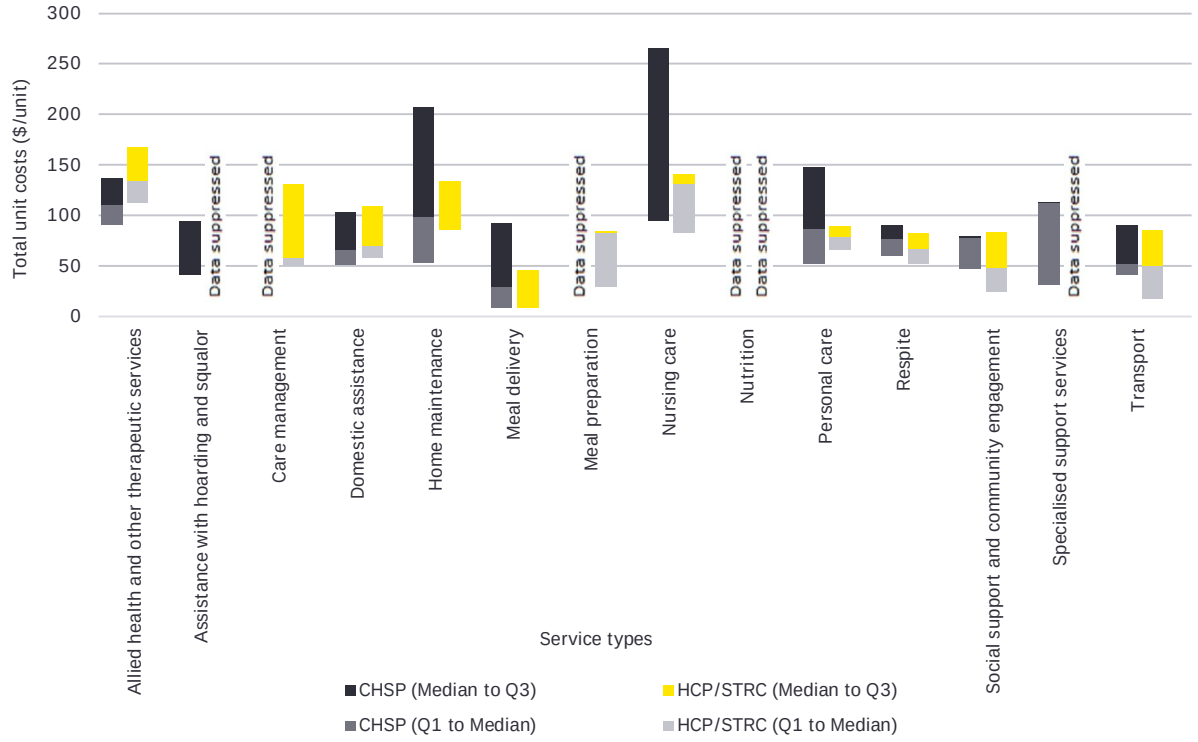
There was no clear evidence that unit costs were higher in general for either HCP/STRC or CHSP. The key insights are highlighted below:

- Median unit costs for HCP and STRC were higher for *allied health and other therapeutic services* ($134 per hour) and *nursing care* ($132 per hour), compared to equivalent services for CHSP ($110 and $95 per hour respectively). In contrast, *meal delivery (*$29 per service) and *social support and community engagement* ($77 per hour) had higher median unit costs for CHSP, compared to $8 per service and $48 per hour for HCP and STRC respectively. The remaining service types had similar median unit costs.

- The large spread in *home maintenance, nursing* care and *personal care* unit costs for CHSP suggests greater unit cost variability for these service types.

- *Care management* and *nutrition* service types did not have activity data from CHSP sessions datasets, hence unit costs could not be calculated.

Figure 12: Distribution of weighted total unit costs by program



5.2.4 Comparison between rurality

Unit cost distributions by rurality showed the most noticeable pattern across service types. Areas where clients were mainly from MMM5-7 typically had higher unit costs than areas where clients were mainly from MMM1-4.

Rurality was assessed at an ACPR-level,[15] and provider ACPRs were grouped into having either more than 50 per cent of clients from MMM1-4 or more than 50 per cent of clients from MMM5-7. The main unit cost insights from Figure 13 are listed as follows:

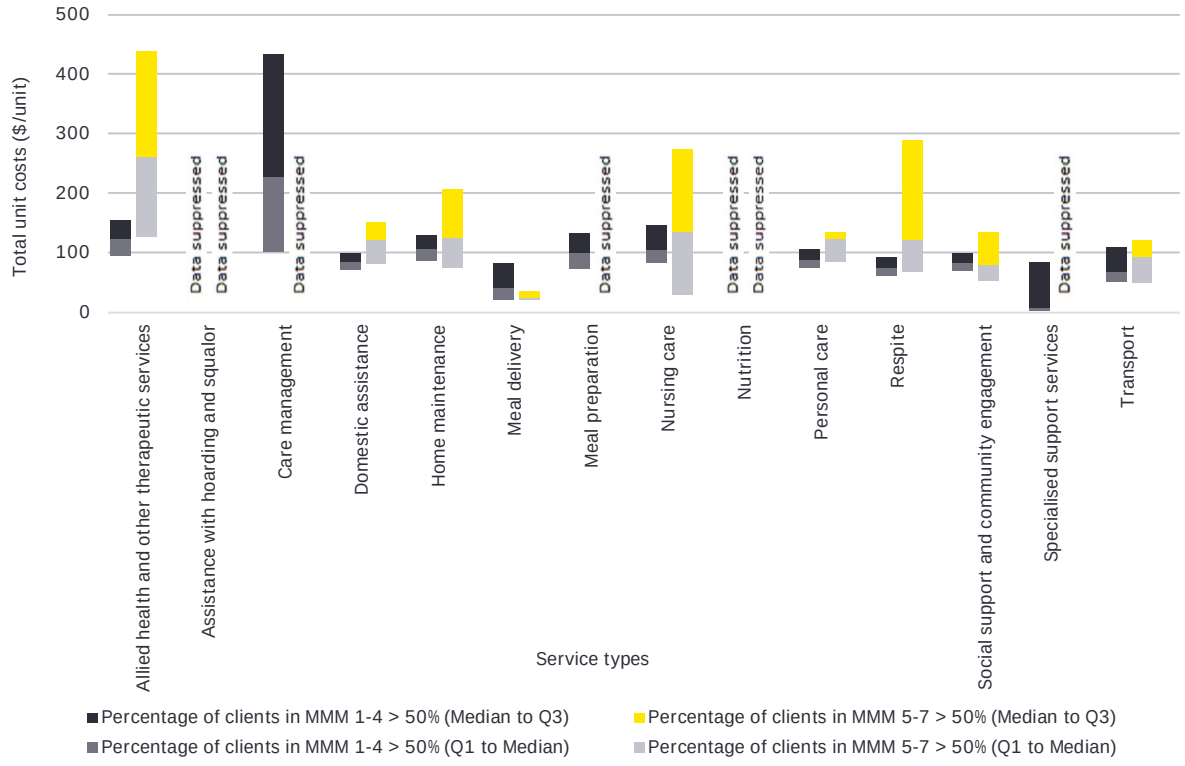
- Median unit costs for most service types were higher in areas where clients were mainly from MMM5-7. The differences in median unit costs between rurality groups were the highest at $138 per hour for *allied health and other therapeutic services*, followed by differences of $47 per hour for *respite*, $37 per hour for *domestic assistance* and $36 per hour for *personal care*.

- The only exceptions were for *meal delivery* and *social support and community engagement,* where the median unit costs were slightly lower in areas where clients were mainly from MMM5-7.

- Unit costs for providers in areas where clients were mainly from MMM5-7 generally had higher variability due to the smaller sample size for each service type.

[15] As providers generally operate across different MMMs, analysis of rurality had been conducted at the most granular data collected in this Study – ACPR-level. As such, some providers contributed to more than one data point in this figure. Unit cost distribution at an ACPR-level did not factor in STRC costs as STRC data were not available at an ACPR-level. Unit costs were also not weighted to represent the distribution at the sector-level, as sample weights data was not available at an ACPR-level.

Figure 13: Distribution of total unit costs by rurality



5.2.5 Comparison between provider size

The number of clients for providers across CHSP, HCP and STRC was used as a proxy measure to represent provider size.[16] A comparison between weighted total unit costs by provider size is demonstrated in Figure 14.[17]

In general, the trends in unit cost distribution by provider size were less apparent and had mixed results. Several service types had large differences in median unit costs between provider size groups or had suppressed data due to small sample sizes. Some key observations include:

- Most of the service types had higher median unit costs for providers with more than 500 clients. For example, *care management* and *respite* had median unit costs of $97 and $77 per hour for providers with more than 500 clients, but $58 and $67 per hour for providers with fewer than 500 clients respectively.

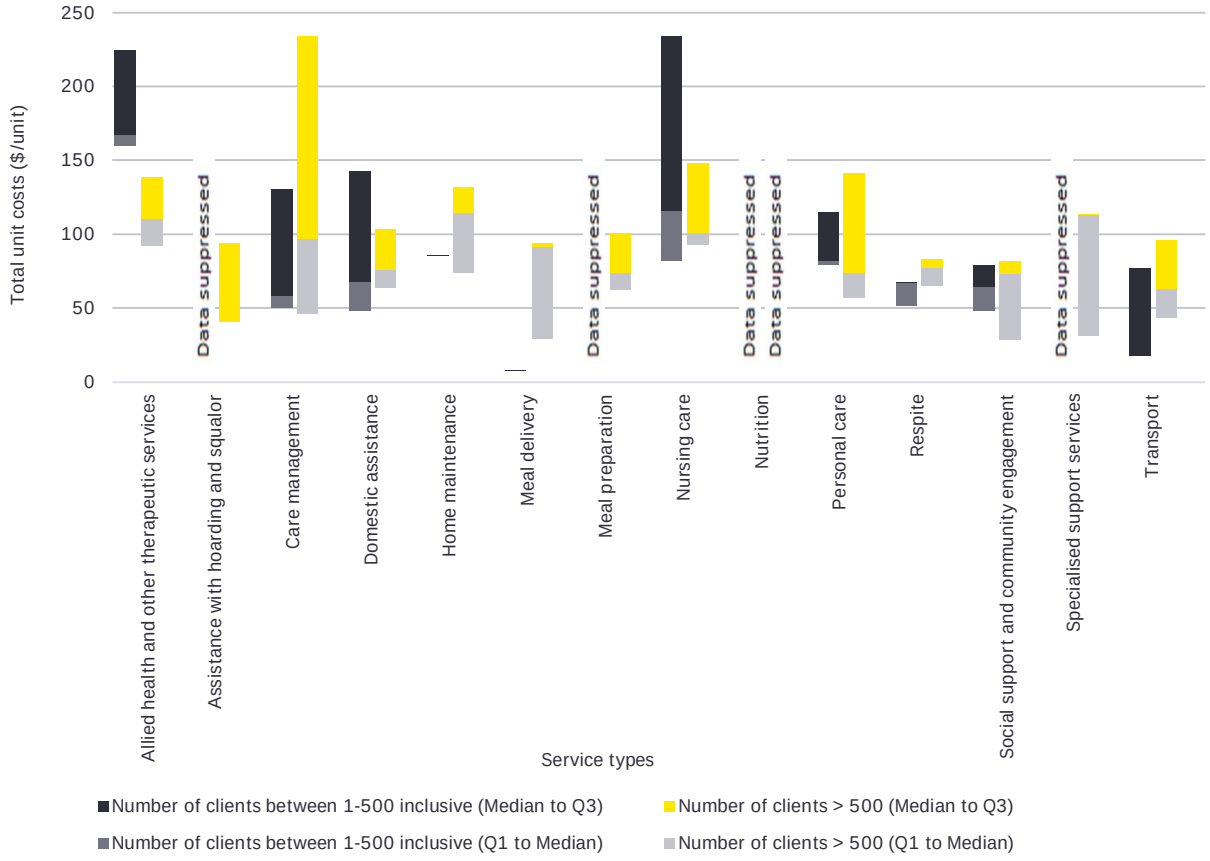
- On the contrary, *allied health and other therapeutic services* and *nursing care* both had higher median unit costs for providers with fewer than 500 clients at $168 and $116 per hour, while the corresponding median unit costs were $111 and $101 per hour for providers with more than 500 clients respectively.

- There were a relatively small number of providers with fewer than 500 clients. This affected the weighted distribution for some service types, namely *home maintenance* and *meal delivery.*

[16] A threshold of 500 clients was chosen for the comparison to balance between retaining sufficient sample size in each service type and minimising the impact of outliers on unit cost distributions due to data quality.

[17] Since there was no unique client identifier across all three programs, a client was considered multiple times if they participated in more than one program.

Figure 14: Distribution of weighted total unit costs by provider size



5.3 Distribution of costs by service type

The Stage 2 data collection collected data by granular expense categories. This supported an understanding of the distributions of costs for each service type. The requested cost data consisted of 41 expense categories, based on the ACFR HCP FY2021-22 expense categories. Within this section, expense categories are grouped into nine expense groups, with the mapping shown in Appendix D.

