Home Care Price Regulation and Market Stewardship

LASA Research Report

November 2021

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Executive Summary

The future-state Support at Home Program will seek to address the impacts of a rationed home care funding approach, responding to the recommendations of the Royal Commission into Aged Care Quality and Safety for enacting entitlement-based funding as part of aged care reform. The aim of the Support at Home Program is to provide a seamless system of care that matches subsidised services to the needs of older people living at home and in the community, while also giving regard to financing arrangements to ensure entitlement can be realised. The Department of Health (DoH) is currently undertaking preparatory work that includes the development and piloting of an assessment, classification and funding (ACF) model for the Support at Home Program in responding to the Royal Commission's recommendations. Complimentary market stewardship reform activities are also underway.

Critical reflection on the design and production of the Support at Home Program suggests that the level of sector engagement by DoH in this process has been met with frustration. DoH consultation with the sector thus far excludes peak agency participation on design reference groups and gives little regard to the accumulative timing and resource imposts for home care providers as Government progresses its commitment to reform at pace in the midst of a pandemic.

LASA's advocacy is focused on seeking Government's adoption of a more considered engagement with home care providers in the co-design and co-production of the Support at Home Program. Poor sector engagement, whereby providers encounter continued frustration in contributing to the design and production process, hinders the realisation of reform progression responsive to the aspirations of older Australians in the context of fiscal pressures associated with an ageing population.

In enacting this intent, LASA advocates for a collaborative co-design and co-production approach for future home care reform. This approach needs to recognise the importance of the following tenets:

a) Enacting an allocation-utilisation paradigm that will see assessment approvals allocate higher levels of support classification to care-recipients relative to what they will likely utilise. This will reduce the demand for reassessment relative to changing care-recipient needs and noting support allocation is based on assessment of need that is matched to entitlement-based funding. Care-recipients will have control in how they utilise their funds allocation and unutilised funding will be retained by Government. Proportions of utilised and unutilised funding will be relative to funds allocation and choice in the available supply of supports.

b) Enacting fixed unit level Government subsidy allocation, means tested care-recipient co-contribution and market-based unit level provider pricing in responding to demand fluidity and supply cost variation across diverse market segments in the national home care landscape. This will enable providers to exercise agility and innovation in response to market demand and cost drivers for the delivery of care and support services.

c) Enacting transparency of care-recipient experiences and outcomes as an extension of price transparency to further strengthen care-recipient engagement in their accessing care and support. This extends beyond strengthening quality regulation mechanisms, implementing a consultative and outcome-focused market stewardship arrangement that is responsive to market variability in care-recipient demand for a diverse range of care and supports as well as the challenges of supply constraints and fiscal pressures.

d) Ensuring the legislative and program environment includes sufficient operational flexibility for home care providers, recognising the dynamic and variable market environment in which future in-home care and supports must be provided. This will require not only a commitment to high quality and safe care from providers but also agility and innovation in their operations to which market stewardship policy settings must be aligned.

LASA argues that the evidence presented in this research report concerning home care cost distribution and price maturation, relative to comparable program policy settings, legitimises the suggested tenets for price regulation as part of the design and production of the Support at Home Program. Moreover, vulnerabilities in the conduct of market stewardship reiterate the importance of adopting a collaborative and outcome-focused approach in the maintenance of the Support at Home Program. LASA's detailed research report goes some way in contributing to co-design and co-production in the context of current sector engagement by Government.

Home Care Package Cost Distribution

Home care cost distribution analysis uses FY18-19 data that has been adjusted to ensure cost ratios exclude unspent funds, reflecting cost utilisation. These costs are attributable to home care package (HCP) provider administration and care-recipient utilisation under consumer-directed care. This analysis approach builds on the HCP Improved Payment Arrangements introduced across 2021.

- By ownership type, average direct care costs account for 65 percent of HCP expenditure relative to care management, averaging 16 percent, and package management, averaging 19 percent.
- By package level, average direct care costs account for between 60 and 67 percent of HCP expenditure relative to care management, averaging between 15 and 19 percent, and package management, averaging between 18 and 21 percent.
- If care-recipients were to choose to utilise their entire unspent funds balance for direct care, average direct care costs would increase to 72 percent of HCP expenditure relative to care management, averaging 13 percent, and package management, averaging 15 percent.

Home Care Package Price Maturation

Home care market-based pricing analysis used a randomly selected national sample of 300 HCP providers, examining median HCP price changes as well as price variation across the 18-months to June 2021. Price accounted for direct care services, care management and package management.

- For direct care services, median hourly pricing at June 2021 increased minimally across the prior 18-months, in the range of 0.0 to 6.2 percent. Variability in pricing between the first and last quartiles for each service type relative to median pricing was in the range of near $8.00 per hour for personal care and $18.00 per hour for nursing care.
- For provider-managed HCPs, median fortnightly care management pricing at June 2021 increased across the prior 18-months in the range of 1.1 to 4.0 percent. This represents an increase in the range of 0.2 to 1.4 percent of total package value over the same period with provider-managed care accounting for near 15 percent of total package value at June 2021.
- For self-managed HCPs, median fortnightly care management pricing at June 2021 increased across the prior 18-months in the range of 5.1 to 8.9 percent. This represents an increase in the range of 0.7 to 1.3 percent of total package value over the same period with self-managed care accounting for near 9 percent of total package value at June 2021.
- For package management, median fortnightly pricing at June 2021 increased across the prior 18-months in the range of 4.5 and 5.9 percent for all package levels. This represents an increase in the range of 0.1 to 0.8 percent of total package value over the same period with package management accounting for near 10 percent of total package value at June 2021.

The extent of HCP price increases and variability of pricing as a proportion of total package value across the first two years of HCP price publishing and relative to FY2018-19 home care cost distribution appears consistent with market-based price maturation for HCP service delivery.

Further work is required in generating standardised and comparable metrics for care management pricing relative to current price publishing arrangements and market variability. The association between quality care management, positive care-recipient experiences and positive care-recipient outcomes is noteworthy. Importantly, transparency of care-recipient experiences and outcomes as an extension of price transparency will be necessary to improve care-recipient choice, decision-making and the engagement of older Australians with regard to accessing care management support.

HCP Market Comparison with CHSP

Comparison between published HCP prices for direct care services and Commonwealth Home Support Programme (CHSP) equivalent service pricing identified that between 85 and 91 percent of HCP provider prices fall within the lower/upper price limits of CHSP prices set for 2021-22 growth funding. The consistency of price variation across these programs supports the legitimacy of market variability in the national home care landscape and use of market-based pricing.

Fluidity of market demand and cost drivers require a considered approach in translating variable home care service expenditure and pricing into a nationally consistent fixed funding and market-based pricing approach in the design and production of the Support at Home Program. This design should be without restriction to home care provider operations, ensuring responsiveness to both individual and community level needs. Considered application of block and/or activity-based funds allocation across the diversity of care and support service types will be required. In particular, block funding will be required for services with high fixed capital costs or operating in thin markets.

HCP Market Comparison with NDIS

Comparison between published HCP prices for direct care services and National Disability Insurance Scheme (NDIS) equivalent service pricing identified that where direct care services are high volume, regular and predictable there is minimal price variation. In contrast, differences in hourly pricing for HCP direct care services in rural and remote locations extended out to between 18.8 and 38.2 percent lower than NDIS prices for similar direct care service types at December 2020. This highlights the challenge that exists for the application of a nationally consistent funds allocation and market-based pricing approach for thin markets within the design and production of the Support at Home Program.

Comparison of HCP and NDIS direct care service prices across December 2019 and 2020 indicates that observed price variations are consistent over time, noting it has been recommended that fixed price controls be removed from the NDIS once the scheme reaches maturity and the market itself can set the price of supports.

Importantly, funds allocation for thin market segments will be applicable to near one quarter of the national home care landscape. The design and production of the Support at Home Program for service delivery in these thin market communities needs to include sufficiently sensitive market stewardship arrangements for response to these dynamic environments demanding thin market intervention.

Market Stewardship

LASA argues that the proposed quality regulation reform measures along with the enhancement of existing quality regulation and system administration structures do not go far enough in establishing a consultative and outcome-focused market stewardship arrangement that will transform future home care service delivery to be the world class market-based Support at Home Program envisaged through the Royal Commission for the care of both current and future generations of older Australians.

LASA suggests that stewardship for the Support at Home Program be developed to give greater account for market variability. A sufficiently sensitive market stewardship approach that comprises localised engagement, data analytics and capability to enact thin market interventions can assist to identify and respond to market segments where care-recipient experiences and outcomes relative to goal-directed care plans are indicative of market failure. This can inform thin market interventions, noting standardised and centrally collated outcome-focused data collection is critical in developing this level of market stewardship sophistication.

Recommendations

LASA recommends that the design and production of the Support at Home Program include:

1. Adopting a more considered engagement process with home care providers in the co-design and co-production of the Support at Home Program. This should include the establishment of a forum for provider and consumer advocates to work with decision makers on key design elements to ensure consumer needs are understood and provider views are accounted for on how best to meet these needs in Program design and production.
2. Implementing assessment approvals that will see higher levels of support classification allocated to care-recipients relative to what they will likely utilise, reducing the need for reassessment.
3. Implementing a fixed unit level Government subsidy allocation, means tested care-recipient co-contribution and market-based unit level provider pricing arrangement to accommodate market variability.
4. Developing infrastructure that will increase the transparency of care-recipient experiences and outcomes as an extension of price transparency with standardised measurement being collated centrally for analysis and review.
5. Making transparent home care cost variation relative to home care provider price variability in all future cost data reviews and analysis.
6. Giving account for increasing provider administration costs associated with implementing home care reforms. This includes responding to supply constraints, workforce and quality regulation, ICT infrastructure demands and innovation development.
7. Refining price transparency metrics to include standardised and comparable hourly care management prices that better support informed care-recipient choice and decision-making concerning care management price variation.
8. Committing to retain block funding for the operation of market segments, including those identified as thin markets or having a high fixed cost component independent of care-related outputs.
9. Committing to implement market stewardship mechanisms that are consultative and outcome focused, being sufficiently sensitive to identify and intervene in thin markets.

1. Introduction

When older Australians are contending with a rationed home care funding environment and unmet care needs, the natural consequence is a heightened focus on the relative value of each available HCP cost component; direct care services, care management services, and package management requirements. Importantly, value-based comparison across these HCP cost components are often made without due regard for the policy and regulatory environment in which HCP operations occur.

The Royal Commission concluded that it is likely that the level of HCP funding is insufficient to meet the care needs of many package holders.[1] LASA's comparison of aged care and NDIS funding highlights the extent of disparity that exists in ensuring reasonable and necessary supports are made available to older Australians.[2] Higher levels of HCP funding have been recommended which consequently will drive up the proportion of HCP funding allocated to direct care costs relative to the actual costs of care management and package management (administration).

The generalisation of high package management and care management fees relative to direct service charges in the current system of HCP operations has not been a helpful narrative in progressing home care reforms. This narrative has often played to the politics of a rationed funding environment, detracting attention away from overall funding deficits within the current system and placing undue viability pressures on HCP provider cost distribution.