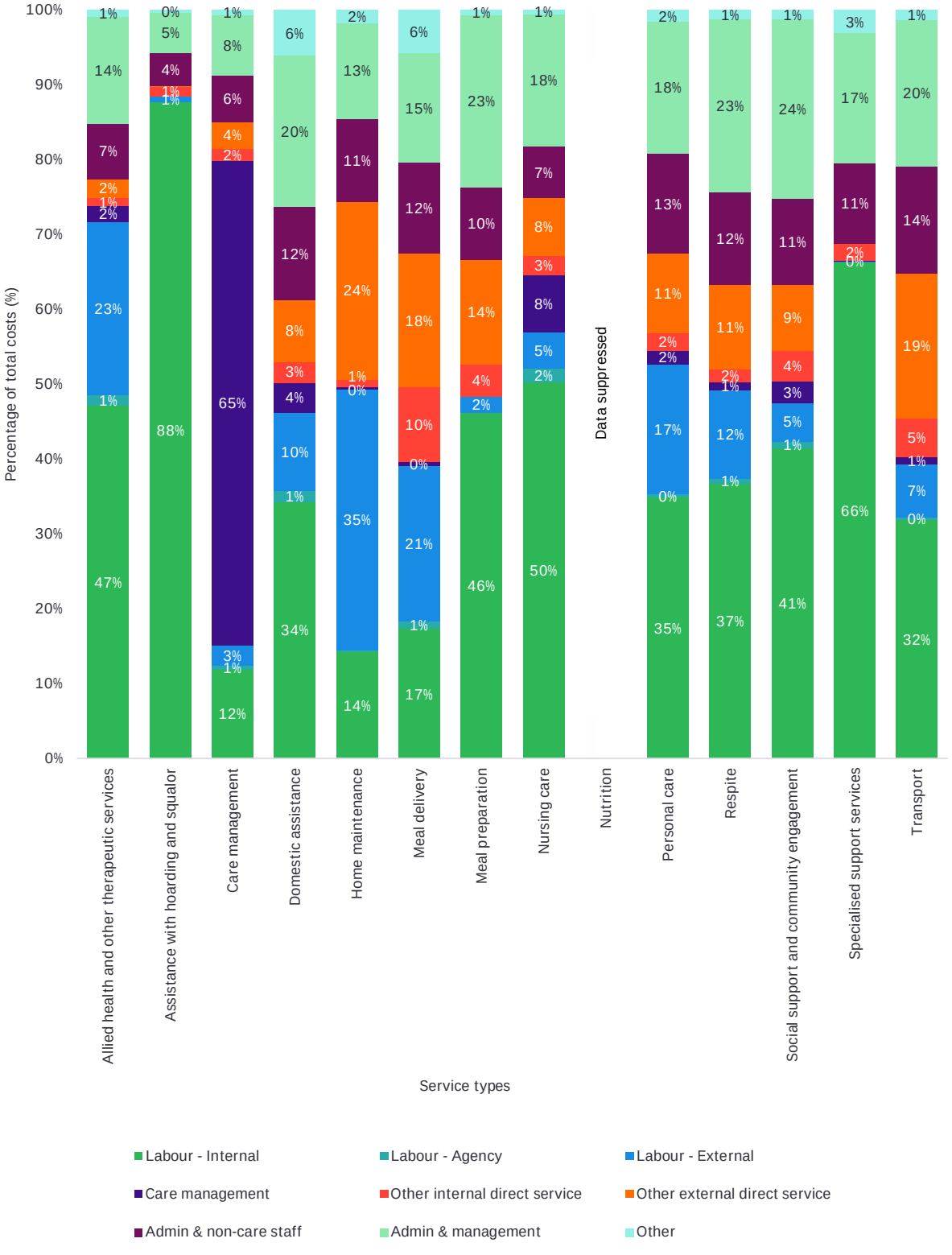
5.3.1 Total costs composition by service type

Total costs composition by grouped expense categories for all service types are shown in Figure 15, and some key findings are outlined below:

- Total labour costs (including internal, agency and external labour costs) were the largest components of all service types (except for *care management)*, accounting for 40 per cent to 60 per cent of the total costs in most service types.
- *Specialised support services*, *assistance with hoarding and squalor*, *meal preparation* and *nursing care* service types were mainly staffed internally, whereas *home maintenance* and *meal delivery* service types utilised more external labour. Agency care staff expenses only accounted for a maximum of 3 per cent of total labour costs across all service types.
- The main component of the *care management* service type was the care management grouped expense category (which included care management staff wages, payroll tax and motor expenses), which represented 65 per cent of the total costs for the service type. Note that this was impacted by business rules described in the *Addendum to the Study Report: Costed Dataset Technical Documentation*.

- Administration and support costs (including administration and management costs, and administration and non-care staff costs) typically accounted for 20 per cent to 35 per cent of the total costs across all service types. These components were the highest for *respite* and *social support and community engagement* representing 36 per cent and 35 per cent of total costs respectively.

Figure 15: Total costs composition by service type and grouped expense categories



5.3.2 Unit costs by service type

Figures 16 to 28 below present the unit costs distributions by grouped expense category for each service type. Some key findings are summarised below:

- For all service types (except *care management*) the internal labour expense category had the highest median unit cost. The highest median unit cost was from *specialised support services* at $75 per hour, followed by *nursing care* at $66 per hour and *allied health and other therapeutic services* at $46 per hour. In addition, internal labour was the largest expense group by percentage of total costs as described in Figure 9.

- For the c*are management* service type, the expense category with the highest median was the care management grouped expense category at $46 per hour. This included a labour component of care management staff wages.

- Provider cost allocation by expense category differed for each provider. Many providers submitted no costs against some expense categories, likely due to differences in business models, causing several median unit costs to be low or zero.

- Internal labour costs had the widest spread across most service types. The low end of the spread, which was generally at or close to zero, was driven by providers that used agency and/or external labour types, and therefore had lower unit costs for internal labour.

Figure 16: Unit costs by grouped expense category for allied health and therapeutic services

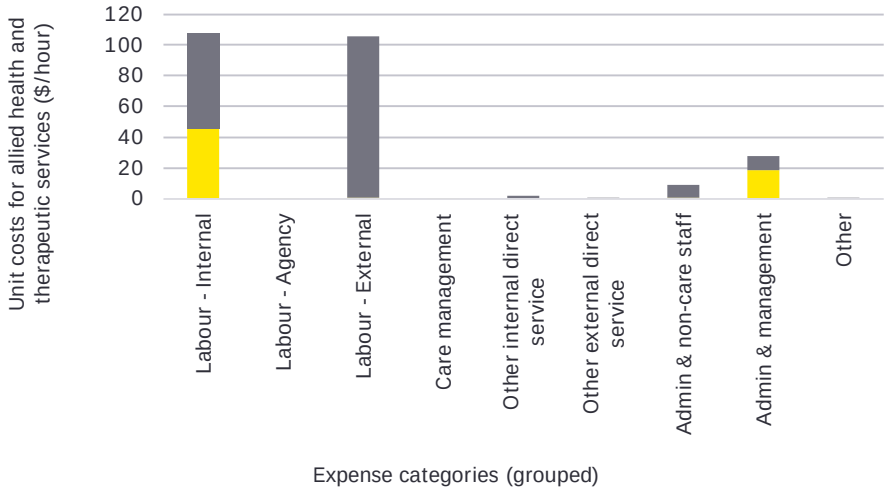


Figure 17: Unit costs by expense category for assistance with hoarding ad squalor

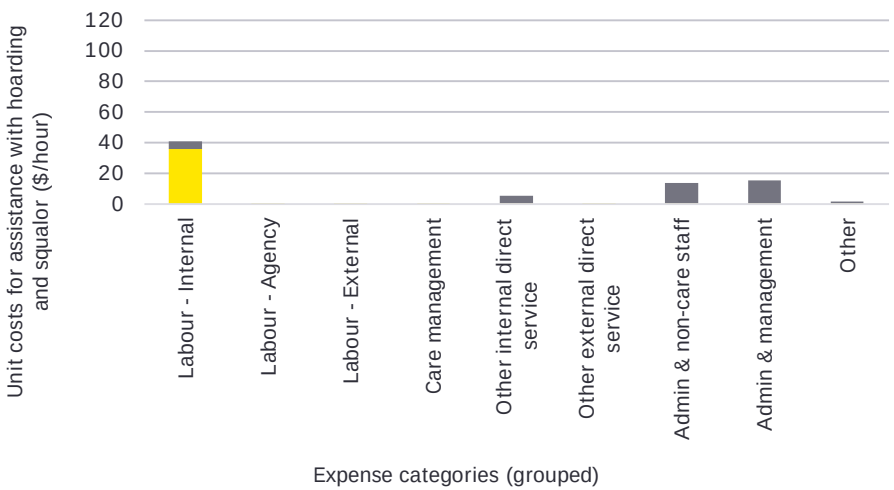


Figure 18: Unit costs by grouped expense category for care management

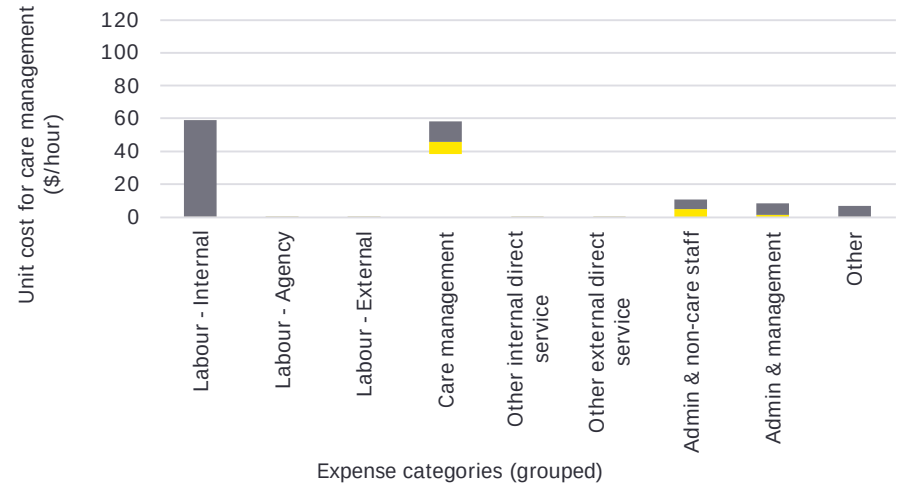
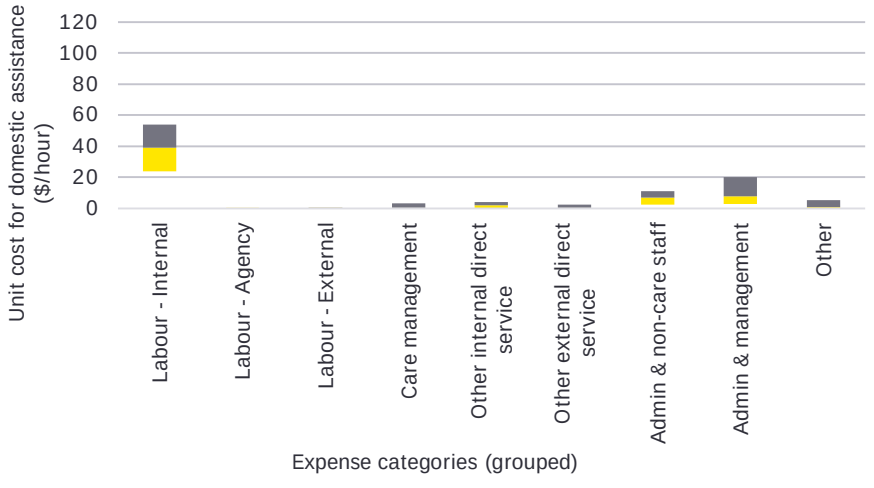