LASA purports that the evidence concerning HCP cost distribution legitimises approved provider price positioning on the various cost components in the HCP market environment. This is in contrast to the highly emotive narrative of high administration fees as has been articulated in the context of a pressured funding environment. The evidence to support this argument is outlined in this paper.

Additionally, the national HCP market environment is directly impacted on by market variability which in turn drives HCP cost variability amongst providers. Market variability describes variations in client demand for services and provider supply of services with account for acuity of need, breadth of service types, diversity of population groups and regions to be serviced. Transparency of market variability and with it, HCP provider price and cost variability, is critical to building an evidence base for market stewardship that supports the process of home care reform. This stewardship needs to recognise the acceptability of price variation relative to median pricing in informing price regulation.

While LASA and its Members stand firmly in support of increased price transparency as part of the future Support at Home Program, it is critical that price transparency occur alongside the transparency of care-recipient experiences and outcomes to be achieved relative to pricing. Market stewardship needs to include reporting of care-recipient experiences and outcomes concurrent to an increased focus on price transparency in justifying market-based price positioning and to inform thin market intervention.

It should be acknowledged that the sophistication of such operational demands will contribute to upward pressure on system and provider administration costs relative to current cost distribution. Therefore, a balanced approach to price regulation and market stewardship is required in accounting for the legitimacy of provider costs while contending with system-level fiscal pressures in the context of an ageing population.

1 https://agedcare.royalcommission.gov.au/publications/final-report-volume-1
2 https://lasa.asn.au/news/ndis-vs-agedcare/

2. Single Support at Home Program

The Department of Health (DoH) is currently undertaking preparatory work to develop a new single Support at Home Program that will replace CHSP, the HCP Program, the Short-Term Restorative Care (STRC) Program and residential respite programs. To support this work, the DoH has commissioned development of an assessment, classification and funding (ACF) model for the Support at Home Program. The Support at Home Program will aim to provide a seamless system of care that matches Government-subsidised services to the needs of older people living at home and in the community.[3]

Figure 1. The assessment, classification and funding model underpinning development of the Support at Home Program.

2.1. Assessment

The design of assessment services in the Support at Home Program includes the replacement of the current Aged Care Assessment Program and the Regional Assessment Services with one single comprehensive assessment process that is independent of approved providers. The assessment process recommendation of the Royal Commission into Aged Care Quality and Safety (Recommendation 28)[1] includes:

- Assessments being conducted prior to services commencing, wherever possible, with interim services being offered where necessary;
- Assessments being efficient and scalable according to the complexity of needs and vulnerability of the older person;
- Assessments being forward looking and promoting older people's autonomy and self-determination;
- Assessment of the need for care management and the intensity and complexity of that need;
- Assessment of any informal carer's needs;
- The use of multidisciplinary teams for more complex needs; and
- Acknowledgement of the need for reassessments in response to reasonable requests where there are changes in older people's care needs.

Government's response to this Royal Commission recommendation indicates that a single assessment workforce will be established using a staged implementation approach commencing October 2022 within residential aged care, and July 2023 within home care. Design of the assessment process includes screening and triage that determines requirements for base assessment, advanced assessment and extended assessment. It will also include requirements for assessment of restorative care and informal carer support needs, with assessment determination informing an assessor generated goal-directed care plan.

LASA understands the assessment tool is based on revision of the National Screening and Assessment Form. Design and production will need to ensure the integrity of the tool for consistent application by the assessment workforce, informing reliable and valid classification determinations and goal-directed care planning.

3 https://acfinhome.com.au

2.2. Classification

The classification design of the Support at Home Program includes variation across the classification of service types with account for assessment determinations and funds allocation. The recommendations of the Royal Commission into Aged Care Quality and Safety reference the application of both block and activity-based funding arrangements aligned to categorical assessment classification.[1] Specifically, these recommendations include:

- Implementation of a **respite supports category** (Recommendation 32) that is block funded, provides a greater range of high-quality respite supports in people's homes, in cottages and in purpose-built facilities and includes a capital component in thin market areas.
- Implementation of a **social supports category** (Recommendation 33) that is block funded, provides support that reduces and prevents social isolation and loneliness among older people, can be coordinated at the community level and includes CHSP service types comprising centre-based day, social support, delivered meals and community transport.
- Implementation of an **assistive technology and home modifications category** (Recommendation 34) that is block funded and provides goods, aids, equipment and services that promotes a level of independence in daily living and includes CHSP service types comprising assistive technology, home modifications and hoarding and squalor.
- Implementation of a **care at home category** (Recommendation 35) that provides activity-based service funding aligned to assessed need and that allows for access to a coordinated and integrated range of care and supports. Importantly, this recommendation includes that the category be developed and iteratively refined in consultation with the aged care sector and older people. Consultation and refinement of this category should look to ensure this category:
  - Supports older people living at home to preserve and restore capacity for independent and dignified living to the greatest extent and prevents inappropriate admission to long-term residential care;
  - Offers episodic or ongoing care from low needs to high needs;
  - Provides coordinated and integrated care and supports that span across a range of domains that include care management, living supports, personal and clinical care, allied health care and restorative interventions, and palliative and end-of-life care;
  - Requires a lead provider to be chosen by the older person, that will be responsible for ensuring services are delivered matched to assessed need, monitor the status of people receiving care with adjustments to care as required, and that will seek a reassessment if an increased need for care persists beyond three months.
- Provision of **care management** (Recommendation 31), unless assessed otherwise, that is matched and scaled up to respond to the complexity of an older person's needs and with regard to their preferences.
- Provision of **allied health supports** (Recommendation 36) with account for type, duration and intensity such that physical and mental health can be restored to the highest level possible in maximising independence and autonomy.

Government's response to this set of Royal Commission recommendations is being progressed through the design and production work of the ACF model. An ACF Data Study is in progress that aims to test the application of a mixed service event and episode level classification approach that is consistent with the Royal Commission's recommendations. The Study draws on the assessment and service utilisation data of existing home care-recipients. This data is being collected with the support of home care providers and has been ongoing since April 2021.[3] LASA understands that more work is required to increase care-recipient participation and strengthen the integrity of the ACF Data Study for testing the ACF model.

Importantly, on completion of this Study, assessment determined classification will need to be aligned to goal-directed care plans, informing service inputs. This can then facilitate the tracking of these service inputs and corresponding impacts via the measurement of resulting care recipient experiences and outcomes.

2.3. Funding

The funding design of the Support at Home Program will be informed by the ACF Data Study through the collection of financial data from home care providers that will support the construction of a cost model to estimate the cost per output unit for each service type delivered by a provider. Costs are to be measured using the actual expenditure of providers participating in the Study.

Concurrent cost modelling has also occurred within the CHSP program, generated from 2018-19 CHSP data.[4] Work is also currently underway, commissioned by the DoH, to support the development of a National Unit Pricing Policy for CHSP.[5] Importantly, modelling unit level service expenditure across both HCP and CHSP programs needs to account for the true cost of provider administered Government-subsidised services in the context of home care reforms that are ongoing.

When considering the balance of administrative overheads to direct services in other industries, KPMG reported an 2010 administration cost benchmark against total expenditure for a large-scale gas distribution company as being 22 percent.[6] In 2010, a comparison of hospital administrative costs across eight nations reported these costs as ranging between 12 and 25 per cent where higher costs were reported in nations with market-orientated payment systems.[7] In 2013, PWC reported among 24 government agencies that corporate service functions collectively accounted for 16 percent of total department expenditure. These functions included ministerial support, public relations, procurement, finance and budgeting, ICT, legal, human resource management and internal audit.[8] Many of these functions are legitimate to home care provider businesses.

Furthermore, this analysis revealed that expenditure across different sized entities over a two-year period have consistently shown that the cost of these administrative functions as a proportion of total departmental expenditure for smaller entities is almost double that of larger entities. By implication, there is a level of administrative fixed cost expenditure whereby larger entities can benefit from economies of scale in reducing the cost of service administration relative to service outputs.[8] The above evidence from other sectors provides indication of service administration cost variability that may apply to home care provider service administration.

Importantly, HCP separation of direct service, care management and package management cost components alongside increasing HCP price transparency from July 2019 provides an important opportunity to understand how the market environment of HCP operations has influenced HCP service administration costs as a priced component of total package value and relative to other HCP cost/price components.

2.4. Co-Design and Co-Production

The transition of the current home care service environment into a future-state single Support at Home Program reiterates the importance of co-design and co-production by which Government can engage existing care-recipients and home care providers in realising a feasible transition approach. The Royal Commission into Aged Care Quality and Safety references a transition approach that is cautious, phased and flexible.[9]

Sector concerns in engaging with the current home care reform approach have been voiced,[10,11] with LASA proactively engaging with the Government on these matters. While official consultation with the sector is being administered though the Ageing and Aged Care Engagement Hub, informing the implementation of reforms,[12] the level of engagement in this regard appears limited.

4 https://www.health.gov.au/resources/publications/commonwealth-home-support-programme-data-study
5 https://www.health.gov.au/resources/publications/commonwealth-home-support-programme-chsp-payment-in-arrears-and-unit-pricing-fact-sheet
6 https://www.aer.gov.au/system/files/Attachment%208.1%20KPMG%20Corporate%20Cost%20Benchmarking%20Report.pdf
7 https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1327
8 https://www.pwc.com.au/pdf/federal-government-benchmarking-corporate-services-dec13.pdf
9 https://agedcare.royalcommission.gov.au/publications/final-report-volume-3a
10 https://communitycarereview.com.au/2021/09/08/home-care-providers-say-consultants-wont-produce-desired-reform/
11 https://www.australianageingagenda.com.au/executive/minister-denies-aged-care-sector-being-left-out-of-reform-process/
12 https://agedcareengagement.health.gov.au/

LASA recognises that consultation thus far has been limited to the siloing of reform measures, giving little regard to the accumulative timing and resource imposts on home care providers in contributing to the design and production of the Support at Home Program. LASA's advocacy efforts are clearly focused on seeking Government's adopting a more considered engagement process with home care providers in the co-design and co-production of the Support at Home Program.

LASA has undertaken a detailed analysis of HCP cost distribution and market-based pricing to inform the co-design and co-production of the Support at Home Program. Comparison of HCP price components with CHSP pricing data and the National Disability Insurance Scheme's (NDIS) fixed price Service Catalogue has also been undertaken, noting comparable elements in these program policy environments.

LASA's intention is to increase understanding about the variability in home care cost distribution and market-based pricing with account for market segments, build a case for applying fixed funding and market-based pricing for the delivery of care and support through the Support at Home Program.

In enacting this intent, LASA advocates for an increasingly collaborative co-design and co-production approach for future home care reform. This could include the establishment of a forum for provider and consumer advocates to work with decision makers on key design elements. This approach needs to recognise the importance of market-based pricing, in accounting for variation and fluidity across diverse market segments in the national home care landscape. LASA believes the fixed funding and market-based pricing approach will be critical relative to the restrictive nature of comparable price control approaches and the continuing fiscal pressures perpetuated by population ageing.