Figure 19: Unit costs by grouped expense category for domestic assistance



Q1 to Median Median to Q3

Figure 20: Unit costs by grouped expense category for home maintenance

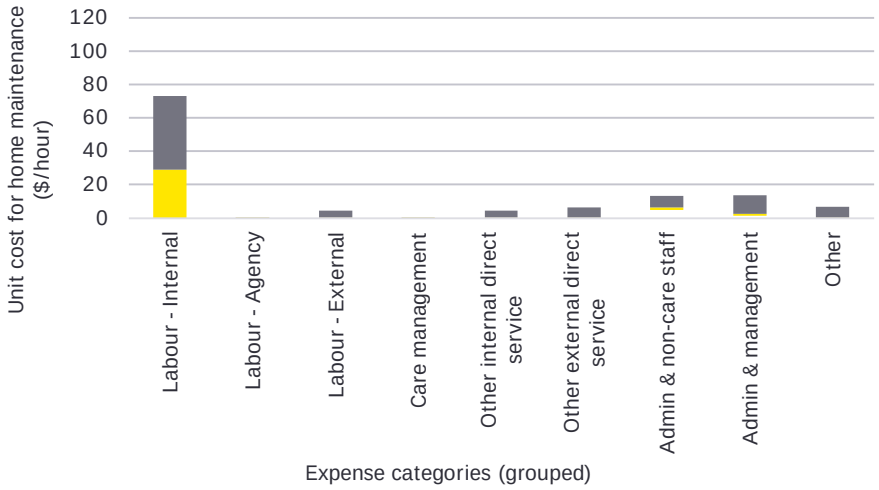


Figure 21: Unit costs by grouped expense category for meal delivery

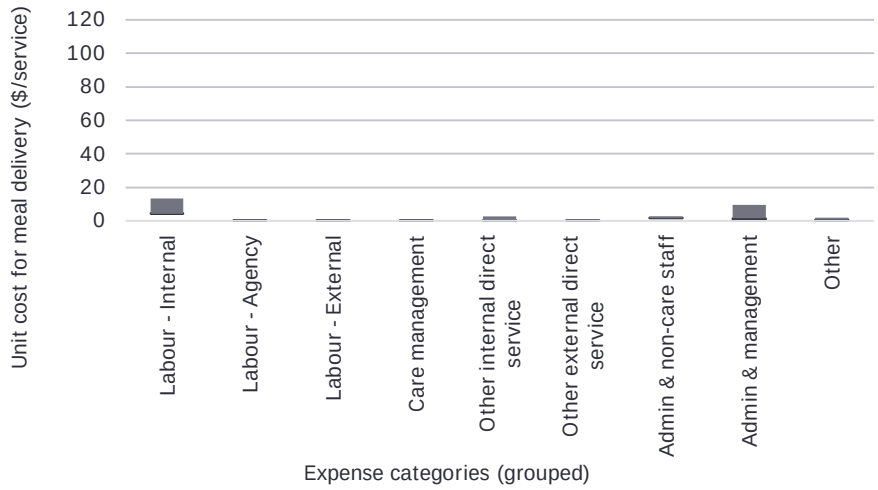


Figure 22: Unit costs by grouped expense category for meal preparation

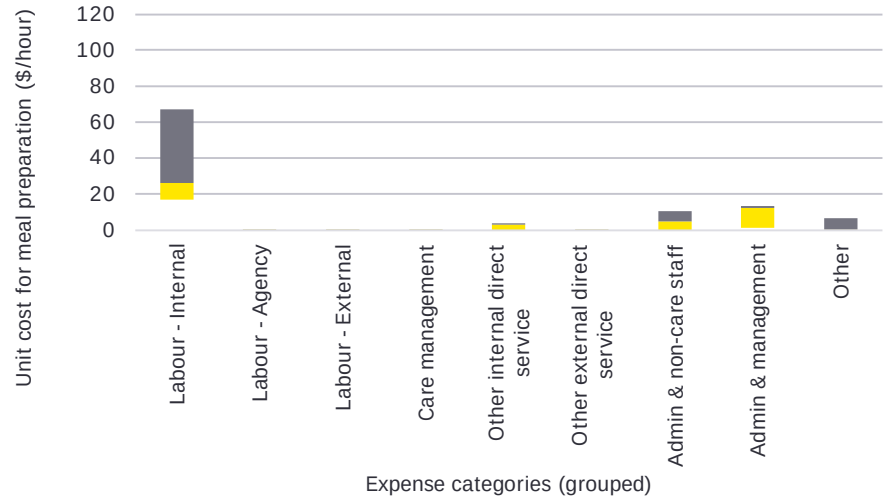


Figure 23: Unit costs by grouped expense category for nursing care

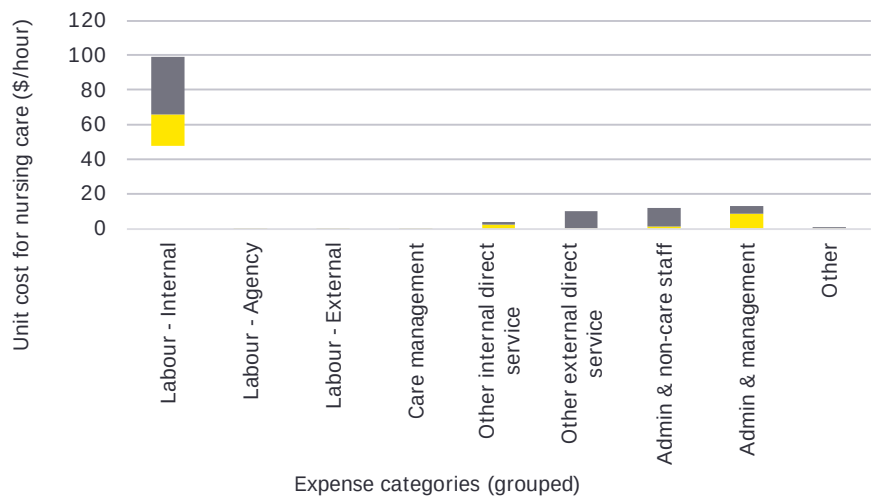


Figure 24: Unit costs by grouped expense category for

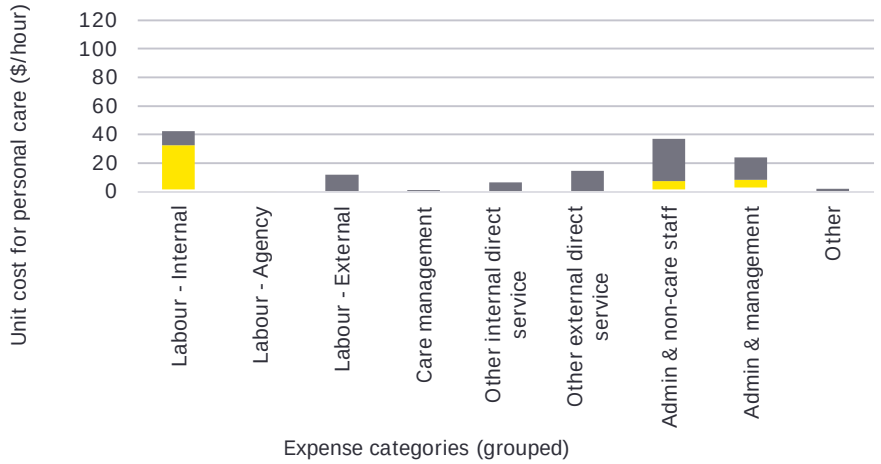


Figure 25: Unit costs by grouped expense category for respite

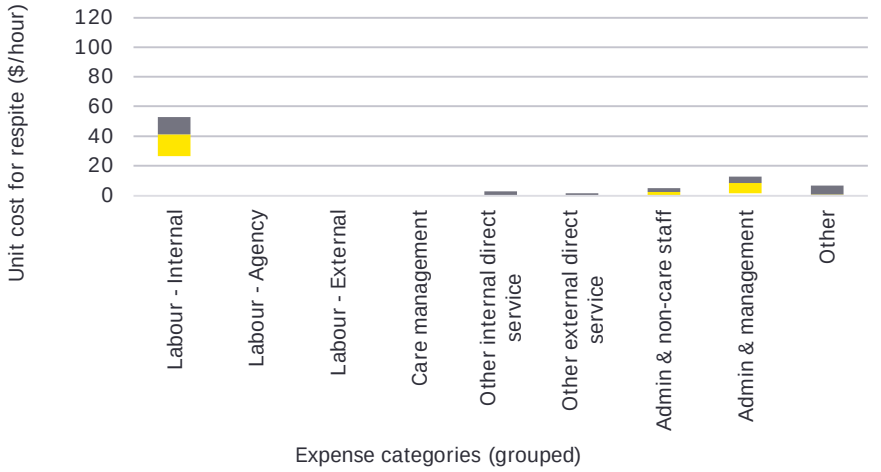


Figure 26: Unit costs by grouped expense category for social support and community engagement

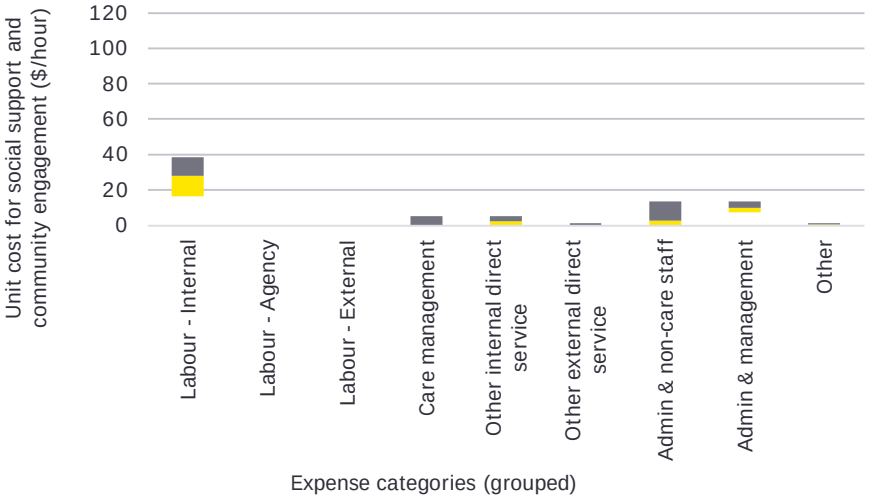


Figure 27: Unit costs by grouped expense category for specialised support services

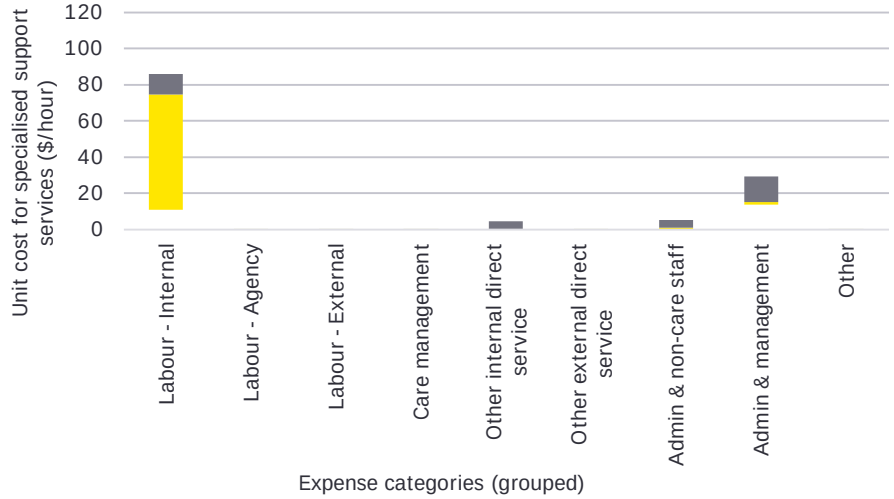
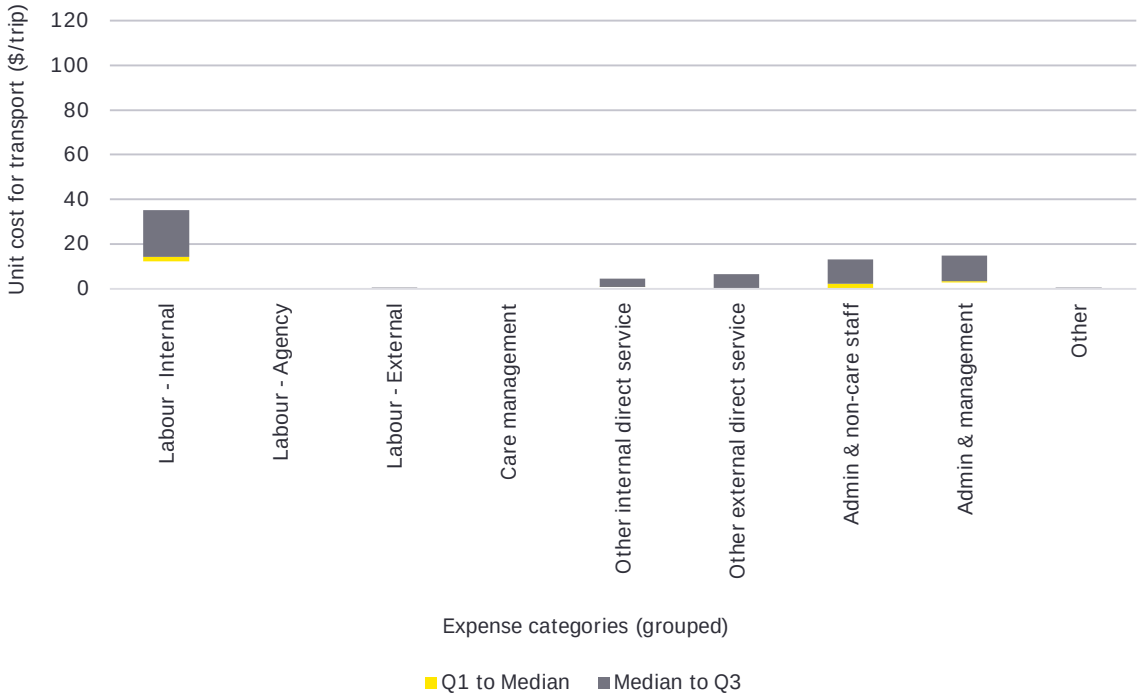


Figure 28: Unit costs by grouped expense category for transport



6. Study limitations

This section provides an overview of the key limitations of the costed dataset developed as part of the Study. The Study limitations should be considered when interpreting the results in this Report.

Table 9 provides a summary of the key limitations that have impacted the Study and should be considered when interpreting results in this Report. Limitations relating to the creation of the costed dataset are described in further detail in the *Addendum to the Study Report: Costed Dataset Technical Documentation*.

Table 9: Overview of study limitations

#	Limitation	Description
1	Representativeness of the sample	Overall, there were a limited number of providers who participated in the Stage 2 data collection due to the tight timeframes of the Study and the absence of a broad sector approach (described in detail in Section 7.3). This resulted in the following limitations: ► Representativeness of the Stage 2 sample: The sample was not representative across all key provider and client characteristics, with low coverage across some characteristics. For these characteristics, this limits the reliability of inferences made with the data collected. The Study also had selection bias, with some providers being more likely to participate in the data collection than others (e.g., providers with more advanced systems). The cost patterns of these providers may differ from providers who were less represented in the data collection. This has been offset to an extent using the sample weight methodology summarised in Section 3.5.6, based on the known key characteristics of providers. ► Sampling error: Data was collected from a sample of providers, and therefore, sampling error will be present in the Study results. The uncertainty varies by service type due to differences in the number of observations available for each service type, as well as differences in the variation in unit costs between providers for service types. ► Service types with few observations: For some service types, there were a relatively small number of observations from which a unit cost can be calculated. This increased uncertainty in the estimate of the unit costs for these service types. ► Small number of STRC providers: Overall, despite there being a higher relative share of STRC providers in the Study compared to other programs, there are relatively few observations for STRC providers in the costed dataset due to the low number of STRC providers in the sector. ► Cost variability between providers: The understanding of cost variability between providers, both in general and for different provider characteristics, is limited by the small sample size of the Study. Larger samples, particularly for some cohorts, will be required to better understand how costs are impacted by certain provider characteristics.
2	Data quality issues were identified	There are known data quality issues in the costed dataset, including: ► Failed quality assurance checks: There were several quality assurance checks (see Section 3.5.5 for further detail) that were not passed, some of which resulted in incomplete data that could not be used to calculate a unit cost. This includes occurrences where some providers did not provide data for all programs or locations that they operate across, and either cost or activity data was incomplete for some providers. These issues also include differences identified between cost data provided compared to other sources (the provider's total expenses recorded within the ACFR FY22 data for HCP and STRC, the total amount of CHSP acquittals for FY22). ► Presence of outliers: There were a material number of observations where the unit costs calculated were considered outliers, including several values that were either far higher or far lower than the outlier bounds. These results also reduce the confidence in other data submitted by the provider, as costs may have been inaccurately allocated between service types in submitted data. Whilst these outliers have been identified, IHACPA will need to apply further trimming rules if using this data to develop pricing advice. ► Allocation of costs across service types: As discussed in Section 3.5.6, to account for all costs in unit cost calculations, unallocated costs were distributed to relevant service types, using either: volume of activity, or business rules (for some service types). The approach adopted has been informed by data, however as the true distribution of costs is not known, the approaches necessarily require assumptions. As there were a notable proportion of unallocated costs, the calculated unit costs were sensitive to the allocation approach adopted.

#	Limitation	Description
		Data quality issues were attempted to be resolved with providers. However, in many cases, these issues could not be fully resolved due to limited time available to receive resubmissions, or limitations in the granularity of data held by providers.
3	There were additional limitations for some service types	In additional to the general limitations of the Study, some service types have additional limitations which should be considered when interpreting results. These include: ► Care management: *Care management* cost data capture is ambiguous and variable, across and within in-home aged care programs. For CHSP and STRC *care management* costs are generally included as part of other direct service delivery. For HCP, *care management* is a service type that all HCP providers are expected to provide to their clients. The amount that can be charged to clients for *care management* was capped on January 2023 and is based on the client's package level.[18] As such, *care management* costs are recorded as direct care expense but additionally are often absorbed within direct service costs for other service types. *Care management* costs may therefore be reported inconsistently between providers (both within and across programs), which poses challenges in understanding the true cost. ► Service types with few observations: In particular, there were few observations for the following service types: *assistance with hoarding and squalor*, *nutrition*, *specialised support services* (for HCP) and *meal preparation* (for CHSP). As discussed above, this could lead to an incomplete or biased estimate of the unit costs associated with these service types.
4	The Support at Home program is still under development	At the time of writing this Report, the program policy, design, and implementation details for the Support at Home program were still under development. The approaches used throughout the Study were based on draft policy and therefore some results may not be relevant once policy is confirmed. The key limitations are as follows: ► Service list: The service types, subcategories and activity units used for the data collection were based on an indicative service list available at the time of the Study, which is subject to change. If the scope and/or definition of the service types defined on the service list change as policy develops, this may impact the cost incurred for those service types, reducing the relevance of the results presented. ► Pricing advice structure: The design of the Study assumed that IHACPA's pricing advice would be structured by service type, based on the units relevant to each service type (which were predominantly in hours). If the future pricing advice structure differs from this assumption (e.g., through the application of loadings to reflect service delivery characteristics), additional supplementary data will be required to form the pricing advice. This is further discussed in Learning 7 in Section 7.4.1.
5	The Study period was based on FY22	The collection of FY22 data was chosen for the Study to align with existing completed and available Department of Health and Aged Care ACFR data. Results presented in this Report have not been indexed, and do not reflect recent expense increases since FY22. In developing pricing advice, IHACPA will apply appropriate cost escalation methods to the FY22 cost data.

Some of the limitations discussed above were known or expected at the commencement of the Study. The Study limitations discussed above lead to several learnings and recommendations for future costing studies, which are discussed in Section 7.

[18] Australian Government Department of Health and Aged Care (2022), Care management and care plans for Home Care Packages. https://www.health.gov.au/our-work/home-care-packages-program/managing/care-management#what-to-include

7. Study learnings and recommendations for future costing studies

This section provides an overview of the key lessons learnt from the Study, including design and stakeholder engagement considerations. It is envisaged that these lessons may be used to inform future costing studies.

7.1 Introduction to the lessons learned

This Study represents one of the foundational steps in understanding the costs in the Support at Home sector in what is an evolving policy landscape and is a proof-of-concept for future costing studies to support pricing advice for the Support at Home program.

This Study builds upon and extends the work performed in previous costing studies, capturing data at a more granular level – by detailed expense categories and by service types. This is useful in considering the feasibility of the regular collection of costs in the future e.g., by potentially increasing the granularity of existing mandatory reporting within the ACFR and QFR.

As the Support at Home program takes shape, there will be a need to collect data from a greater number of providers to increase the representativeness of the data captured. Several learnings from this Study can be used to inform future costing studies. These learnings are detailed within this section, relating to:

- Overarching Study learnings
- Stakeholder engagement
- Data collection design and process
- Timing and timeframe of future costing studies.

7.2 Overarching study learnings

There are several overarching Study learnings which are outlined in this section.

Learning 1: Future costing studies can build upon this Study to fill in gaps and increase the representativeness of the sample.

This Study is intended to be the first of several costing studies to understand costs across the Support at Home programs. It is paramount that future costing studies are conducted to achieve representative coverage across service types/subcategories, provider characteristics and client characteristics.

Given that the roll-out of the Support at Home has been staggered, with HCP and STRC transitioning to the new program from 1 July 2025, it is recommended that the focus of the next costing study is on collecting data on a representative sample of providers for HCP and STRC and filling in gaps from this Study, including:

- Provider characteristics with low number of data points: Although this Study had coverage over all programs, organisation types, provider size, and geography (based on the MMM and jurisdiction), there were a lower number of data points for STRC providers, providers operating in Northern Territory, South Australia, Tasmania, and in MMM7. The sampling frames developed for future costing studies should target these characteristics.

- *Care management*: As noted in limitation 3 in Section 6, *care management* costs are currently reported in a variable manner. When the Support at Home policy is finalised and the definition of the *care management* service type is confirmed, understanding the costs for *care management* should be a focus for future costing studies.

- Other service types with low number of observations: As noted in limitation 3 in Section 6, *assistance with hoarding and squalor*, *specialised support services* and *meal preparation* had low volume of observations in the data collected.[19] Future costing studies should target providers who provide these service types.

The learnings from this Study are important in improving the outcomes of these future costing studies.

Recommendation 1

IHACPA should conduct future costing studies to increase the representativeness of the costed dataset, particularly focusing on HCP and STRC initially. These future costing studies should seek to target gaps in the data collected in this Study, including STRC providers, providers operating in Northern Territory, South Australia, Tasmania, and in MMM7, and the *care management*, *assistance with hoarding and squalor*, *nutrition*, *specialised support services* and *meal preparation* service types.

Learning 2: To understand costs, there is a need to triangulate the current and future costing study results to other data inputs.

Whilst this Study and future costing studies contribute towards the evidence base to understanding costs, there are other data sources that can be used to cross-validate against. The triangulation of different data sources is particularly useful in the absence of a representative sample of data.

As the providers of in-home aged care operate across other adjacent sectors and provide similar services to different cohorts, it is possible to observe the price points in the market. This can also be complemented by cost modelling using existing data sources, using top-down and bottom-up cost modelling techniques.

Recommendation 2

To gain an understanding of costs, IHACPA should consider the use of other data inputs, in addition to the outputs of this Study and future costing studies. These data inputs include price points in adjacent sectors and the outputs of complementary cost modelling.

Learning 3: It will be important to obtain feedback from providers who participated in this Study to inform the design, implementation, and timing of future costing studies.

Whilst the project team received ad-hoc feedback from providers during the Study, it is important to survey providers who were engaged in the Stage 2 data collection to gain their perspectives on the Study. This survey can explore areas such as effectiveness of stakeholder engagement methods during data collection, challenges in providing the requested data (including reasons for why some providers dropped out), effort/workload to provide the requested data and proposed timeframes for future costing studies. Specific feedback can be sought on alternate approaches to the Study, including seeking commentary on:

[19] There were also a low number of observations for *nutrition*. However, it is possible that *nutrition* is funded at cost via a reimbursement mechanism, so this may not be a high priority for future cost collections.

- Expense categories: The cost data requested from providers is based on the ACFR HCP FY2021-22 expense categories, with 41 expense categories. Feedback can be sought on whether these expense categories can be aggregated/updated to better reflect the relevant Support at Home costs, and/or improve the ease of providing cost data.

- Allocation of costs to service types: Refer to Learning 10 for further details.

Recommendation 3

IHACPA should conduct a survey for providers who participated in the Stage 2 data collection to obtain feedback on what went well and what could be improved on, to inform future costing studies.

Learning 4: Future data collections may need to be mandated and/or integrated with other data collection processes to increase provider participation and reduce provider burden.

Data collection requires significant effort from providers and therefore other activities (such as mandated reporting) may take precedence over the costing study. Mandating the data provision and/or integrating with other data collection processes may improve provider participation and minimise the data collection burden. Specifically, there may be an opportunity to expand the ACFR and QFR data collections to include cost data at the service type-level. Existing routine data collections held by the Department of Health and Aged Care should also be expanded to collect service type-level activity data for the Support at Home programs.

Recommendation 4

In the long-term, IHACPA should explore opportunities to expand existing mandatory data collections, such as the ACFR/QFR and other routinely collected datasets held by the Department of Health and Aged Care, to capture service type-level cost and activity data.

7.3 Stakeholder engagement

Intensive stakeholder engagement efforts were pivotal in obtaining provider participation in this Study. Several lessons from these engagement efforts are described below.

Learning 5: Broad sector engagement and education to providers on the study may have been beneficial in reducing the lead time to recruit and onboard providers and increase participation.

In the future, broad sector education on the work of IHACPA and their costing studies should be undertaken prior to conducting a costing study such that the sector is informed, prepared and taken on the journey with the costing process. This was not possible ahead of this Study due to the policy timelines.

As this was the first time that IHACPA has undertaken a costing study with the in-home aged care sector, substantial time and effort was needed to quickly build awareness of the Study and educate providers on the data requirements to meet the Study timelines. In addition, provider participation in this Study may not have been as optimal as it could have been with a broader sector engagement approach prior the Study commencement.

There are opportunities for IHACPA to build on the engagement efforts from this Study to attract and support provider participation in future studies from a broader audience. This includes the development of a sector engagement and education strategy to keep the sector informed and engaged ahead of future costing studies, and so that they understand the data requirements and timelines ahead of the commencement of any future studies.

Recommendation 5

IHACPA should implement a sector engagement and education strategy that maintains the provider relationships established through this Study and to facilitate the establishment of new relationships, so that providers are kept informed and are engaged ahead of the commencement of future costing studies.

Recommendation 6

IHACPA should maintain a client relationship management tool of in-home aged care providers for future studies.

Learning 6: A resource-intensive and multifaceted approach was needed to attract provider participation in the Stage 2 data collection and to support providers to improve data quality and obtain data within the Study timelines.

Obtaining providers to participate in the Stage 2 data collection was challenging, despite the goodwill of providers who had been engaged wanting to participate. This was due to a number of factors, including the absence of a broad engagement approach to the sector (as mentioned in Learning 5), the timing and timeframe in which the Study was conducted which limited the capacity of providers to participate in the Study (discussed in Section 7.5), as well as the variability in provider capability (e.g., data systems and data granularity of providers, reliance on certain individuals etc). Hence, a resource-intensive and multifaceted approach was required to increase provider engagement and participation in the Stage 2 data collection.

Throughout the Stage 2 data collection, intensive support (more than expected) was provided to participants via a range of activities to educate providers on the data requirements in the DRS template, to educate them on the data submission process and to support providers with ad-hoc queries on the Stage 2 data collection requirements.

This was primarily due to the variability in the maturity of providers' data collections and systems to provide data at the granularity required as part of the Stage 2 data collection. In addition, these resource-intensive activities were critical to collecting data within the Study timelines and minimising data quality issues to the extent possible. Stakeholder engagement activities included:

- Establishing an email helpdesk function to answer any queries from providers related to the Study or the Stage 2 data collection.
- Hosting a webinar and weekly drop-in sessions to outline the Study and provide a step-by-step of how the data collection would occur, with a live Q&A held.
- Following up providers via email and telephone on at least a biweekly basis to check in on providers' progress and answer any queries over the entirety of the data collection period (described in more detail in Section 3.5.4).
- Conducting stakeholder consultations with providers to walk-through their organisations' DRS submission and answer any queries regarding the DRS template.

While the use of multiple forms of provider communication (e.g., webinar, drop-in sessions, consultations, helpdesk) was successful in maintaining provider engagement throughout the Stage 2 data collection, a significant drop off rate was observed due to several challenges (e.g., timing of Study, lack of awareness, capability of providers). Despite this, providers (including those who had dropped out of the Study) displayed positive sentiment towards the Study and the support they received. For example, providers noted the value of having multiple touch points with the Study team to receive support on Study activities and data collection requirements. Hence, future studies should consider the effort needed to provide ongoing support and education to providers to increase data quality and participation.