3. Home Care Package Cost Distribution

Examination of HCP cost distribution data provides considerable insight into the current state of home care service expenditure to inform a fixed funding and market-based pricing approach for the new single Support at Home Program. The Home Care Provider Survey[13] provides a detailed breakdown of HCP cost distribution for the 2018-19 financial year to assist in understanding the cost profile for delivering home care services to older Australians. It is based on service utilisation and financial survey data from 416 HCP providers, representing 54,823 HCPs.

3.1. Cost Components

The Survey references three key cost components for HCPs; direct care services, care management and package management. It references HCP unspent funds, describing the portion of Government subsidy and care-recipient contribution having not been expended on the three key cost components and remaining available for expenditure.

3.1.1. Direct Care Services

Direct care services describe those services delivered to a care-recipient in their home in response to their care and support needs. The quantity and mix of direct care service components may vary across care-recipients, determining the cost for direct care services as a portion of total HCP expenditure. Direct care service expenditure includes but is not limited to:

- Personal care;
- Nursing care;
- Cleaning and undertaking household tasks (domestic assistance);
- Meal preparation;
- Providing social support, shopping and community access support;
- Light gardening;
- In-home respite;
- Transport services;
- Allied health services;
- Consumables and capital purchases;
- Home modifications;
- Home maintenance; and
- Other services required to maintain the care-recipient at home.

3.1.2. Care Management

Care management is an essential component of every HCP. It describes a process of assessment, review, planning, facilitation and advocacy between the care-recipient/family/carer and their care and support delivery network. It ensures care-recipients receive the appropriate level of support in a way that meets their current and future care needs. Approaches to care management may vary, ranging from provider-managed through to self-managed care and support delivery. Responsibility for self-managed care differs from provider-managed care in that it is largely undertaken by the care-recipient, their family and/or carer with input from the service provider as required. When accounting for the actual cost requirements for care management, cost components include:

13 https://www.health.gov.au/resources/publications/home-care-provider-survey-analysis-of-data-collected

- Reviewing a care-recipient's home care agreement and care plan;
- Coordination and scheduling of services;
- Ensuring care-recipient care is aligned with complimentary supports;
- Providing a point-of-contact for care-recipients or their support network;
- Ensuring the care received is respectful of culture;
- Family conferences and liaison;
- Change or variation on reassessment;
- Liaison with assessors, GPs and other health professionals;
- Ad hoc calls and communications;
- Ordering and delivering of in-home maintenance equipment and consumables;
- Liaison with pharmacy for medications where this is not automatic or family controlled; and
- Identifying and addressing risks to a care-recipient's safety.

Cost components of care management attended to as part of provider-managed care are predominantly the responsibility of the provider and consequently attract a higher cost than does self-managed care.

3.1.3. Package Management

Package management describes the ongoing administration and organisational activities associated with ensuring the smooth delivery and management of a care-recipient's HCP. Cost components include the costs for preparing monthly statements, managing package funds and adherence with compliance and quality assurance requirements for HCP administration.[14]

3.2. Distribution by Ownership Type

Distribution of HCP costs in the Survey[13] as a function of ownership type is reported in Table 1, identifying variation in HCP cost distribution across Not-For-Profit, For-Profit and Government ownership. No variation was reported in HCP cost distribution as a function of provider size. Survey methodology prohibited the identification of any variation in HCP cost distribution as a function of provider location across metropolitan, regional and rural locations.

Table 1. Percentage distribution of average component costs with all HCPs included by ownership type as a proportion of total HCP program income and average care hours per fortnight for FY18-19.[13]

	Not For Profit	For Profit	Government	Total
Number of Providers	262	108	46	416
Number of HCPs	44,243	7465	3,115	54,823
Average HCP Value	$1,034	$1,055	$874	$1,028
Average HCP Expenditure	$851	$818	$655	$835
Unspent Funds	18%	22%	25%	19%
Package Management	15%	11%	17%	15%
Care Management (CM)	14%	9%	17%	13%
Direct Care (DC)	53%	58%	41%	53%

Across all ownership types, only 53 percent of average HCP value per care-recipient is expended on direct care provision, excluding care management. While differences in the direct care cost ratio by ownership type averages up to 17 percentage points, the extent of cost differences is more marginal across other HCP cost components. The extent of difference observed in the direct care cost ratio by ownership type may be largely attributed to the accumulative differences reported for other HCP cost components. In this regard, observed differences in cost distribution by ownership type are reasonably variable and may largely reflect the differences in business approaches for operation of HCPs among approved providers.

14 https://www.health.gov.au/resources/publications/home-care-pricing-schedule-definitions

3.3. Distribution by Package Level

Distribution of HCP costs in the Survey[13] as a function of HCP level is reported in Table 2.

Table 2. Percentage distribution of average component costs with all HCPs included by package level as a proportion of total HCP program income and average care hours per fortnight for FY18-19.[13]

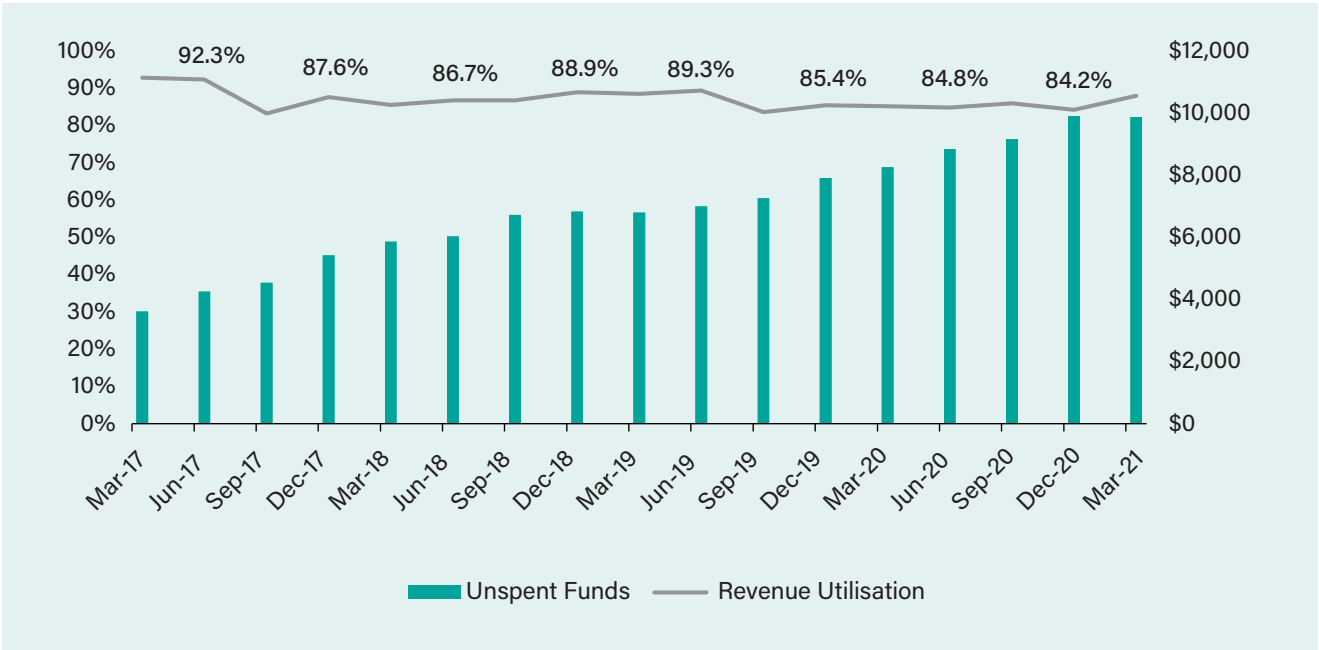
	Level 1	Level 2	Level 3	Level 4
Number of HCPs	3,222	27,234	9,973	14,394
Average HCP Value	$433	$585	$1,126	$1,932
Average HCP Expenditure	$231	$472	$885	$1,622
Unspent Funds	47%	19%	21%	16%
Package Management	11%	15%	15%	15%
Care Management (CM)	10%	15%	13%	13%
Direct Care (DC)	32%	51%	51%	56%

While cost distribution across HCP levels two to four appear reasonably consistent, there is cost variation between level one HCPs and all other HCP levels across direct care, care management and package management costs. Some of this difference may be explained by level one HCP recipients building up contingency funds in planning for the occurrence of sudden additional unplanned care needs, greater reliance on non-HCP care and supports already in place and the experience of graduated HCP expenditure relative to commencing a HCP. As these care-recipients transition to higher HCP levels, expenditure through HCP funding increases relative to need.

3.4. Accounting for Unspent Funds

Within the Survey,[13] unspent funds accounted for 19 percent of average package value, being the difference between funds allocation and utilisation. This compares with average NDIS unspent funds at 31 March 2021 that reduced from 56 to 27 percent of average package value as a function of four sequential plan reviews across the term of participation in the NDIS.[15]

Figure 2. Average HCP revenue utilisation and unspent funds balance at each quarter from March 2017 to March 2021.[16]



15 https://www.ndis.gov.au/about-us/publications/quarterly-reports

Figure 2 highlights that the average rate of HCP utilisation as a proportion of HCP funds allocation has remained stable over time, ranging between 83.2 and 92.8 percent across the three-years to March 2021, and despite an accumulating HCP program unspent funds balance across the same period.[16] Introduction of improved HCP payment administration arrangements from 1 September 2021 will see policy settings introduced for HCP provider operations that will result in unspent funds retention by Government as is provided for within the NDIS funds allocation-utilisation paradigm.

This paradigm acknowledges funds differentiation across the allocation and utilisation of care-recipient funding in the context of consumer-directed care. It mobiles assessment approvals to allocate higher levels of support classification relative to what care-recipients will likely utilise. This, in turn, reduces assessor demand for reassessment in the context of workforce supply constraints and relative to changing care-recipient needs. Importantly, the demand for reassessments will likely be higher for older Australians navigating functional decline when compared with NDIS participants.

Unspent funds as a HCP cost component in the Survey[13] is separate from HCP costs attributable to approved provider administration of HCPs. Under consumer-directed care, HCP recipients may exercise their preference to hold a reasonable unspent funds balance in response to anticipatory future needs. In fact, a conservative care expenditure approach appears to be a reasonable choice/preference under consumer-direction within the HCP allocation-utilisation paradigm. When care-recipients are contending with a rationed funding environment where age-related care trajectories may include the emergence of sudden additional unplanned care needs, a conservative utilisation approach recognises the legitimacy of a care-recipient planning for the unplanned in the context of system sluggishness in response to the immediacy of changing care-recipient needs.

Excluding unspent funds from the HCP cost attribution analysis may better account for actual HCP cost distribution attributable to approved provider administration of HCPs, providing an adjusted direct care cost ratio (see Tables 3 & 4).

Table 3. Percentage distribution of average component costs with all HCPs included by ownership type as a proportion of total HCP program expenditure (with unspent funds excluded) per fortnight for FY18-19[13]

	Not For Profit	For Profit	Government	Total
Average HCP Expenditure	$851	$818	$655	$835
Package Management	18%	14%	22%	19%
Care Management (CM)	17%	12%	23%	16%
Direct Care (DC)	65%	75%	55%	65%

Adjusted HCP cost distribution as a function of ownership type reveals that average direct care costs account for 65 percent of HCP expenditure while care management averages 16 percent and package management averages 19 percent.

Table 4. Percentage distribution of average component costs with all HCPs included by package level as a proportion of total HCP program expenditure (with unspent funds excluded) per fortnight for FY18-19.[13]

	Level 1	Level 2	Level 3	Level 4
Average HCP Expenditure	$231	$472	$885	$1,622
Package Management	21%	19%	19%	18%
Care Management (CM)	19%	19%	16%	15%
Direct Care (DC)	60%	62%	65%	67%

Adjusted HCP cost distribution as a function of package level reveals that average direct care costs account for between 60 and 67 percent of HCP expenditure across package levels while care management averages between 15 and 19 percent and package management averages between 18 and 21 percent. If care-recipients were to choose to utilise their unspent funds balance, the direct care cost ratio would extend out to an average 72 percent of average HCP expenditure while care management would reduce to an average 13 percent and package management would reduce to an average 15 percent of HCP expenditure.

16 https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192n

Similarly, the Aged Care Financing Authority have drawn from HCP provider financial reports and examined average HCP cost distribution for each care-recipient across 2019-20. Direct care costs accounted for an average 68 per cent of HCP expenditure while care management averaged 17 per cent and package management averaged 13 per cent.[17]

This cost distribution analysis, with inclusion of adjusted HCP cost distribution ratios to exclude unspent funds, is suggested to be far more representative of provider administered HCP expenditure than prior reports including unspent funds. HCP cost distribution also appears to be within an acceptable range when accounting for administration costs as a proportion of total program costs, as has been reported in other industries.[6,7,8] This is in contrast to media narratives concerning high HCP administration fees that misrepresent industry in the context of funding deficits within the current system and that place undue viability pressures on HCP provider cost distribution. Further detail on HCP cost distribution is included in the appendices with stratification by ownership type and package level.

3.5. Care Hours and Cost Distribution

Noting direct care is a key component of total HCP cost distribution and directly translates to the total number of care hours delivered to care recipients in supporting them to remain living independently at home, the Survey[13] examined changes in the average number of direct care service hours provided to care-recipients as a function of introducing the Increasing Choice in Home Care (ICHC) policy environment in 2017. The ICHC policy environment represents a fundamental shift in home care program operations that has prioritised individualised funds allocation to packaged home care recipients with their directing care and support utilisation through HCP expenditure.

Average weekly direct care and care management hours were compared across the 2008 Community Care Census and FY2018-19 HCP provider operations (see Table 5). Average weekly direct care and care management hours are also reported by package level for HCP provider operations in FY2018-19 (see Table 6).

Table 5. Average direct care (DC) hours and combined care management and direct care (CM & DC) hours per week across the 2008 Community Care Census and the FY18-19 HCP Provider Survey, noting percentage reduction in weekly hours.[13]

	Low Care Package			High Care Package		
Weekly Hours	2008 Census	HCP Provider Survey	Percentage reduction	2008 Census	HCP Provider Survey	Percentage reduction
Care Hours (CM & DC)	6.8	2.8	59%	16.4	8.8	46%
Care Hours (DC only)	5.4	2.4	56%	14.1	7.8	45%

Table 6. Average direct care (DC) hours and combined care management and direct care (CM & DC) hours per week by package level for FY18-19.[13]

	Level 1	Level 2	Level 3	Level 4
Care Hours (CM & DC)	1.6	2.8	5.1	8.8
Care Hours (DC only)	1.2	2.4	4.4	7.8

Review of average weekly direct care service hours across the 2008 Community Care Census and FY2018-19 HCP provider operations indicates that there has been a near 50 percent reduction in the average number of direct care hours provided to care-recipients across this ten-year period. In FY2018-19, the average weekly number of direct care and care management hours across HCP levels range between 1.6 hours for a level 1 HCP and 8.8 hours for a level 4 HCP. The average weekly number of care management hours during the same period ranged between near 30 minutes for a level 1 HCP and 60 minutes for a level 4 HCP.

17 https://www.health.gov.au/resources/publications/ninth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2021

Noting the average rate of HCP utilisation as a proportion of HCP funds allocation has been reported as having remained relatively stable since the introduction of ICHC, the near 50 percent reduction in average weekly care hours across the ten years from 2008 to 2018 may represent HCP expenditure changes that include the offering of a greater diversity of care and supports for HCP expenditure. This is driven by care-recipient and provider interpretation of HCP expenditure against the specified range of care and supports listed in Schedule 3 of the *Quality of Care Principles*[18] when compared with simply delivering direct care service hours independent of consumer-direction.

Importantly, the design and production of the Support at Home Program will need to account for continued delivery of a diversity of care and supports in building on the gains of ICHC and recognising the human-right principles for ageing in place.[1] It will need to acknowledge the dynamic and fluid nature of age-related care trajectories across the continuum of in-home care that will shape care-recipient preferences in accessing care and support. This emphasises the importance of care-recipient access to information, care finder supports and comprehensive care management in ensuring that care assigned through the Support at Home Program's classification categories is correctly targeted and of sufficient intensity/duration. Following identification of care requirements through comprehensive and accurate assessments, this can then extend to facilitate early identification, informed decision-making and early intervention consistent with the principles of a human rights-based approach to ageing in place.

The Support at Home Program needs to ensure that there is sufficient operational flexibility rather than regulatory restriction for the provision of entitlement-based care in the context of individualised care-recipient funding arrangements. Such flexibility will support providers in responding to not only individualised care-recipient needs and preferences but also in their development of innovations for responding to increasing community demand for diversified care and supports in the context of an ageing population and supply constraints. This tension emphasises the dynamic market environment in which the future of home care and its market stewardship must operate. This will require agility and capability in provider operations and innovations to which policy settings must be aligned.

18 https://www.health.gov.au/initiatives-and-programs/home-care-packages-program/managing-home-care-packages/price-transparency-for-home-care-packages

4. Home Care Package Price Maturation

Examination of HCP pricing, noting the recent move to publish median HCP prices,[19] provides considerable insight into the current state of market-based home care pricing to inform a fixed funding and market-based pricing approach for the new single Support at Home Program. LASA has undertaken analysis of HCP prices published in the My Aged Care Price Schedule commencing July 2019. A national sample of 300 HCP providers were randomly selected with stratification matched to Modified Monash Model (MMM) classification,[20] ensuring one third of the sampled HCP provider prices had MMM classification for outer regional, rural and remote locations (MMM 5-7).

Median published prices were collected between July 2019 to June 2021 for direct care, care management and package management using repeat measures. Considerable movement in pricing occurred between July and December 2019, the period in which pricing information was initially published. Consequently, this initial pricing period was excluded from the analysis. The investigation explored the maturation and variability in HCP pricing among home care providers across the subsequent 18-month period, December 2019 to June 2021.

Rates with which price schedules have been updated in My Aged Care across the 18 -months to June 2021 are reported in Table 7. At June 2021, 70 percent of sampled price schedules had been updated within the prior year while seven percent had closed.

Table 7. Rate of pricing schedule updates from December 2019 to June 2021, at intervals grouped by updates during the last 6 months, between 6-12 months, and greater than 12 months.

	December 2019	June 2020	December 2020	June 2021
Within the last 6 months	88%	41%	63%	33%
Between 7-12 months ago	3%	52%	13%	37%
Greater than 12 months ago	-	2%	17%	24%
Not published	9%	3%	1%	-
Schedule closed	-	3%	5%	7%

4.1. Direct Care Pricing

Published direct care service hourly prices for the 18-months to June 2021 are reported in Table 8. Median hourly pricing has increased minimally, in the range of 0.0 to 6.2 percent across the 18-month period to June 2021. Price variation has remained stable over time. This extended in June 2021 from a near $8.00 hourly price difference across the 75th and 25th percentiles for personal care up to an $18.00 hourly price difference across the 75th and 25th percentiles for nursing care, noting nursing care may include the use of enrolled or registered nurses. The extent of price increases appears consistent with early stage market maturation in HCP service delivery. Variability in price points for each type of direct care service appears to be within an acceptable range relative to market-based pricing.

LASA notes that there is no detailed information on direct care cost variation within the Home Care Provider Survey[13] relative to our analysis of price variation. Instead, the Survey only reports variation in average cost across ownership type – 17 percentage points. Further detailed information is required to understand home care cost variation relative to the price variation reported here. LASA recommends that preparatory work in the design and production of the Support at Home Program make transparent the extent of home care cost variation relative to the variability observed in home care provider price setting. This will ensure goodness of fit in realising a fixed funding approach that supports market-based pricing and is relative to expectations for care-recipient co-contribution.

19 https://www.health.gov.au/initiatives-and-programs/home-care-packages-program/managing-home-care-packages/price-transparency-for-home-care-packages

20 https://www.health.gov.au/health-topics/health-workforce/health-workforce-classifications/modified-monash-model

Table 8. Median, 75th percentile and 25th percentile hourly pricing for HCP direct care services from December 2019 to June 2021, including 18-month pricing adjustment across this period.

	December 2019	June 2020	December 2020	June 2021	18-month price adjustment
Domestic Assistance (DA)	**$54.14**	**$54.14**	**$55.00**	**$55.00**	**1.6%**
DA – 75th percentile	$57.42	$58.00	$59.00	$59.00	2.8%
DA – 25th percentile	$49.90	$49.90	$50.00	$50.00	0.2%
Personal Care (PC)	**$55.00**	**$55.00**	**$55.00**	**$55.00**	**0.0%**
PC – 75th percentile	$58.30	$58.68	$59.00	$59.43	1.9%
PC – 25th percentile	$50.00	$50.00	$51.00	$51.44	2.9%
Nursing Care (NC)	**$90.57**	**$90.25**	**$94.00**	**$95.00**	**4.9%**
NC – 75th percentile	$100.00	$100.00	$101.00	$103.00	3.0%
NC – 25th percentile	$82.66	$84.88	$85.00	$85.00	2.8%
Respite Care (RC)	**$55.00**	**$55.00**	**$55.00**	**$55.00**	**0.0%**
RC – 75th percentile	$58.08	$58.80	$59.13	$59.43	2.3%
RC – 25th percentile	$50.00	$50.00	$51.00	$51.19	2.4%
Light Gardening (LG)	**$55.00**	**$55.00**	**$57.00**	**$58.43**	**6.2%**
LG – 75th percentile	$65.00	$65.00	$65.00	$65.00	0.0%
LG – 25th percentile	$51.00	$51.75	$52.00	$54.00	5.9%

Pricing for direct care services is largely driven by the cost of wages for the home care workforce, including workers compensation, superannuation and payroll taxes. Any increase in direct care prices will be predominately driven by increases to these employment costs. Consequently, adjustments across fixed unit level Government subsidy allocation and means tested care-recipient co-contribution will need to keep pace with market-based unit level provider pricing. Current HCP subsidy increases have not increased at the same rate as the modern award pay rates or accounted for the increase in superannuation. The design and production of the Support at Home Program, its market stewardship and price regulation will need to be responsive to these market variations.