Recommendation 7

IHACPA should consider this Study as a guide for stakeholder support requirements during future costing studies (e.g., resourcing and time required) to increase provider participation, along with the number and quality of data submissions.

7.4 Data collection design and process

There are several learnings around the end-to-end data collection process, which are detailed within this section.

7.4.1 Data collected and design of the DRS template

The nature of data collected, including the granularity of data, was primarily informed by the Provider Survey and subsequent consultations with select providers. The DRS template was tested with a sample of providers prior to the data collection period.

Generally, the design of the DRS template was well received, with minimal queries relating to the DRS design itself. Feedback generally related to the ability of providers to submit the required granularity. The use of an excel spreadsheet, aligning with the ACFR FY22 HCP Income and Expenditure Statement expense categories and the development of a detailed manual, appeared to simplify completion of the data request for providers and this would be beneficial to continue in future studies.

There are several lessons regarding the data collected and how the DRS template was designed, which can be considered in future studies.

Learning 7: Having access to the structure of the pricing advice that IHACPA provides to the Minister would have supported the data collection to be more tailored.

At the time that this Study was designed and performed, the policy for Support at Home was still under development, including the finalised service list and structure of the pricing advice that IHACPA provides to the Minister. The granularity and structure of data collected for this Study was chosen to strike the balance between ease for providers of providing data within the timeframes, and sufficient granularity to explore cost differences between program, service type, expense categories and rurality.

For future costing studies, it is important to align the data collected to the required structure of the pricing advice. Possible factors that the pricing advice may vary by include:

- Rurality: The Department of Health and Aged Care noted that the Support at Home program end state will entail extra grant funds for services in rural and remote areas.[20] If the determination of these grant funds is informed by IHACPA's pricing advice, future costing studies should be designed to capture this level of detail.

[20] Australian Government Department of Health and Aged Care (2023), New Aged Care Act and Support at Home program update, 14 December 2023. https://www.health.gov.au/sites/default/files/2023-12/new-aged-care-act-and-support-at-home-program-update-webinar-slides.pdf

- Subcategories: In the indicative service list, there are 54 subcategories across the 14 service types. If the pricing advice is provided at a subcategory-level, additional information is required to understand the cost differentials between subcategories. However, as most providers may not collect costs across all subcategories, it is recommended that a blend of data collection and other data sources can inform subcategory-level pricing advice. Throughout this Study, providers have indicated that there are some subcategories where there are significant variations in cost within a service type. These include, but are not limited to, the subcategories within: *allied health and other therapy services* and *nursing care*, clinical versus non-clinical *care management,* and group versus individual *social support and community engagement.*

- Service delivery characteristics: Within the pricing arrangements of adjacent sectors, such as the National Disability Insurance Scheme (NDIS), there are loadings for non-standard hours. Currently the initial pricing advice structure does not include additional adjustments for service delivery characteristics such as time of service delivery, setting of service delivery, the method of delivery (e.g., individual versus group sessions) and the extent that the care required significant travel to, from and between clients.

- Other factors: There are other factors that may lead to variation in the cost per service type, including other provider/service characteristics (such as provider size, organisation type, specialisations, business model, staffing mix, span of control and supervision model, and safety and quality indicators) and client characteristics (such as Aboriginal and Torres Strait Islander status, culturally and linguistically diverse status, clinical complexity, and housing conditions). Whilst the future pricing advice may not differentiate between all of these factors, it is important to understand which characteristics drive costs in the sector.

From the Study data, there were emerging trends that showed higher costs for rural and remote providers (refer to Section 5.2.4). The trends of cost variability for other observable characteristics were not as pronounced. Additional data collections and further statistical analysis are required to validate these trends and understand the extent that these factors lead to variations in cost.

Recommendation 8

IHACPA should seek to align future costing studies to the finalised service list and the structure of the pricing advice that IHACPA provides to the Minister. This may include designing the costing study to capture more explicitly: costs and activity using the MMM/Remoteness Area (RA) classifications, subcategory-level costs, and provider, service and service delivery characteristics.

Learning 8: Discrepancies between administrative data and data on provider systems led to challenges in calculating unit costs.

Both cost and activity data are required to understand the cost per unit of activity for each service type. The data request specifications used in the Study sought costs per service type across all three in-home aged care programs, but only requested activity data from HCP and STRC. The rationale for this design choice was to decrease the administrative burden for providers, as CHSP activity data currently exists within the CHSP administrative data held by the Department of Health and Aged Care.[21]

From the Study, there were discrepancies between the location of outlets within the CHSP administrative data and the ACPRs that providers submitted data for within the data collection. This mismatch in ACPRs led to challenges in calculating unit costs within the data. There were also some mismatches between the service types that providers submitted data for within the data collection and the service types within the CHSP administrative data.

[21] This data is submitted by providers through the Department of Social Services (DSS) Data Exchange (DEX) reporting.

Recommendation 9

To minimise the discrepancies between different data sources, in the short-term it is recommended that CHSP activity at a service type-level is collected within the costing studies.

Recommendation 10

IHACPA should inform the Department of Health and Aged Care about the identified data discrepancies and work with them to understand and resolve issues where possible, enhancing the quality of the data.

Learning 9: Providers experienced challenges with providing FY22 data in the Stage 2 data collection.

The use of less recent (FY22) data was chosen for the Study to align with existing completed and available ACFR data. This requested time period had the following limitations:

- Some providers had upgraded their systems since FY22 and were required to access unsupported and outdated systems, which produced less granular data.
- Staff turnover since FY22 meant there was some corporate knowledge loss on how to retrieve the requested data.
- Expenses had reportedly increased significantly since FY22, resulting in provider concerns that the Study would understate costs (noting that cost escalation will be carefully considered and addressed in IHACPA's pricing advice).

Recommendation 11

In conducting future costing studies, IHACPA should consider using more recent data, if possible. IHACPA should also analyse the costs obtained in future costing studies to understand the extent that current and future reforms impact costs to providers.

Learning 10: A number of approaches to allocation can be used in the future, which vary in the extent that providers allocate the costs themselves.

The introduction of the Support at Home program necessitates an understanding of unit costs at a service type-level to form the price list. However, data and systems are not currently configured to collect costs and/or activity at the service type-level, particularly for HCP/STRC. This requires the use of cost allocation methodologies to allocate cost data to the service type-level.

Within the Study, several different options were considered in collecting cost data allocated to service type, relating to the extent that providers allocate all costs to service types themselves. These options, and their respective advantages and disadvantages, are outlined in Table 10.

Table 10: Options in collecting cost data allocated to service type

Option	Advantages	Disadvantages
Option 1: Costs fully allocated by provider Providers allocate the entirety of their costs across service types.	► Supports providers to reflect actual expenses and/or use relevant cost driver(s): The allocation of costs to service types by providers supports the use of actual expenses or use of cost driver(s) that are appropriate to the business.	► May deter some providers from participating: If providers are not able to fully allocate their costs, this option may deter them from participating in the costing study.

Option	Advantages	Disadvantages
	► Does not require separate allocation business rules by EY: As the entirety of their costs are allocated across service types, there are no additional allocation business rules required to understand unit costs.	
Option 2: Costs allocated by provider, where possible Providers allocate their costs across service types if possible. Where not possible, they provide the costs in a "Value unable to be allocated to service type" bucket. EY subsequently allocate the costs in "Value unable to be allocated to service type" using a set of business rules.	► Supports providers to reflect actual expenses and/or use relevant cost driver(s): The allocation of costs to service types by providers supports the use of actual expenses or use of cost driver(s) that are appropriate to the business. ► Accommodates providers with varying levels of data granularity: Providers differ in their data and systems, and ability to allocate to service types. This option provides flexibility for the provider to provide costs where they are able to allocate themselves, and account for other costs within a catch-all bucket. ► Able to understand ease of allocation by expense category: This approach supports EY to understand which expense categories are more readily allocated to service types, including information about the cost driver(s) used, and which may be more challenging for providers to allocate.	► Limitations to allocation business rules: This option relies on the development of a set of allocation business rules to allocate the costs in "Value unable to be allocated to service type" across service types, such that the unit costs reflect fully absorbed costs. These business rules are applied across all providers, and the unit costs are sensitive to these business rules.
Option 3: Costs allocated by EY, using defined cost driver(s) Providers provide costs by expense category (not allocated to service type) and data on defined cost driver(s). EY allocate costs using the defined cost driver(s) and a set of business rules. The defined cost driver(s) should be appropriate across providers and Aged Care Planning Regions. Examples include activity, number of clients and revenue.	► May reduce effort for providers in conducting the allocation: Costs would be allocated by EY, reducing the workload for providers.	► Requires providers to provide data for the defined cost driver(s): Additional data is required from the providers on the defined cost driver(s). This data should be at a service type-level. Further assumptions will need to be made if the provider does not have cost driver data at the required granularity. ► Defined cost driver(s) may not be appropriate across all providers: There is a diversity of provider and business structures. The blanket allocation of costs using defined cost driver(s) may not reflect the actual costs incurred.

During the design of the data collection process, EY consulted with several providers around the allocation approach. These providers noted that they preferred to allocate the costs themselves, rather than the option of having costs allocated by EY (Option 3). As such, Option 2 was selected for this Study.

As noted in Section 7.1, it is recommended that a survey is conducted to understand the experiences of providers who participated in the data collection for this Study to inform future approaches. Questions can be included in this survey to obtain specific commentary from providers on their ease in allocating costs to service types themselves, and whether they would prefer alternative approaches in the future (such as Options 1 or 3, as outlined in Table 10).[22]

[22] An example of how the survey can explore allocation approaches is as follows. In this Study, where providers were not able to allocate their costs to the 14 service types, they had an option to put costs to "Value unable to be allocated to service type". The survey can explore the feasibility of fully allocating providers' Support at Home costs to service types and removing the "Value unable to be allocated to service type" option.

Recommendation 12

Building on Recommendation 3, the survey could include questions that seek feedback from providers on their ease in allocating costs to service types themselves, and whether there are alternative approaches that could be used in the future.

Learning 11: Insights gained within this Study are useful for refining the cost allocation methodology and developing costing standards for the Support at Home program.

Through the information collected on allocation methods used by providers during the Stage 2 data collection, there are insights that can be used to refine the cost allocation methodology to allocate cost data to the service type-level and support the development of costing standards for the Support at Home program.

Additional information was collected from providers on which of the allocation methods they used (actual allocation, proportionate allocation, and general allocation) and the cost drivers used, as mentioned in Section 3.5.2. The key findings are as outlined in Table 11 below.

Table 11: Findings related to allocation methods

Theme	Finding
Proportion of costs able to be allocated	► Providers were able to allocate a majority of their care management and labour costs to service types. Within the labour expense categories (internal, agency and external staff), internal staff costs were more readily allocated to service types, while external staff costs were most challenging to allocate. As total labour costs represent almost 50 per cent of total costs across all three programs, this indicates that a reasonable proportion of the total costs were able to be allocated by providers. ► Administration and support costs and external direct non-labour costs were poorly allocated by providers.
Method of allocation chosen by provider	► Data on allocation methods were fairly incomplete, with less than half of the providers completing these data fields. ► Out of the providers that provided information on their allocation methods, labour costs and care management costs were usually allocated based on actual expenses, consistent with the proportion of these costs that were able to be allocated. ► Where indicated, administration and support costs and other miscellaneous costs were typically allocated proportionally or generally across service types. Considering that only small proportion of these costs were allocated by providers as noted above, this suggests that these expense categories are the most difficult to be allocated across service types.
Cost drivers	► Only some providers provided information on their cost drivers. Where this was submitted, the most common cost driver used by providers was revenue, followed by FTE, number of clients or number of service events provided. Some providers used expenses, mainly wage costs, as a cost driver or applied assumptions based on a fixed percentage of wage costs.

There would be value in developing costing standards for the Support at Home program to improve the consistency of cost data collected. Similar to the Australian Hospital Patient Costing Standards for hospital costing, these costing standards would provide direction and guidance to providers in their costing process. In understanding the "best practice" costing methods, providers can improve their data and systems to align to these standards.

The costing standards should be developed with provider capacity and capability in mind. The standards should be cognisant of the availability of staff to conduct costing, and the current systems in place.

In particular, the costing standards should cover the following areas: (1) how staff travel is allocated to service types, (2) costing of *care management*, (3) overhead allocation approaches, and (4) treatment of depreciation.

Recommendation 13

When the Support at Home program takes shape and the service list is finalised, IHACPA should develop a transparent cost allocation method and costing standards for the Support at Home program to improve the quality of data collected.

7.4.2 Data transfer

Providers submitted data to IHACPA via the SDMS, which was paramount to maintaining data security. There were several learnings relating to the process of data transfer.

Learning 12: The use of IHACPA's secure data portal was critical in maintaining data security, although onboarding providers to this data portal took longer than planned.

The use of IHACPA's secure data portal was beneficial in maintaining data security for the data collection of this Study and was critical in protecting the sensitive data collected from providers. However, should the use of the secure data portal continue into future studies, there are several considerations to support timely access and a robust user experience for providers. This includes:

- The need for longer lead times to onboard providers given this process is managed by IHACPA's DXC team, in order to reduce delays in the onboarding process and provider access.
- Maintaining provider access to the secure data portal, given the expiry of access after the conclusion of the data collection period/Study.
- Allowing providers to nominate an additional contact for secure data portal access, to reduce lead time needed to onboard providers if the original contact is on leave or exits the organisation.

Recommendation 14

IHACPA should build in sufficient time to allow for new providers to be engaged and onboarded to the secure data portal, both at the outset and over the course of the data collection period.

Recommendation 15

IHACPA should consider allowing multiple relevant contacts per organisation to be identified and provided access to the secure data portal.

7.4.3 Quality assurance and data quality

The Study involved efforts to conduct quality assurance on the data submitted by providers. This required intensive efforts in undergoing a series of checks, which are summarised in Section 3.5.5. There are several learnings that can improve the efficiency of these checks and increase the reliability of the submitted data.

Learning 13: The process of sharing queries with providers and requesting resubmissions used in this Study can be refined for future studies.

During the Study, data queries and requests for resubmission were shared with providers via the secure data portal. Provider responses were also communicated to IHACPA/EY via the secure data portal. This was to mitigate the sharing of data via email. Whilst the secure data portal was effective in maintaining data security, there were additional steps for the provider to access and respond to the queries compared to liaising via email.

A learning from this Study is to refine the process to conducting quality assurance, to reduce the number of subsequent queries required. This involves building in additional automated checks within the data request specifications, so that the providers can check whether their data passes these checks prior to their initial submission. These checks can include:

- Unit cost comparisons: An initial unit cost can be calculated (prior to allocating costs in the "Value unable to be allocated to service type" bucket) and compared to broad ranges. This check will flag to the provider where their data does not sit within the expected ranges.

- Consistency checks: The data request specifications can include checks to identify mismatches between service types across the cost and activity data (both on a provider and on an Aged Care Planning Region-level).

- Negative values: Whilst the data request specifications had built in data validation such that cost and activity entered into the DRS cannot be negative, there were some instances where negative costs were submitted where providers had linked cells to external spreadsheets. An additional check can be included to flag where negative values were inputted.

Recommendation 16

For future costing studies, IHACPA should consider building in additional automated checks within the DRS template to reduce the extent of the data-related queries required during the quality assurance process.

Learning 14: Obtaining sign-off from providers on data submissions could increase the quality of data in the future.

Within the Study, the cost data provided was compared to other data sources to assess the reliability of data provided. Specifically, HCP and STRC costs were compared to the providers' expenses within the FY22 ACFR, and CHSP costs were compared to the total amount of CHSP acquittals in FY22. Where the submitted data was materially different from these comparator datasets and no commentary was provided detailing why this was the case, this was queried with the provider.

Data quality and reliability can be further improved by obtaining sign-off from providers. This could be conducted at various stages of the data collection process, such as at the point that the provider submits their initial completed DRS template, and/or on the final data following quality assurance and allocation processes. Considerations in implementing this process include the amount of information collected (i.e. the extent that additional explanations are requested as part of the sign-off process), and the additional burden to providers as a result of this sign-off process. The approach to doing so can be based on methods used in existing data collections, such as:

- ACFR: In submitting the ACFR, an ACFR Declaration is required to be signed by a member of the governing board.

- Public hospital costs: Jurisdictions are required to submit a National Hospital Cost Data Collection (NHCDC) Data Quality Statement, which provides additional information about their data submissions which may be pertinent in processing or interpreting the data.

Recommendation 17

IHACPA should obtain provider sign-off to increase data quality. This sign-off could be at the point of submission, and on the final data post quality assurance and allocation processes. This could be similar to an ACFR Declaration, which is signed by a member of the governing board.

7.5 Timing and timeframe of future studies

The timing in which this Study was conducted, as well as the timeframe of the Study period, are important considerations for future studies. Key timing and timeframe lessons learnt are detailed below.

Learning 15: Lengthening the period for data collection would have supported greater provider participation and improved data quality.

Due to the tight timeframes of the Study, the period for data collection (including receiving resubmissions) spanned over an 8-week period. This period included the process to submit queries to providers, and request/receive resubmissions. These data collection timeframes were broadly determined based on Stage 1 Provider Survey responses.

The time period for data collection was challenging in achieving optimal Study outcomes. Specific impacts of this short time period for data collection include: some providers dropping out of the Study, some providers providing less granular data or a subset of the requested data, and limited time to resolve queries identified through the quality assurance process.

For future costing studies, it is recommended that timeline buffers are added to account for time required to grant secure data portal access to providers (as noted in Recommendation 14), time required to provide queries and request resubmissions (including quality assurance checks of resubmitted data), varying amounts of time for providers to extract data at the requested granularity, and to reduce the impact of staff turnover/leave on participation rates.

Recommendation 18

IHACPA should lengthen the period for data collection, beyond the eight-week period used for this Study, to increase provider participation and improve data quality.

Learning 16: Considering the suitability of the data collection timing for providers would have better supported provider participation.

Providers involved in the Stage 2 data collection consistently reported challenges in meeting data collection timeframes, and/or requested to withdraw because of competing priorities with the ACFR and QFR. Lessons learnt include:

- The ACFR and QFR are legislative requirements and as such, the completion of the DRS was de-prioritised when timeframes were concurrent which impacted provider participation during the Stage 2 data collection.
- Despite drop-in sessions and multiple engagement points with providers (e.g., bi-weekly emails, phone calls) during the Stage 2 data collection, providers had minimal queries on the DRS template until the fourth week of the data collection period, with providers indicating that competing priorities (e.g., resource constraints) had impacted their capacity to complete the DRS.

Whilst competing priorities are always present, they may have been less pronounced at other times of the year, enabling increased participation. Key events likely to impact future data collection timeframes include budgeting and forecasting (May), end of financial year and auditing requirements (June – August), ACFR and QFR submissions due simultaneously (October – early November), and the holiday period (December – January).

Recommendation 19

IHACPA should take into account the timing of competing reporting priorities for future data collection requests, to increase provider participation.

Appendices

Appendix A Indicative service list provided by IHACPA

The analysis and insights to date for the Study is based on an indicative service list provided by IHACPA.

Table 12: SAHCS service type definitions

Service types	Unit	Subcategories	Description
Domestic assistance	Per hour	► General house cleaning ► Assistance with household activities.	Supports the older person with domestic chores they can no longer complete independently due to functional decline or impairment to maintain their capacity to manage everyday activities in a safe and healthy home environment. Includes activities such as: ► General house cleaning (e.g., dusting, vacuuming, mopping, making beds, dishwashing) ► Unaccompanied bill paying ► Collection of firewood (rural and remote areas). Assistance may include support to increase knowledge, skills, confidence and or safety in domestic activities. This may be under the guidance of an appropriately qualified medical or allied health professional.
Domestic assistance	Per hour	► Laundry services	► Supports the older person with laundry services they can no longer complete independently due to functional decline or impairment to maintain a safe and healthy home environment. Includes activities such as: ► Access to laundry facilities ► Support to launder and iron the older person's clothing and bedding within the home or from a commercial laundry service ► Assistance to arrange dry cleaning services for items that cannot be machine washed. Care recipients with permanent and severe incontinence may access: ► Specialist cleaning for soft furnishings and bedding (including mattresses) where there is a need to maintain appropriate levels of hygiene ► Consideration of washing machine repairs or replacement through the assistive technology and home modifications scheme.
Domestic assistance	Per hour	► Shopping delivery	Delivery of groceries and other essential items such as chemist supplies. Includes shopping delivery through: ► A retailer such as a supermarket or pharmacy ► Delivery by an aged care provider where a retail service is unavailable or not able to deliver within the required timeframe.
Home maintenance	Per hour	► Maintenance of outdoor areas	Supports the older person with gardening and yard maintenance activities they can no longer complete independently due to functional decline or impairment to maintain their home in a safe and habitable condition.

Service types	Unit	Subcategories	Description
			Includes activities such as: ► Minimal alterations to garden design and pathway repair to ensure safe access ► Essential garden maintenance previously completed by the older person to ensure safety and access including pruning, lawn mowing, weeding ► Yard clearance where there are issues of safety and access ► Advising the older person on areas of concern outside of their home that pose safety risks and ways to mitigate the risks.
Home maintenance	Per hour	► Home maintenance and repairs	Assistance to complete home maintenance and repairs that the older person previously did themselves or where required to keep the home in a safe and habitable condition. Includes activities such as: ► Minor plumbing, electrical and carpentry repairs where safety is an issue (e.g., unplug a blocked toilet or repair a broken door handle) ► Working-at-height related repairs or cleaning for the older person's health and safety (e.g., removing leaves from gutters, changing smoke alarms, changing lightbulbs) ► Advise on areas of concern in the home that pose safety risks and ways to mitigate risks.
Meal delivery	Per service/ meal delivered	► Meal delivery	Access to meals for an older person who requires assistance with food preparation where the older person is unable to prepare meals independently due to functional decline or impairment. Includes: ► Meals provided in a senior citizen centre and other community-based venues (carers accompanying may also be provided with a meal) ► Providers accessing information on the older person's specific dietary needs (e.g., nutritional guidelines, dietician). Assistance may include access to kitchens for an older person who does not have appropriate meal preparation facilities within their home (e.g., meal preparation at a community hub).
Meal preparation	Per hour	► Meal preparation	Access to meals for an older person who requires assistance with food preparation where the older person is unable to prepare meals independently due to functional decline or impairment. Includes: ► Meal preparation within the home, includes ensuring the meals accommodate the older persons dietary requirements for health conditions, religious, cultural, or other reasons ► Meal preparation and delivery from a meal service provider ► Meals provided in a senior citizen centre and other community-based venues (carers accompanying may also be provided with a meal) ► Providers accessing information on the older person's specific dietary needs (e.g., nutritional guidelines, dietician). Assistance may include access to kitchens for an older person who does not have appropriate meal preparation facilities within their home (e.g., meal preparation at a community hub).

Service types	Unit	Subcategories	Description
			► Meal preparation may include preparing enough food to allow other members of the household to share in the meal. ► Assistance with meals may also include support to increase knowledge, skills, confidence and or safety in meal preparation and nutrition. This may be under the guidance of an appropriately qualified Medical or allied health professional.
Nutrition	Based on the cost of the products via a reimbursement mechanism	► Nutrition	► Access to specialised equipment and food for older people with enteral feeding and specialised supplementary diet requirements. ► Must be prescribed and monitored by a health professional operating within their scope of practice and the condition related to functional decline (e.g., dysphagia or cognitive impairment). Includes: ► Formulated meal replacements and formulated foods per *Australia New Zealand Food Standards Code – Standard 2.9.3* where the item is prescribed to prevent malnutrition and deconditioning such as Sustagen. ► Specialised foods for special medical purposes per the *Australia New Zealand Food Standards Code – Standard 2.9.5* such as Resource Plus, Ensure Plus, Nepro LP, Nutren Diabetes, Glucerna Triplecare Can, Resource ThickenUp Can. Older persons with enteral feeding requirements may access equipment (e.g., nasogastric tubes, orogastric tubes and gastrostomy (PEG)), formula and other products associated with the administration of enteral feeding through the assistive technology and home modifications scheme.
Social support and community engagement	Per hour	► Group social support ► Individual social support ► Accompanied activities.	Services that support a person's need for social contact, company, and participation in community life. Includes: ► Arranging for the older person to identify and attend services and activities ► Assistance to participate in social interactions away from home from a fixed base facility, community-based settings, or through online activities facilitated by the provider ► Visiting services, telephone and web-based check-in services ► Accompanied activities (e.g., shopping, in-person bill-paying, attendance at appointments) ► Provision of emotional support.
Social support and community engagement	Per hour	► Cultural support	Support to engage in cultural activities for older people who identify as Aboriginal or Torres Strait Islander, those who are from culturally and linguistically diverse communities, and other diverse groups such as people who identify as LGBTIQ+. Includes: ► Assistance to access translating and interpreting services translation of information into the older person's chosen language ► Referral pathways to advocacy or community organisations ► Assistance in attending cultural and community events.
Social support and community engagement	Per hour	► Digital education and support	Assistance to an older person in the use of technologies and improving digital literacy. Support may be provided on an individual basis or group setting.