Transparency of complementary information on care-recipient experiences and outcomes at the HCP provider level may assist in monitoring the impact of market variation, explaining some of the critical price variability to support care-recipient choice of home care provider and care-related decision-making. Such information is not currently available in supporting care-recipient choice. Prioritisation of reform work to progress care-recipient experience and outcome transparency as an extension of price transparency is required in the design and production of the Support at Home Program.

4.2. Care Management Pricing

The analysis of care management prices examined fortnightly pricing across the 18-month period to June 2021, as well as pricing as a proportion of total package value (TPV) comprising provider charged basic daily fees (where published) and Commonwealth subsidy.

4.2.1. Provider-Managed

Fortnightly prices for provider-managed care, including variability and adjustment over the 18-month period to June 2021 are reported in Table 9.

Table 9. Median, 75th percentile and 25th percentile care management prices (fortnightly) among provider-managed HCPs across the 18-month period to June 2021, including price adjustment across this period.

Provider-Managed Care Management		December 2019	June 2020	December 2020	June 2021	18-month price adjustment
Level 1	**Median**	**$56.40**	**$56.40**	**$56.40**	**$57.00**	**1.1%**
	75th percentile	$67.40	$67.53	$71.00	$68.47	1.6%
	25th percentile	$45.00	$45.00	$43.20	$47.51	5.6%
Level 2	**Median**	**$98.05**	**$100.00**	**$101.50**	**$100.90**	**3.0%**
	75th percentile	$118.58	$119.00	$120.50	$120.48	1.6%
	25th percentile	$81.70	$82.57	$72.02	$84.88	3.9%
Level 3	**Median**	**$199.00**	**$206.00**	**$205.12**	**$207.00**	**4.0%**
	75th percentile	$243.48	$246.00	$252.75	$248.50	2.1%
	25th percentile	$157.80	$159.00	$160.25	$166.22	5.4%
Level 4	**Median**	**$294.18**	**$300.00**	**$312.38**	**$300.00**	**2.0%**
	75th percentile	$362.00	$365.00	$390.34	$368.82	1.9%
	25th percentile	$229.50	$231.60	$245.80	$245.50	7.0%

Median fortnightly care management prices for provider-managed HCPs have increased minimally across the 18-month period to June 2021, ranging from 1.1 to 4.0 percent. Provider-managed care as a proportion of TPV and adjustments for the 18-month period to June 2021 are reported in Table 10.

Table 10. Median, 75th percentile and 25th percentile care management prices (fortnightly) as a proportion of total package value among provider-managed HCPs across the 18-month period to June 2021, including proportion adjustments across this period.

Provider-Managed Care Management		December 2019	June 2020	December 2020	June 2021	18-month price adjustment
Level 1	**Median**	**13.6%**	**14.2%**	**14.8%**	**15.0%**	**1.4%**
	75th percentile	17.6%	17.8%	19.9%	18.0%	0.4%
	25th percentile	10.9%	11.3%	11.7%	12.1%	1.2%
Level 2	**Median**	**14.9%**	**14.9%**	**15.0%**	**15.8%**	**0.9%**
	75th percentile	17.5%	18.1%	19.1%	18.3%	0.8%
	25th percentile	12.1%	12.1%	11.9%	12.5%	0.4%
Level 3	**Median**	**14.8%**	**15.0%**	**15.4%**	**15.4%**	**0.6%**
	75th percentile	17.7%	17.8%	18.7%	18.1%	0.4%
	25th percentile	11.6%	11.8	12.0%	12.2%	0.6%
Level 4	**Median**	**14.8%**	**15.0%**	**15.3%**	**15.0%**	**0.2%**
	75th percentile	17.7%	17.8%	19.3%	18.0%	0.3%
	25th percentile	10.9%	11.4%	12.0%	11.9%	1.0%

Median fortnightly care management prices for provider-managed HCPs as a proportion of TPV have increased minimally across the 18-month period to June 2021, ranging from 0.2 to 1.4 percent whereby provider-managed care accounted for near 15 percent of TPV at June 2021. Variability across the 75th and 25th percentiles as a proportion of TPV at June 2021 averaged 5.9 percentage points for all package levels.

4.2.2. Self-Managed

Fortnightly prices for self-managed care, including variability and adjustment over the 18-month period to June 2021 are reported in Table 11.

Table 11. Median, 75th percentile and 25th percentile care management prices (fortnightly) among self-managed HCPs across the 18-month period to June 2021, including price adjustment across this period.

Self-Managed Care Management		December 2019	June 2020	December 2020	June 2021	18-month price adjustment
Level 1	**Median**	**$31.20**	**$31.35**	**$33.00**	**$33.79**	**8.3%**
	75th percentile	$45.00	$45.00	$47.60	$46.00	2.2%
	25th percentile	$21.00	$23.59	$23.00	$25.59	21.9%
Level 2	**Median**	**$57.69**	**$59.29**	**$60.80**	**$60.80**	**5.4%**
	75th percentile	$80.51	$82.75	$85.00	$82.25	2.2%
	25th percentile	$38.00	$41.98	$45.00	$45.00	18.4%
Level 3	**Median**	**$114.23**	**$114.23**	**$120.40**	**$120.00**	**5.1%**
	75th percentile	$150.00	$147.73	$168.89	$159.78	6.5%
	25th percentile	$65.00	$76.50	$76.50	$79.71	22.6%
Level 4	**Median**	**$165.00**	**$171.97**	**$180.30**	**$179.60**	**8.9%**
	75th percentile	$206.61	$209.07	$240.81	$235.00	13.7%
	25th percentile	$96.87	$98.50	$100.00	$105.00	8.4%

Median fortnightly care management prices for self-managed HCPs have increased more markedly across the 18-month period to June 2021 than median fortnightly care management prices for provider-managed HCPs, ranging from 5.1 to 8.9 percent. Self-managed care as a proportion of TPV and adjustments for the 18-month period to June 2021 are reported in Table 12. Median fortnightly care management prices for self-managed HCPs as a proportion of TPV have increased minimally across the 18-month period to June 2021, ranging from 0.7 to 1.3 percent whereby self-managed care accounted for near 9 percent of TPV at June 2021. Variability across the 75th and 25th percentiles as a proportion of TPV averaged 6.1 percentage points for all package levels at June 2021.

Table 12. Median, 75th percentile and 25th percentile care management prices (fortnightly) as a proportion of total package value among self-managed HCPs across the 18-month period to June 2021, including proportion adjustments across this period.

Self-Managed Care Management		December 2019	June 2020	December 2020	June 2021	18-month price adjustment
Level 1	**Median**	**7.2%**	**8.2%**	**9.1%**	**9.1%**	**1.3%**
	75th percentile	12.9%	13.2%	12.9%	12.5%	-0.4%
	25th percentile	5.0%	5.4%	6.5%	7.0%	2.0%
Level 2	**Median**	**8.3%**	**8.3%**	**10.1%**	**9.9%**	**1.6%**
	75th percentile	12.6%	12.7%	13.2%	12.7%	0.1%
	25th percentile	5.1%	6.0%	6.5%	6.3%	1.2%
Level 3	**Median**	**8.2%**	**8.6%**	**9.7%**	**8.9%**	**0.7%**
	75th percentile	10.9%	10.9%	12.6%	12.1%	1.2%
	25th percentile	5.0%	5.7%	5.6%	5.9%	0.9%
Level 4	**Median**	**8.0%**	**8.9%**	**9.4%**	**8.9%**	**0.9%**
	75th percentile	10.5%	10.8%	12.7%	11.2%	0.7%
	25th percentile	4.5%	5.0%	5.1%	5.0%	0.5%

Taken together, the rate of median care management price increases for self-managed HCPs across the 18-month period to June 2021 (5.1 to 8.9 percent) along with the corresponding price movement as a proportion of TPV over the same period (0.7 to 1.3 percent) suggests that provider prices below the median price for self-managed HCPs have increased more than provider prices above the median price. This type of market adjustment was anticipated in the realisation of actual provider costs for delivering self-managed HCPs in a regulated market environment where providers retain regulatory responsibility for care management while supporting care-recipient involvement and capacity-building in the exercising of these responsibilities.[21]

4.2.3. Price Design

Median fortnightly prices for care management across HCP levels have increased relative to market maturation across the 18-month period to June 2021 with the extent of increase being more apparent for self-managed HCPs when compared with provider-managed HCPs. LASA notes that there is no detailed information on care management cost variation within the Home Care Provider Survey[13] relative to the analysis of price variation. Instead, the Survey only reports variation in average cost across ownership type – 8 percentage points.

Despite these observations, interpretation of care management pricing is cautioned in its current format and in contributing to overall HCP price transparency policy settings. Published care management price metrics fail to account for published care management hours. Currently, each published care management price is proportionate to the number of published care management hours with which it corresponds. Transformation of median care management prices to a standardised price that accounts for variability in published care management hours is required in achieving a reliable standardised indicator for unit level price transparency across HCP levels.

Standardised hourly care management unit prices have been generated in Table 13 using the LASA sample, applying the conversion of published fortnightly care management prices and hours by each HCP level at June 2021.

Table 13. Published median prices and hours for HCP care management (fortnightly) for both provider-managed and self-managed HCPs at June 2021, converted to an hourly care management unit price.

	Provider-Managed			Self-Managed		
	Price	Fortnightly Hours	$/Hr	$	Fortnightly Hours	$/Hr
Level 1	$57.00	1	$57.00	$33.79	1	$33.79
Level 2	$100.90	2	$50.45	$60.80	1	$60.80
Level 3	$207.00	3	$69.00	$120.00	2	$60.00
Level 4	$300.00	4	$75.00	$179.60	3	$59.86

This level of analysis has revealed shortcomings in current fortnightly care management price publishing arrangements given the range of variation in median hourly care management prices calculated ($33.79-$75.00 per hour). It is noted that care management hours are currently published as whole hours and lack sensitivity with regard to the minute intervals within each period. This lack of sensitivity in published care management hours limits the validity of generating any comparable hourly price rates for care management using current pricing information. LASA has previously reported this issue to the DoH and recommends it be addressed in the design and productions of the Support at Home Program.

21 LASA Fusion Magazine, Spring 2018. The emerging landscape of self-managed home care packages. https://lasa.asn.au/wp-content/uploads/2018/09/LASA-Spring-18-issuu.pdf

4.2.4. Market Variability

Quality care management serves as an important function in the motivation of care-recipient engagement in achieving desired care outcomes, promoting wellness and reablement interventions, and facilitating early identification/intervention activities where issues of concern emerge that can ameliorate functional and quality of life outcomes.[22]

Noting the Support at Home Program will include the delivery of higher levels of in-home care when compared to what is currently provided through HCPs, better access to care management pricing and utilisation data is required to inform both funds allocation and market-based provider pricing for care management in the context of increasing care needs.

An increase in supports for the delivery of complex care in the home will require not only higher levels of care management support but also care management delivered by a more skilled workforce that can mobilise primary health care interventions more closely matched to care-recipient need. Unit level care management funding and pricing will likely be required that gives account to the variability of care management and primary health care market demand and supply.

Provider reports on current care management experiences suggest that both the DoH and the Aged Care Quality and Safety Commission (ACQSC) have not clearly defined care management variability relative to market demand. Providers report receiving mixed messages about Government expectations for care management outcomes. The design and production of the Support at Home Program needs to recognise the extent of care management variability through assessment, classification and funding mechanisms, as well as program assurance reviews,[23] where fluctuations in demand for care management support will be relative to changing care needs.

Providers are concerned that the design and production of the Support at Home Program, with poor regard for care management market variability, may restrict and reduce care-recipient access to quality care management supports in terms of the amount and price of supports that providers can offer. This in turn impacts upon a provider's ability to attract and retaining qualified and skilled care managers who are restricted by design constraints in the discharging of their responsibilities. By implication, relationship-based care may be reduced to transactional care.

Hourly care management prices along with utilisation information will provide meaningful metrics for care-recipient decision making about quality care management in supporting consumer-directed care. Furthermore, quality indicator measurement in care-recipient utilisation of both provider and self-managed care, and with regard to their care management experiences and outcomes, will be necessary to help inform care management funds allocation relative to market-based provider pricing, market stewardship activity, and care-recipient choice and market engagement.

4.3. Package Management Pricing

Fortnightly prices for package management, including variability and adjustment over the 18-month period to June 2021 are reported in Table 14. Median fortnightly package management prices have increased moderately across the 18-month period to June 2021, ranging from 4.5 to 5.9 percent. This follows package management prices having reduced by near 15 percentage points per fortnight across the first 6-months of price publishing to December 2019.

22 LASA Fusion Magazine, Autumn 2020. Integrated care for older Australians. https://lasa.asn.au/wp-content/uploads/2020/03/LASA-Autumn-2020-LR.pdf

23 https://www.health.gov.au/initiatives-and-programs/home-care-packages-program/about-the-home-care-packages-program/program-assurance-of-the-home-care-packages-program

Table 14. Median, 75th percentile and 25th percentile package management prices (fortnightly) for HCPs across the 18-month period to June 2021, including price adjustment across this period.

Package Management		December 2019	June 2020	December 2020	June 2021	18-month price adjustment
Level 1	**Median**	**$34.00**	**$34.36**	**$35.00**	**$36.00**	**5.9%**
	75th percentile	$47.60	$48.51	$48/07	$50.62	6.3%
	25th percentile	$26.00	$26.98	$27.86	$30.00	15.4%
Level 2	**Median**	**$64.63**	**$69.00**	**$68.00**	**$68.00**	**5.2%**
	75th percentile	$86.80	$87.95	$88.92	$90.00	3.7%
	25th percentile	$53.27	$55.50	$54.61	$56.00	5.1%
Level 3	**Median**	**$135.80**	**$141.93**	**$142.10**	**$142.31**	**4.8%**
	75th percentile	$190.40	$192.02	$192.02	$196.56	3.2%
	25th percentile	$114.25	$115.56	$117.74	$119.00	4.2%
Level 4	**Median**	**$200.00**	**$205.00**	**$207.69**	**$209.00**	**4.5%**
	75th percentile	$289.60	$290.09	$290.09	$294.18	1.6%
	25th percentile	$154.30	$156.00	$159.52	$164.50	6.6%

Price analysis of package management as a proportion of total package value, as well as price adjustments over the 18-month period to June 2021 are reported in Table 15. Median fortnightly package management prices have increased across the 18-month period to June 2021, ranging from 0.1 to 0.8 percent whereby package management prices accounted for near 10 percent of TPV at June 2021. Notably, this is less than the 15 percent package management expense as a proportion of total HCP expense reported by providers across FY2018-19.[13] Variability across the 75th and 25th percentiles as a proportion of TPV averaged 7.3 percentage points for all package levels at June 2021, noting larger entities benefit from economies of scale.[8]

Table 15. Median, 75th percentile and 25th percentile HCP package management prices (fortnightly) as a proportion of total package value across the 18-month period to June 2021, including proportion adjustments across this period.

Package Management		December 2019	June 2020	December 2020	June 2021	18-month price adjustment
Level 1	**Median**	**8.5%**	**8.8%**	**9.0%**	**9.3%**	**0.8%**
	75th percentile	13.1%	13.8%	13.0%	13.0%	-0.1%
	25th percentile	4.5%	5.4%	5.9%	5.8%	1.3%
Level 2	**Median**	**9.5%**	**10.0%**	**9.8%**	**9.9%**	**0.4%**
	75th percentile	13.1%	14.3%	14.3%	14.4%	1.3%
	25th percentile	5.9%	6.6%	6.9%	6.9%	1.0%
Level 3	**Median**	**9.7%**	**10.0%**	**9.8%**	**9.8%**	**0.1%**
	75th percentile	14.0%	14.3%	13.8%	14.1%	0.1%
	25th percentile	5.4%	6.5%	7.0%	7.0%	1.6%
Level 4	**Median**	**9.6%**	**10.0%**	**9.9%**	**9.9%**	**0.3%**
	75th percentile	14.2%	14.8%	13.9%	14.0%	-0.2%
	25th percentile	5.1%	6.0%	6.7%	6.5%	1.4%

LASA notes that there is no detailed information on package management cost variation within the Home Care Provider Survey[13] relative to the analysis of price variation. Instead, the Survey only reports variation in average cost across ownership type – 6 percentage points. Further detailed information is required to understand home care cost variation relative to the price variation reported here.

Importantly, significant cost and work is required by HCP providers to meet the ever-increasing Government compliance demands and reporting requirements for providing subsidised home care services and engaging with the DoH, ACQSC and Services Australia. Providers need to recover these costs against HCP package management prices to remain viable. The proportion of HCP funds allocated to package management is expected to be relative to the actual cost of an approved provider's package administration responsibilities.

4.4. Home Care Reforms and Pricing

When accounting for the policy and regulatory demands that contribute to package management, LASA notes incremental policy adjustments on the July 2019 home care package operational environment that has resulted in additional unfunded provider implementation costs that has required market-based provider price adjustments.

In conjunction with this, it is anticipated that with ongoing and rapidly evolving home care reforms further incremental adjustments to home care provider operations will be required. By design, incremental home care reforms will influence market-based price setting to accommodate revised administrative costs that all care-recipients must pay for. The design and production of the Support at Home Program, price regulation and market stewardship will all need to be responsive to these reform-related price adjustments.

The Royal Commission into Aged Care Quality and Safety[1] has recommended the revision of the Accountability Principles 2014 (Recommendation 116), now completed by Government with revision to Aged Care Prudential and Financial Reporting arrangements by home care providers currently underway. Reported provider costs are likely to be utilised as key inputs for the function of a future-state Pricing Authority from July 2023 (Recommendation 115). Any fixed unit level funding schedule developed in the design and production of the Support at Home Program needs to account for further reform-related administration demands as an extension of current market-based provider pricing.

5. Pricing and Comparable Program Policy Settings

Comparison of HCP component pricing with other similar human service program pricing arrangements further informs the application of a fixed funding and market-based pricing approach for the design and production of the Support at Home Program. LASA has undertaken comparison of HCP component prices with pricing arrangements for the CHSP and NDIS using comparable data points.

5.1. Commonwealth Home Support Program

Changes to CHSP Grant Agreements from July 2022 were announced in Government's response to the recommendations of the Royal Commission into Aged Care Quality and Safety to help position CHSP providers for transition to the future-state Support at Home Program. Preparatory work is being undertaken to inform the CHSP 2022-23 Grant Extension. This includes development of a National Unit Pricing Policy for CHSP, acknowledging prior analysis of CHSP costing data has identified variability in unit level costs across CHSP service types and grant agreements.[4]

5.1.1. Price Comparison

LASA has undertaken price comparison between the national sample of 300 published prices for HCP direct care services at June 2021 and the lower/upper limits of CHSP unit price ranges for equivalent service types. These CHSP unit price ranges, dated January 2021, were issued to CHSP providers for the CHSP 2021-22 growth funding round (see Table 16).

Table 16. Comparison of standard hourly HCP prices for direct care services with CHSP lower and upper limit prices for equivalent service types published in January 2021 for CHSP 2021-22 growth funding, reporting the percentage (%) of HCP provider prices below the CHSP lower limit price, above the CHSP upper limit price, and within the CHSP price range.

	Lower Limit	HCP pricing below CHSP Lower Limit	Upper Limit	HCP pricing above CHSP Upper Limit	HCP pricing within CHSP Range
Personal Care	$47.00	9%	$78.00	0%	91%
Domestic Assistance	$43.00	6%	$64.00	9%	85%
Respite	$48.00	9%	$90.00	0%	91%
Gardening	$49.00	10%	$89.00	4%	86%
Nursing	$93.00	46%	$152.00	0%	54%

Between 85 and 91 percent of HCP provider prices for direct care services fall within the lower/upper price limits of published CHSP price ranges for equivalent service types, excluding nursing care. For nursing care, 46 percent of HCP provider prices were lower than the lower price limit for the CHSP price range. Interpretation of this price difference may be attributable to a range of factors.

CHSP nursing care may be priced for the use of registered nurses while HCP nursing care may be priced for greater use of enrolled nurses, attracting a lower price point. This may be driven by market forces such as workforce constraints and/or care-recipient preferences for purchasing low cost nursing care relative to other packaged care and support needs. The difference in nursing care prices across CHSP and HCPs could also be partially explained by CHSP price loading for consumables while HCP providers may charge separately for these consumables. The Home Care Provider Survey[13] identified an average fortnightly cost of $19.23 per HCP for consumables separate from other direct care costs. These consumables included bandages and dressings.

In explaining some of the consistently lower price points observed in HCP prices when compared to the CHSP lower price limit, ranging between 6 to 10 percent excluding nursing care, CHSP unit prices will also likely include administration and travel expenses for which HCP providers are required to separate out these price components.

With regard to nine percent of HCP provider prices for domestic assistance being above the CHSP upper price limit for an equivalent service, HCP prices for domestic assistance appear to be priced similar to personal care across HCPs and CHSP. The HCP direct care workforce may often do a combination of domestic assistance and personal care tasks within a single care episode, offering flexible consumer-centric care and support. This is somewhat different for older Australians receiving entry-level CHSP support. Care-recipients of entry-level support are often more independent than those receiving a HCP. They generally have lower levels of personal care and support needs while still seeking domestic assistance. Such an explanation is consistent with the findings in the Home Care Provider Survey[13] that indicate recipients of HCPs tend to access higher levels of personal and clinical care services as package levels increase.

With regard to four percent of HCP provider prices for gardening services being above the CHSP upper price limit for an equivalent service, it is suggested that there is a greater reliance on the use of external contractors to deliver these services among HCP providers. By design, this creates for greater variability in HCP prices for the provision of gardening services to account for the use of external suppliers.

5.1.2. Cost Variability

Noting the above price comparison, it is important to recognise that variability in CHSP service prices will likely be influenced by variability in costs across providers for delivering each service type. Understanding and accommodating CHSP provider cost variation is a necessary pre-requisite in establishing a nationally consistent CHSP unit pricing policy and transitioning CHSP service provision to the Support at Home Program.