Service types	Unit	Subcategories	Description
			In most cases the purchase of IT equipment and internet and telephone costs are the responsibility of the individual. These costs may be considered in the following circumstances: ► A smart device for the exclusive purpose of supporting communication due to a speech or hearing impairment, or other impairment/s, and the need for the aid will be prescribed by a health professional within the scope of their practice, may be accessed through the assistive technology and home modifications scheme. ► On-going monthly telephone and internet costs may be paid for care recipients who are homeless or at risk of homelessness (as identified at assessment) where the support is needed to ensure connection with service providers.
Social support and community engagement	Per hour	► Maintain personal affairs	Assistance to access support services to maintain personal affairs (e.g., housing services, food banks and charities, legal or financial advice and counselling) Includes assistance to: ► Identify services ► Make phone calls and set up meetings.
Transport	Per trip	► Direct transport (driver and car provided) – differentiates between short/medium/ long trips and simple/complex/ wheelchair-using clients ► Indirect transport (taxi vouchers, rideshare services).	► Transport support where required due to functional decline or impairment and public transport is not available or accessible. ► Includes group and individual transport services to connect the older person with their usual activities such as to shop, visit health practitioners, or attend social activities. ► Taxi vouchers may be better value for money than using a support worker and should be considered when determining which type of transport assistance is required. ► Fuel cards for private vehicles may be considered where an informal carer is assisting older persons who live in rural and remote areas (MMM4–7) to access essential services and social activities where provider transport or taxis are not available. ► Costs associated with the relocation of specialist medical equipment and assistive technologies may be considered where standard methods of transportation are not available.
Care management	Per hour	► Care management – clinical ► Care management – non-clinical.	Care management services are delivered by care partners who assist an older person with the day-to-day coordination and delivery of care services in support of independence and well-being. All care management services include: ► Coordination of care and services, including budgeting ► Care plan development (including goal setting), assessment, and reviews ► Monitoring and evaluation of individual goals, service delivery outcomes, changing needs, and risks ► Meeting quality monitoring obligations ► Assistance to access services outside of the aged care sector. Some older people with more complex needs will require support from clinical care partners. Clinical care partners are health professionals qualified in nursing or allied health. Clinical care management services include: ► Clinical case conferencing

Service types	Unit	Subcategories	Description
			► Clinical assessment, monitoring, evaluation, and review ► Health promotion and education.
Care management	Per hour	► Care management – restorative	► Restorative care involves the delivery of goal oriented, coordinated, multidisciplinary services to restore/regain function and wellbeing. This is delivered over a 12-week period, with consideration for an extension of time in Exceptional circumstances. ► Restorative care episodes are supported by restorative care partners who like clinical care partners, are health professionals qualified in nursing or allied health. ► Restorative care management services include the functions described in "care management – standard" and "care management – clinical," with an additional element of discharge planning. Restorative care management services are also delivered to complement ongoing services if in place, and ultimately focus on the goal of restoring/regaining function and wellbeing.
Personal care	Per hour	► Assistance with self-care and activities of daily living	Attendant care to meet essential and on-going needs. Includes support with activities such as: ► Transfers ► Mobility ► Dexterity ► Communication ► Eating ► Personal hygiene and bathing ► Personal grooming (where the activity can no longer be completed independently due to functional decline or impairment (e.g., hair washing, nail trimming) ► Toileting (including access to facilities) ► Dressing ► Checking and fitting of aids. Assistance may also include support to build or restore abilities where safe and appropriate. This may be under the guidance of an appropriately qualified medical or allied health professional.
Personal care	Per hour	► Assistance with the self-administration of medications	Medication management to support care recipients when taking their medicine. Includes support with activities such as: ► Self-administration of medications ► Supporting an older person to set up arrangements with a pharmacist and to access other government funded programs such as a Home Medicine Review.
Personal care	Per hour	► Management of Skin Integrity	Assistance with care practices which maintain clean and intact skin. Support may include: ► Monitoring and reporting of skin integrity ► Providing bandages and dressings

Service types	Unit	Subcategories	Description
			► Access to skin emollients (prescribed by a health professional or medical practitioner within the scope of their practice) ► Application of skin emollients.
Personal care	Per hour	► Continence management	Assistance for older people with continence issues to access continence aids and equipment. Care may include: ► Support to access health professionals for assessment and treatment ► Support to access continence advisory services ► Assistance to complete the Continence Aids Payment Scheme (CAPS) application ► Assistance to shop for recommended aids and equipment ► Assistance fitting and changing aids and equipment.
Nursing care	Per hour	► Registered nurse ► Enrolled nurse ► Nursing assistant.	Nursing assistance to meet clinical care needs where the age-related need is most appropriately met through nursing care delivered at home. Services may be delivered in person or through remote monitoring or telehealth services where appropriate. Support may include: ► Assessment, treatment and monitoring of medically diagnosed clinical conditions ► Administration of medications and assistance with medication management wound care ► Educating the older person in maintaining good health practices to slow functional decline ► Treatments and care that improve the older person's capacity to self-manage ► Support To Access Specialist Services Including Palliative Care. Whilst nursing care must be provided by a registered or enrolled nurse some nursing-related tasks may be overseen by a nurse through delegation to other workers, including nursing assistants or personal care workers where it is safe and appropriate.
Allied health and other therapeutic services	Per hour	► Aboriginal and Torres Strait Islander health practitioner ► Aboriginal and Torres Strait Islander health worker ► Allied health assistant ► Art therapist ► Counsellor or psychotherapist ► Chiropractor ► Diversional therapy	► Assistance for an older person to regain or maintain physical, functional, and cognitive abilities which support them to either maintain or recover a level of independence, allowing them to remain living in the community. ► Assistance may include a range of clinical interventions, expertise, care and treatment, education including techniques for self-management, and advice and supervision to improve capacity. ► Services may be delivered in person or through remote monitoring or telehealth services. ► Treatment programs should aim to provide the older person the skills and knowledge to manage their own condition and promote independent recovery where appropriate. ► Intervention delivered to an older person in a group setting, including exercise classes, must be clinically necessary and tailored to the older person's needs. Consultation fees should cover any gym or pool entry costs. ► Massage treatments may be provided by a physiotherapist, osteopath or chiropractor as part of a treatment plan.

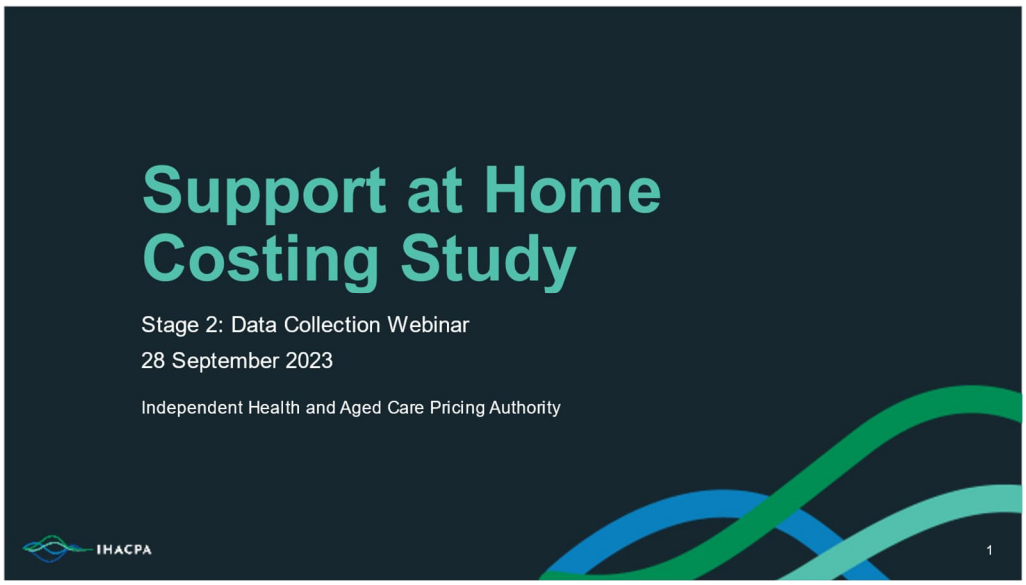
Service types	Unit	Subcategories	Description
		► Dietician or nutritionist ► Exercise physiologist ► Music therapist ► Occupational therapist ► Osteopath ► Physiotherapist ► Podiatrist ► Psychologist ► Social worker ► Speech pathologist.	► Depending on the respective accreditation and registration requirements, certain therapeutic activities may be undertaken by an assistant in allied health or support worker under the guidance and supervision of an allied health specialist working within the scope of their practice. ► Where the need for allied health relates to the assessment and prescription of aids or modifications to the home (e.g., orthotics, installation of handrails) this will be accessed through the assistive technology and home modifications scheme.
Assistance with hoarding and squalor	Per hour	► Hoarding and squalor supports	Support to live in safe habitable accommodation for older people on low incomes who are at risk of homelessness or unable to access the supports they need because of living with hoarding behaviour and/or living in a squalid environment. Assistance includes activities such as: ► Create and review care plan ► One-off specialist clean-ups ► Linkage with specialist support services ► Coordination with other services.
Specialised support services	Per hour	► Continence advisory services ► Dementia advisory services ► Vision support services ► Hearing support services ► Advisory and support services for other clinical conditions ► Advisory or support services provided to diverse groups in aged care.	Specialised or tailored services for a specific age-related condition. Supports the older person to manage these conditions and maximise their independence. Support may include: ► Developing plans and strategies to manage clients' conditions, incorporating elements of prevention and risk reduction ► Conducting timely evaluations and monitoring progress ► Establish client-centred goals ► Providing advocacy, education and advice ► Capacity building sessions for those with a clinical condition and/or specialised needs.

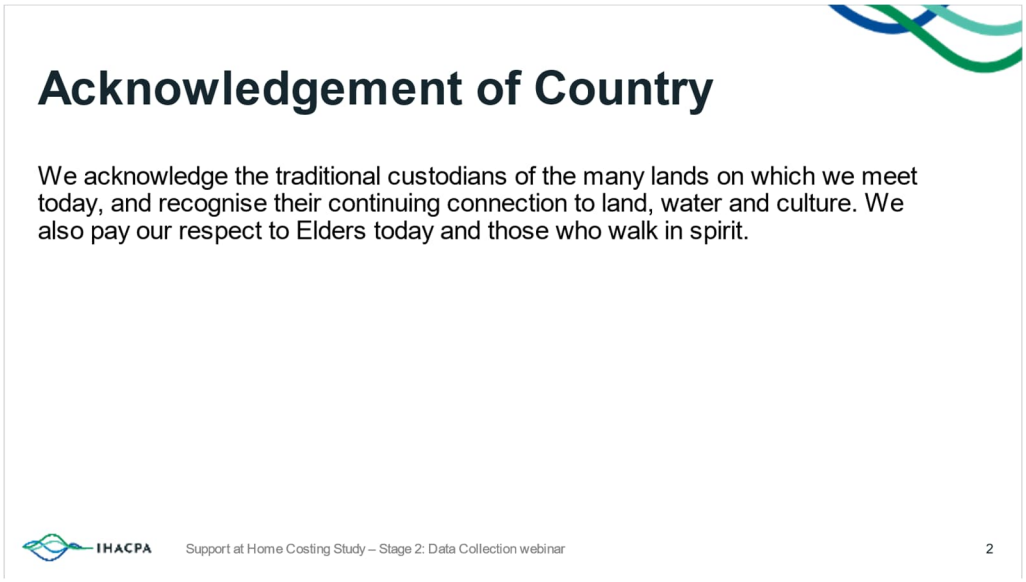
Service types	Unit	Subcategories	Description
Respite	Per hour	► Flexible respite ► Community and centre-based respite ► Cottage respite.	► Supervision and assistance of an older person by a person other than their usual informal carer. ► An informal carer may or may not be present during the delivery of the service. Flexible respite is usually provided on a one-on-one basis. It may include: ► In-home respite (day or overnight) ► The provision of support services to the care recipient in the home whilst their carer has a break ► Community access–individual ► The provision of support services to the care recipient in the home whilst their carer has a break ► Host family (day or overnight) ► Support services received by an older person from a host family ► Mobile respite ► Respite care delivered from a mobile setting ► Other – innovative types of respite service delivery. Community and centre-based respite is respite delivered in a group setting. It may include: ► Centre based day respite ► Structured group activities in a community setting ► Residential day respite ► Day respite in a residential facility ► Community access group ► Small group day outings. Cottage respite provides overnight care delivered in a cottage-style respite facility or community settings other than the home of the carer, care recipient or host family.

Appendix B Stage 2 data collection webinar slides

In preparation for the commencement of the Stage 2 data collection, a webinar was held with participating providers to outline the Study. This provided a step-by-step of how the data collection would occur and included a Q&A session. The webinar was recorded and shared with participating providers.

The webinar slides presented on 28 September 2023 are outlined below.





Agenda

	Section	Time (min)
1	About theIndependent Health and Aged Care Pricing Authority	5
2	Overview of the Support at Home Costing Study	5
3	Stage 2 of the Costing Study	5
4	Data Request Specifications (DRS) template walkthrough	15
5	Next steps	5
6	Q&A session	15

This webinar will be recorded and made available to all participants.

If you have any questions throughout the session, please drop them in the Q&A section. We will endeavour to answer all questions at the end of the webinar.

About the Independent Health and Aged Care Pricing Authority (IHACPA)

IHACPA's role in aged care pricing

About IHACPA

The Independent Health and Aged Care Pricing Authority and their role in aged care

Overview of IHACPA

- Independent government agency established under the National Health Reform Act 2011
- Provides independent costing and pricing expertise across public hospitals and aged care
- Independent, impartial, evidence-based advice to Australian governments
- Developing and implementing robust and transparent systems to support activity based funding

IHACPA's role in aged care pricing

Recommendations of the Royal Commission into Aged Care Quality and Safety included the establishment of an independent pricing authority for aged care services.

As a result, IHACPA's role was expanded in August 2022 to provide independent costing and pricing expertise to the aged care sector and the Minister for Health and Aged care including for the new Support at Home program.

Intent of the Study

IHACPA's aged care pricing advice approach and the importance of the Support at Home Costing Study

Why is this study being undertaken?

Currently, in-home aged care consists of four programs: (1) Commonwealth Home Support Program (CHSP), (2) Home Care Packages (HCP), (3) Short-term Restorative Care (STRC).

The Department of Health and Aged Care (DoHAC) plans to reform in-home aged care with the new Support at Home program. The reform – including program policy, design, and implementation detail – is currently under development, with the new program to be implemented from 1 July 2025.

This Study serves as an important first step in understanding the costs of the in-home aged care sector and is being delivered within an evolving policy context. As such, this Study will be the first of many that will be needed to fully understand cost, to then determine pricing advice.

Aged care pricing advice

Costing Study overview

Overview of the approach to the Support at Home Costing Study

Support at Home Costing Study

Overview of the approach to the Costing Study

Overview

The Support at Home Costing Study is being undertaken by IHACPA, and supported by Ernst and Young (EY), to assist with future pricing advice.