The CHSP Data Study[4] identified considerable variation between market segments, distinguishing between liquid, balanced and thin markets. Liquid markets describe market segments whereby supply is in excess of demand but demand is still greater than in comparable markets. Thin markets describe market segments whereby a market experiences supply or demand challenges when compared to other markets. A balanced market describes market segments that fall in between liquid and thin markets with regard to demand and supply of services. CHSP market variability during 2018-19 included 40 percent of SA2 regions[24] nationally being classified liquid markets, 37 percent being classified balanced markets and 23 percent being classified thin markets. There was also some degree degree of market variability reported across state jurisdictions with a greater degree of market variability across CHSP service types.[4] The extent of market variability reported in the national home care landscape will likely be a major influence in CHSP provider cost variability. This in turn requires a considered approach in translating variable CHSP service expenditure into a nationally consistent unit pricing policy that aligns with the design and production of the Support at Home Program.

LASA notes the DoH has referenced current unit prices across different CHSP service types as being largely variable, nationally inconsistent and not reflecting the actual cost of delivering services.[5] LASA suggests that there are four different cost variability clusters of CHSP service types for which both revised unit pricing and payment approaches, introduced through CHSP 2022-23 Grant Extensions, would likely have varied impacts. The four different cost variability CHSP service type clusters include:

- Service types at the care-recipient level that are predictable and regular, having strong continuous market demand (e.g. domestic assistance);
- Service types at the care-recipient level that are predictable but episodic, having strong variable market demand (e.g. allied health);
- Service types at the care-recipient level that are infrequent with variable price points (e.g. home modifications, assistive technology); and
- Service types that have a high fixed capital cost component independent of variability in care-recipient level outputs delivered (e.g. transport, group social support programs and respite day centres).

24 Statistical Areas Level 2 (SA2) are medium-sized general-purpose areas built up from whole Statistical Areas Level 1. Their purpose is to represent a community that interacts together socially and economically.

Differentiation across CHSP service types, with account for market demand and cost drivers, is an important consideration in striving for a feasible national unit pricing policy and revised payment approach that supports flexibility in CHSP provider operations while also striving for greater consistency. In response, LASA cautions CHSP services with high fixed capital costs or operating in thin markets being funded through an activity-based funding arrangement. Such services may be better delivered as block funded community programs to ensure service continuity is retained with efficiencies better realised through transition support incentives that promote scale, collaboration and consortium arrangements. The Royal Commission into Aged Care Quality and Safety recommended both block and activity-based funding arrangements (Recommendation 117), accounting directly for these considerations.[1]

The design and production of the Support at Home Program should include provision for care-recipient access to block funded support categories using the classification recommendations of the Royal Commission. This includes the respite supports category, social supports category, and assistive technology and home modifications category. Block funded community services can then be offered to care recipients alongside being assigned individualised activity-based funding for care and support aligned to the care at home category. Such an approach is consistent with the Royal Commission classification recommendations and will help to map out a feasible transition approach of current home care provider operations to the Support at Home Program.

5.2. National Disability Insurance Scheme

LASA has undertaken price comparison between published prices for HCP service components matched to equivalent NDIS service prices. This has occurred noting temporary price controls are in place within the NDIS to ensure participants can access affordable supports. It has been recommended, however, that these price controls be removed once the NDIS and its market stewardship structures have matured, at which point the market itself will set the price of supports.[25]

5.2.1. Price Comparison

Comparison of hourly prices for HCP and equivalent NDIS services has targeted the following direct care service types: personal care, domestic assistance, gardening and nursing. Price comparison for these direct care services occurred across December 2019 and 2020. They have been stratified using the MMM classification system to account for differences by metropolitan/regional (MMM 1-5) and rural/remote (MMM 6-7) service delivery locations consistent with the price structures of the NDIS Pricing Arrangements and Price Limits.[26] Comparison of HCP and NDIS hourly prices for direct care services are reported in Tables 17 (metropolitan/regional) and 18 (rural/remote).

25 https://www.ndis.gov.au/media/359/download
26 https://www.ndis.gov.au/providers/pricing-arrangements

Table 17. Comparison of standard hourly prices across HCP and NDIS direct care service types in metropolitan and regional locations (MMM 1-5) at December 2019 and 2020 with account for actual price ($) and percentage (%) differences.

	2019				2020			
	Difference (HCP-NDIS)				Difference (HCP-NDIS)			
	HCP	NDIS	$	%	HCP	NDIS	$	%
Personal Care	$54.12	$52.85	$1.27	2.4%	$55.12	$55.47	-$0.35	-0.6%
Domestic Assistance	$53.04	$49.16	$3.88	7.9%	$54.12	$50.20	$3.92	7.8%
Light Gardening	$58.97	$48.28	$10.69	22.1%	$60.76	$49.30	$11.46	23.2%
Enrolled Nurse	$89.70	$86.62	$3.08	3.6%	$92.91	$86.62	$6.29	7.3%
Registered Nurse		$107.25	-$17.55	-16.4%		$107.25	-$14.34	-13.4%

Table 18. Comparison of standard hourly prices across HCP and NDIS direct care service types in rural and remote locations (MMM 6-7) at December 2019 and 2020 with account for actual price ($) and percentage (%) differences.

	2019				2020			
	Difference (HCP-NDIS)				Difference (HCP-NDIS)			
	HCP	NDIS	$	%	HCP	NDIS	$	%
Personal Care	$56.74	$76.64	-$19.90	-26.0%	$56.62	$80.44	-$23.82	-29.6%
Domestic Assistance	$55.83	$71.28	-$15.45	-21.7%	$55.67	$72.79	-$17.12	-23.5%
Light Gardening	$58.20	$70.01	-$11.81	-16.9%	$58.07	$71.49	-$13.42	-18.8%
Enrolled Nurse	$94.19	$125.60	-$31.41	-25.0%	$96.12	$125.60	-$29.48	-23.5%
Registered Nurse		$155.52	-$61.33	-39.4%		$155.52	-$59.40	-38.2%

There were differences in HCP and NDIS direct care service prices across service types that appear to have remained consistent over time. The median hourly HCP nursing care price in metropolitan and regional locations at December 2020 was 7.3 percent higher and 13.4 percent lower when compared to the NDIS enrolled and registered nurse prices, respectively. The median hourly HCP gardening price in metropolitan and regional locations at December 2020 was 23.2 percent higher when compared to the NDIS.

In contrast, variation across HCP and NDIS pricing for personal care and domestic assistance at December 2020 was minimal in metropolitan and regional locations, ranging between -0.6 and 7.8 percent. Noting these service types are regular, predictable and have strong market demand relative to other areas of HCP expenditure.[13] This comparison provides evidence of HCP market maturation following the introduction of home care price transparency. As such, retaining market-based provider pricing arrangements consistent with HCP operations appears justified and this level of analysis highlights the need for flexible provider pricing arrangements in response to market variability as part of the design of the future Support at Home Program.

5.2.2. Thin Markets

Comparison of hourly prices across HCP and NDIS direct care services in rural and remote locations highlights more substantiative differences when compared to price comparison for metropolitan and regional locations. Differences in median hourly pricing for HCP direct care services in rural and remote locations extend out to between 18.8 and 38.2 percent lower than NDIS prices for equivalent service types with these variations appearing to have remained consistent over time. As such, HCP market-based pricing in rural and remote locations may not be representative of the actual care costs attributable to delivering services in these thin markets. Pricing for care delivery in these thin market communities may be better reflected in unit pricing for alternate in-home care programs.

To progress this line of thinking, the upper price limit of the CHSP unit price range assigned to CHSP providers through the growth funding round at January 2021 was compared with NDIS direct service prices at December 2020, with a focus on equivalent service type prices specified for rural and remote locations (MMM 6-7). Comparison of direct service prices for personal care, domestic assistance, light gardening and nursing care are reported in Table 19.

Table 19. CHSP price range (lower and upper limits) at January 2021, with comparison between CHSP upper limit and NDIS prices for direct care service types delivered in rural and remote locations (MMM 6-7) from December 2020 with account for actual price ($) and percentage (%) differences.

	CHSP		NDIS	CHSP Upper Limit Comparison	
	Lower Limit	Upper Limit	MMM 6-7	$	%
Personal Care	$47.00	$78.00	$80.44	-$ 2.44	-3.0%
Domestic Assistance	$43.00	$64.00	$72.79	-$ 8.79	-12.1%
Light Gardening	$49.00	$89.00	$71.49	$17.52	24.5%
Nursing (Enrolled)	$93.00	$152.00	$125.60	$26.40	21.0%
Nursing (Registered)			$155.52	-$3.51	-2.3%

Differences in CHSP upper limit prices and NDIS MMM 6-7 prices for personal care and registered nursing care in rural and remote locations was minimal, with CHSP upper limit prices being between 2.3 and 3.0 percent lower. NDIS pricing for domestic assistance in rural and remote locations was 12.1 percent higher than the CHSP upper price limit. In contrast, NDIS pricing for light gardening in rural and remote locations was 24.5 percent lower than the CHSP upper limit price. The observed variability in prices across NDIS and CHSP service types with regard to thin market pricing for service delivery in rural and remote location relative to metropolitan and regional locations reflects the challenges that exist for the application of a nationally consistent unit level pricing policy in thin market segments. Based on the CHSP Data Study, this equates to near one quarter of SA2 regions serviced across the national home care landscape.[4] Consideration of how thin markets will be accounted for in the design and production of the Support at Home Care Program, price regulation and market stewardship is highlighted in this level of the analysis. Access to robust outcome-focused care-recipient information will be central to such considerations.

6. Market Stewardship, Care-Recipient Experiences and Outcomes

Government's response to the recommendations of the Royal Commission into Aged Care Quality and Safety signals that the design and production elements of the Support at Home Program will be centrally focused on productivity indicator measurement targeting total cost of care inputs funded and total number of care outputs delivered in the context of fiscal pressures and an ageing population. With this program evaluation focus in mind, the suggested productivity measurement approach will be bolstered by the application of proportionate risk-based quality regulation structures. These structures are designed and produced to ensure acceptable home care provider performance levels are achieved against quality and safety standards.

Proportionate risk-based quality regulation structures complimenting the design and production of the Support at Home Program will include:

- Review of the Aged Care Quality Standards through which to regulate provider performance (Recommendations 19-21);
- Development of Clinical Care Standards through which to regulate provider performance (Recommendation 18);
- Expansion of the Serious Incident Response Scheme to include all HCP and CHSP providers (Recommendation 100);
- Introduction of a tiered approach to the accreditation of approved home care providers to account for the accreditation of high-level home care services (Recommendation 93); and
- Introduction of quality indicators, including quality of life indicators for in-home care (Recommendation 22).

Combined, these quality regulation reform measures along with the enhancement of existing quality regulation structures, will contribute to inform the development of a star rating system to be implemented for the Support at Home Program by 2024 (Recommendation 24). This will highlight the quality of home care provided to older Australians through the Support at Home Program and support care-recipient access to better information that will empower them to have an informed say in the care they receive.