The objectives of the Costing Study are to:

1. Build an understanding of the in-home aged care sector's existing costing structure and data
2. Develop knowledge on the existing data infrastructure, business systems and programs used by providers to collect data (financial and service delivery)
3. Perform a data collection to prepare a costed dataset to inform pricing for Support at Home services, building on existing data.

Staged approach to understanding costs

Activities and timeframes of the data collection

Overview of the data collection and data request specifications template

IHACPA 9

Support at Home Costing Study

Data collection– In-home aged care providers

Objective of the data collection

The objective is to perform a data collection with providers and produce a costed data set for in-home aged care.

This will be used by IHACPA in combination with other data to inform future costing and pricing advice to the Minister for Health and Aged Care for the new Support at Home program.

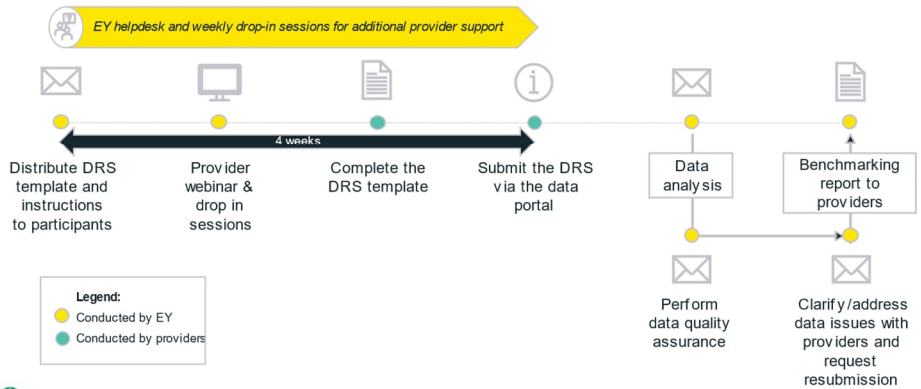
Data collection activities will provide valuable insight into the costs, workforce and activity data of the sector.

Focus of the data collection

1. Service type level expense data for some providers across CHSP, HCP and STRC.
2. More granular expense data for CHSP given current reporting is not at the same level of granularity as HCP and STRC.
3. Understanding the volume of activity by service type for HCP and STRC.
4. Care management costs and variability in this cost data on costs of care management for CHSP and STRC is not currently known, but providers report incurring these costs.

IHACPA Support at Home Costing Study: Data Collection Webinar 10

Data collection activities and timeframes



IHACPA Support at Home Costing Study: Data Collection Webinar 11

Data Request Specifications (DRS)

Template walkthrough

IHACPA

12

Overview

The DRS template consists of two key sections

The DRS template[1] is the tool we are using to collect cost, activity and workforce data from participating providers regarding their current in-home aged care programs. The DRS template consists of:

1. A Setup tab, which allows providers to select the in-home aged care programs, service types, and CHSP/HCP Planning Regions (if applicable) where services were delivered during FY2021-22 to populate in corresponding data collection tabs.
2. Three key sections consisting of (1) cost, (2) activity, and (3) workforce data, which are to be populated by providers for their respective in-home aged care programs delivered.

There is an accompanying manual that provides detailed instructions and definitions.

[1] *Please enable macros when opening the DRS for full functionality*

What data are we requesting?

The data being requested reflects what providers indicated would be feasible during the provider survey

- Period of interest is FY2021-22, workforce data may be current FY if easier to provide
- Only complete the tabs for the programs you deliver
- Complete all green tabs first

Program / type of data	Costs (in accordance with the ACFR HCP FY2021-22 expense categories)	Activity	Workforce
CHSP	ACPR-level costs by service type	N/A No activity data required for CHSP only	N/A Workforce data is collected across all programs
HCP	ACPR-level costs by service type	ACPR-level activity volumes by service type	N/A Workforce data is collected across all programs
		ACPR-level activity volumes by subcategory	
STRC	Provider-level costs by service type	Provider-level activity volumes by service type	N/A Workforce data is collected across all programs
		Provider-level activity volumes by subcategory	
All programs (combined)	Cost data differs between program	Provider-level activity volumes by time of the week delivered and service type, measured as a percentage breakdown of activity performed acro days	Staff Full-time Equivalent (FTE) within awards / enterprise bargaining agreement (EBA)

Data requirement legend: Highest priority

DRS demonstration of data tabs

Important:

- Enable macros when opening the spreadsheet
- Ensure all data is deidentified (i.e., void of any sensitive or personally identifiable information such as client information, do not include your provider details in any free text cells or in the file name).

Data security

IHACPA data portal access

The IHACPA data portal will be used as the file transfer tool for the Support at Home Costing Study, enabling your data to be hosted securely in IHACPA's environment. Given the Study timeframes, we are hoping to have your data portal access established as soon as possible (if not already!)

A gentle reminder…

Look out for an email from **ihacpa-sd@dxc.com** to arrange a time to set up your access to the portal.

Key actions:
1. Respond to the email you received from IHACPA or email ihacpasd@dxc.com directly

Data privacy

All data are to be submitted through IHACPA's data portal. Data must be **de-identified** (i.e., void of any sensitive or personally identifiable information such as client information).
All data that IHACPA owns or is the custodian of is appropriately protected and secured in accordance with relevant laws and regulations.

Please note…

It is a provider's legal obligation to use secure transfer methods to protect client and organisation data. Please ensure the correct process is followed.

Upload process (1/5)

Submitting the template to the IHACPA data (file transfer) portal

Submit the DRS within the submission date (refer to email sent to you)

Before submitting:
1. Check that no identifiable information has been included (i.e., in comments).
2. Save file using the following naming convention: **SAHCS_DRS_v1.xlsm**
3. Check all required fields in the template are completed.

Your provider name is **not** to be included in the file name or within the file.

Step 1

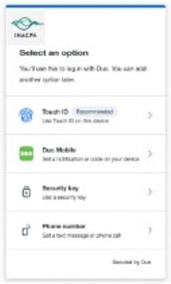
- Open an internet browser and enter the following address to access the portal: https://data.portal.ihacpa.gov.au
- Enter your portal account information in 'Username' and 'Password' and click the 'Sign In' button to log in

Upload process (2/5)

Submitting the template to the IHACPA File Transfer portal

Step 2

Perform two-factor authentication through one of the following options via the Duo Mobile app:



Upload process (3/5)

Submitting the template to the IHACPA File Transfer portal

Step 3

- Once you are successfully authenticated, you will be directed to the IHACPA SDMS File Transfer Portal Home page.
- Select the 'Upload File' tab on the IHACPA SDMS File Transfer Portal Home page navigation pane and click on 'Browse'
- Select your completed DRS template to upload.

Upload process (4/5)

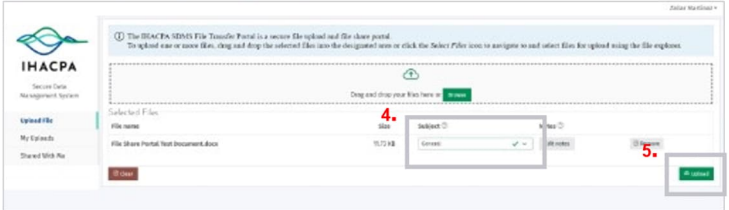
Submitting the template to the IHACPA File Transfer portal

Step 4

- After you selected a file to upload, the file will be added to the 'Selected Files' list. You will be required to choose a 'Subject' for your selected file by selecting an option from the 'Subject'-drop-down box. The subject for users will be 'AgedCare'.

Step 5

- Complete upload to the portal by clicking the "Upload" button



Upload process (5/5)

Submitting the template to the IHACPA File Transfer portal

Step 6

- Close all windows
- Log out of the IHACPA File Transfer Portal

If you have any issues accessing the IHACPA File Transfer Portal, you may contact the IHACPA Service Desk through email (ihacpaSD@dxc.com).

Next steps

What's next for you?

Next steps

Instructions on next steps will be sent to participating providers via email.

Need more help?

A recording of the webinar will be available to all data collection participants

Weekly drop-in sessions via Teams will be held to answer any further questions you may have

(invitations to be sent shortly)

The importance of your role

Play a part in key decision making and pricing advice to the Government for in home aged care

Receive a benchmarking report which compares your costs to other providers who participated

Key activities and decisions

Contributions will help inform the Support at Home program from 1 July 2025

Key information and contacts

Webinar recording

The webinar recording will be shared with participants following this session.

Study contacts

If you experience technical issues with accessing or uploading to the IHACPA data portal, contact IHACPA IT via: ihacpa-SD@dxc.com

Please direct any questions regarding the Study or DRS template to the EY Support at Home Costing Study team via: sah.costingstudy@au.ey.com

Q&A

Did you have any questions for us?

FAQs

Data collection and process

- Why is FY22 being requested within the DRS and not more recent data?
- What is the process to reassign an alternate person to upload the DRS on to the portal?
- Does this data collection duplicate what is already submitted to the Department of Health and Aged Care (DoHAC)?
- What if I can't submit all the required data in time?
- Will you give providers an extension for their data submissions?
- What support can you provide me to complete the template?
- What if my organisation's security settings do not allow content to be enabled in macro-enabled spreadsheets?

FAQs

Data security
• Will my participation in this Study be confidential? • How will my data will be protected? • Do I need to submit sensitive or personal data?

Next steps	Policy, reform and pricing
• What are the next steps after the data collection? • What are the next steps after the Study?	• How will this Study inform future pricing decisions? • How will local and contextual factors be factored into pricing given these are not included in the DRS?

Appendix C Weighted median unit costs

This Appendix provides the weighted median unit costs for figures shown in Section 5. Weighted median unit costs were suppressed if less than five providers supplied both cost and activity data for a given service type, as denoted by *.

Table 13: Weighted median unit costs by service type and provider characteristics

Service type	Overall *(Figure 11)*	Program *(Figure 12)*		Rurality[23] *(Figure 13)*		Provider size *(Figure 14)*	
	Total unit cost ($)	Unit cost for CHSP providers ($)	Unit cost for HCP/STRC providers ($)	Unit cost for providers with percentage of clients in MMM1-4 > 50% ($)	Unit cost for providers with percentage of clients in MMM5-7 > 50% ($)	Unit cost for providers with Number of clients between 1-500 inclusive ($)	Unit cost for providers with Number of clients more than 500 ($)
Allied health and therapeutic services	122	110	134	124	262	168	111
Assistance with hoarding and squalor	41	41	*	*	*	*	41
Care management	58	*	58	228	*	58	97
Domestic assistance	74	66	70	86	122	68	76
Home maintenance	86	99	86	108	127	86	115
Meal delivery	12	29	8	41	24	8	92
Meal preparation	83	*	83	101	*	*	74
Nursing care	101	95	132	105	135	116	101
Nutrition	*	*	*	*	*	*	*
Personal care	82	87	78	89	124	82	74
Respite	67	77	67	76	123	67	77
Social support and community engagement	73	77	48	83	80	65	73
Specialised support services	113	113	*	8	*	*	113
Transport	44	52	50	68	94	18	64

[23] Note that the median unit costs for the rurality view were unweighted, as detailed in Section 5.2.4.

Appendix D ACFR expense category mapping

Table 14: ACFR expense category mapping

Expense category	Expense group
Internal direct service costs	
Labour cost – internal direct care - employee	
Registered Nurses	Labour - Internal
Enrolled nurses (registered with the Nursing and Midwifery Board of Australia (NMBA))	
Personal care workers (including gardening & cleaning)	
Allied health	
Other employee staff	
Labour cost – internal direct care – agency care staff	
Registered Nurses	Labour - Agency
Enrolled nurses (registered with the NMBA)	
Personal care workers (including gardening & cleaning)	
Allied health	
Other employee staff	
Payroll Tax - Care Staff	Other internal direct service
Care Related Expenses	
Motor Vehicle Expenses	
Other Internal Direct Service Costs	
External direct service costs	
Sub-contracted or brokered client services – external direct care service cost	
Registered Nurses	Labour - External
Enrolled nurses (registered with the NMBA)	
Personal care workers (including gardening & cleaning)	
Allied health	
Other employee staff	
Consumables	Other external direct service
Home Modifications	
Client Capital Purchases	
Transport Services	
Commission/Brokerage fee/Franchisee fee	
Other External Direct Service Costs	
Care management	
Wages and Salaries - Care Management Staff	Care management
Payroll Tax - Care Management Staff	
Motor Vehicle Expenses	
Administration & support	
Wages and Salaries - Administration & Non-Care Staff	Administration & Non-care Staff
Workers Compensation Insurance	
Payroll Tax - Administration & Non-Care Staff	

Expense category	Expense group
Administration costs and management fees	
Education/Training & Quality Control Expense	Administration & Management
General Insurances	
Rent, Utilities and Property Outgoings	
IT and Communication Expenses	
Corporate Recharge	
Other Administration Costs	
Depreciation Expenses	
Interest Expenses	
Other expenses	
COVID-19 Expenses	Other
Other Expenses	

EY | Building a better working world

EY exists to build a better working world, helping to create long-term value for clients, people and society and build trust in the capital markets.

Enabled by data and technology, diverse EY teams in over 150 countries provide trust through assurance and help clients grow, transform and operate.

Working across assurance, consulting, law, strategy, tax and transactions, EY teams ask better questions to find new answers for the complex issues facing our world today.

ED None

Our report may be relied upon by Independent Health and Aged Care Pricing Authority in accordance with and for the purpose set out in the terms of our engagement letter dated 3 March 2023. We disclaim all responsibility to any other party for any loss or liability that the other party may suffer or incur arising from or relating to or in any way connected with the contents of our report, the provision of our report to the other party or the reliance upon our report by the other party.

ey.com