LASA questions the robustness of this productivity-performance indicator measurement approach with respect to system administration, data analytics, program evaluation and market stewardship. It does not go far enough in transforming future home care service delivery to be the world class market-based Support at Home Program envisaged through the Royal Commission for the care of both current and future generations of older Australians. Measurement of care-recipient experiences and outcomes appear to be absent in the preparatory work for the design and production of the Support at Home Program. Rather, a national quality indicator program will be established, it being implemented somewhat separate from the design and production of the Support at Home Program. This presents as a major concern for home care providers, noting price transparency needs to be matched closely with transparency of care-recipient experiences and outcomes to inform care-recipient choice of home care provider, care evaluation and care preference decision-making.[10]

Looking through the consultative mechanisms currently available as part of reform implementation, home care providers have suggested that home care reform mechanisms largely reflect tinkering at the edges in the application of current program structures.[10,11] There needs to be better coordination in reform implementation across Government departments and with more considered input from home care providers to account for transition demands. Co-design and co-production should aim to take the Support at Home Program even further to realise the aspirations of older Australians in the context of fiscal pressures and an ageing population.

Mere adjustments and improvements to the current system will not achieve what is required to provide high quality care that is predictable, reliable and delivered through a system which is sustainable. A profound shift is required in which the people receiving care are placed at the centre of the new aged care system.

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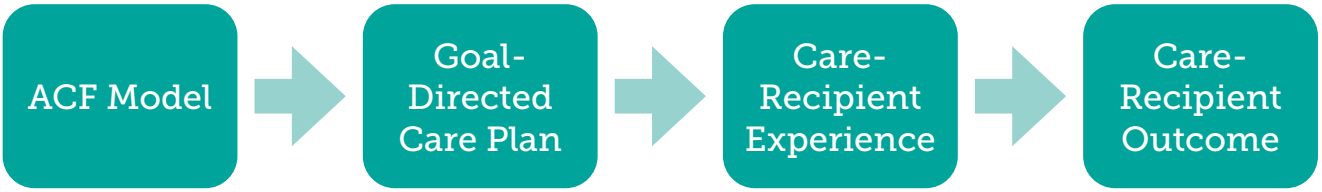
With the ACF model design and production for the Support at Home Program now underway, assessments will inform the generation of goal-directed care plans as an output of assessor classification determinations (classification category x intensity of support x funding allocation). This goal-directed care plan provides a clear frame of reference against which to measure care-recipient experiences and outcomes across time. Routine care-recipient experience and outcome data collection against goal-directed care plans should be developed as an extension of the ACF model (see Figure 3).

Figure 3. Extension of the assessment, classification and funding model underpinning development of the Support at Home Program to include measurement of care-recipient experiences and outcomes against goal-directed care plans.



6.1. Market Stewardship

Market stewardship refers to efforts made to address market deficiencies, gaps and failures. These often take the form of policy and market interventions. It is typically approached through a design and production focus targeting inputs such as funds, resources and time while measuring outputs such as profits, losses and service or product availability.

Given the market variability reported in the national home care landscape with respect to care-recipient demand for a diverse range of care and supports, as well as the challenges of workforce supply and fiscal pressures, there is a clear need to develop a sufficiently sophisticated market stewardship approach for the Support at Home Program. This approach needs to give regard to market segmentation that accounts for acuity of need, breadth of service types, diversity of care-recipient population groups and regions to be serviced.

The Royal Commission into Aged Care Quality and Safety has drawn attention to the importance of sensitivity in market stewardship in establishing a needs-based and demand-driven system. The Commissioners state that effective market governance requires both centralised top-down coordination and local bottom-up approaches to system management. They also highlight that, historically, aged care has remained highly centralised within the Government with limited presence at the regional and local level. As such, the planning process needs to involve local consultation with the community, the aged care sector and other stakeholder groups to provide a qualitative element that ensures the understanding of demand and supply is truly reflective of local need.[9] The CHSP Sector Support and Development services have attempted to bridge this gap in some regions[27] but overall there has been a general lack of sensitivity in market stewardship that has led to gaps in planning, development and the management of services.[1]

Consistently, it is noted that a key shortcoming in implementation of the NDIS market approach has been the lack of consideration for care-recipient lived experience in market stewardship consultation. A consultative and outcome-focused approach to measuring care-recipient lived experience has been recommended to improve the operation of needs-based and demand-driven disability market segments.[28] LASA argues that a similar approach to stewardship design and production for the Support at Home Program be developed in response to market variability. This approach should seek to capture information on care-recipient experiences and outcomes achieved and that is collated centrally, with localised data analytics capability being developed to increase transparency of this information. A sufficiently sensitive market stewardship approach can assist to identify market segments where care-recipient experiences and outcomes are indicative of market failure. This can then inform thin market interventions to ensure care-recipients have equitable access to in-home care and supports across market segments. Robust quality indicator data collection is critical in developing this level of market stewardship sophistication.

27 https://www.health.gov.au/sites/default/files/documents/2021/05/review-of-sector-support-and-development-ssd_1.pdf
28 https://unsw.adfa.edu.au/newsroom/news/critical-lessons-ndis-disability-services-new-market-stewardship-framework

6.2. Care-Recipient Experiences

From July 2019, the ACQSC had implemented standardised consumer experience reporting as part of performance assessments against the Aged Care Quality Standards.[29] Routine publishing of consumer experience report information has since ceased. The interpretation of prior results matched to a provider's service appear to have been somewhat problematic given the low number of care-recipient experiences reported relative to total care-recipients receiving services, some ten percent. Government's response to the Royal Commission into Aged Care Quality and Safety recommendations indicates that greater weight will need to be attached to the experience of people receiving care with a commitment to publish this information alongside quality star ratings (Recommendation 94).

Importantly, care-recipient experience is relative to expectation when planning and delivering home care. Alignment between a care-recipient's expectations and experiences is central to realising quality care. Assessor generated goal-directed care plans provide a critical marker for providers in mapping care-recipient expectations against which to measure care-recipient experience through the Support at Home Program. Acknowledging the traditional approach of satisfaction surveys through which providers have measured care-recipient experience and the ACQSC approach to survey a small proportion of care-recipient experiences, LASA suggests a more sophisticated and standardised approach for measuring care-recipient experience alongside care plan expectations and care outcomes be included in home care quality indicator development. Collectively, this could support the development of a sufficiently sensitive data set concerning care-recipient lived experience.

6.3. Care-Recipient Outcomes

Currently home care for older Australians includes the sporadic use of care-recipient outcome measurement by some service providers with no clear policy direction to build on this work in promoting a standardised approach to measuring care-recipient outcomes and publishing these outcomes to promote increased care transparency matched to price transparency mechanisms.

Demonstrating evidence of care-recipient outcomes for high quality and safe care is central to the Aged Care Quality Standards. Routine data collection against assessor generated goal-directed care plans and the publishing of care-recipient outcomes relative to implementation of these care plans, along with care-recipient experiences, provides a robust approach to communicate a home care provider's value proposition with supporting evidence.

Across industry there are varied levels of sophistication for demonstrating care-recipient outcomes achieved in planning and delivering care. The Support at Home Program needs to include co-design and co-production mechanisms for the integration of outcome evaluation into the Program's design. Ideally, this should be integrated into the initial design approach as part of program logic rather than implemented as siloed quality indicator reform activity that builds on residential care quality indicator program implementation, independent of the design and production of the Support at Home Program.

Goal Attainment Scaling, as an individualised approach to demonstrating subjective care-recipient outcomes, has merit for supporting industry realisation of outcome measurement relative to care-recipient expectations and experiences. Similarly, standardised measures using tools such as the Adult Social Care Outcomes Toolkit (ASCOT), Australian Community Care Outcomes Measurement (ACCOM) and ICEpop CAPability measure for Older people (ICECAP-O) provide robust metric approaches to measure care-recipient outcomes concerned with quality of life attributes such as a care-recipient's daily life, personal safety, social participation, accommodation, sense of dignity, purpose, enjoyment and control. Such metrics align with the intent of the Royal Commission into Aged Care Quality and Safety recommendation for the development of a comprehensive quality of life assessment tool for people receiving care at home (Recommendation 22).[1] LASA notes a quality of life assessment tool is being developed as part of the home care quality indicator program design.

Key challenges for providers in demonstrating evidence of care-recipient outcomes includes the development of internal capability and a sufficiently mature care planning framework that can support data metrics. Ideally these metrics, if progressed through home care reforms, should provide policy-driven momentum that enables the translating of individualised care-recipient outcome data into home care program level outcome data, thus supporting overall impact evaluation to confirm a home care provider's market value relative to total cost of care inputs funded and total number of care outputs delivered.

29 https://www.agedcarequality.gov.au/consumers/consumer-experience-reports-home-and-community-care

7. Conclusion

LASA has undertaken a comprehensive review of evidence surrounding home care price regulation and market stewardship in advocating for a collaborative co-design and co-production approach for establishment of the future Support at Home Program.

This review has considered home care cost distribution and price maturation relative to comparable program policy settings, legitimising the suggested tenets for price regulation. It has also reiterated the importance of adopting a collaborative and outcome-focused approach to market stewardship that includes structures for measuring care-recipient experiences and outcomes as an extension of quality regulation in response to market variability.

Evidence-based tenets for the future Support at Home Program as proposed by LASA in contributing to co-design and co-production include:

e) Enacting an *allocation-utilisation paradigm* that will see assessment approvals allocate higher levels of support classification to care-recipients relative to what they will likely utilise. This will reduce the demand for reassessment relative to changing care-recipient needs and noting support allocation is based on assessment of need that is matched to entitlement-based funding. Care-recipients will have control in how they utilise their funds allocation and unutilised funding will be retained by Government. Proportions of utilised and unutilised funding will be relative to funds allocation and choice in the available supply of supports.

f) Enacting *fixed unit level Government subsidy allocation, means tested care-recipient co-contribution and market-based unit level provider pricing* in responding to demand fluidity and supply cost variation across diverse market segments in the national home care landscape. This will enable providers to exercise agility and innovation in response to market demand and cost drivers for the delivery of care and support services.

g) Enacting *transparency of care-recipient experiences and outcomes* as an extension of price transparency to further strengthen care-recipient engagement in their accessing care and support. This extends beyond strengthening quality regulation mechanisms, implementing a consultative and outcome-focused market stewardship arrangement that is responsive to market variability in care-recipient demand for a diverse range of care and supports as well as the challenges of supply constraints and fiscal pressures.

h) Ensuring the *legislative and program environment includes sufficient operational flexibility* for home care providers, recognising the dynamic and variable market environment in which future in-home care and supports must be provided. This will require not only a commitment to high quality and safe care from providers but also agility and innovation in their operations to which market stewardship policy settings must be aligned.

LASA will continue to engage with Government and other key stakeholders concerning the implementation of home care reforms, demonstrating industry leadership in working with our Members to identify key aged care issues, consider appropriate solutions, and advocate with authority and influence to enhance the delivery of aged care programs on behalf of LASA Members and older Australians.

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Appendix 1

Tables 20-23. Percentage distribution of average care costs for each HCP level by ownership type as a proportion of total HCP level program expenditure and average care hours per fortnight for FY18-19.[13]

Level 1 Home Care Packages	Not For Profit	For Profit	Government	Total
Number of HCPs	2,518	550	145	3,222
Total Receipts per HCP	$449	$395	$309	$433
Unspent Funds	50%	30%	49%	47%
Average Expenditure per HCP	$226	$278	$157	$231
Package Management	11%	10%	15%	11%
Care Management (CM)	10%	9%	11%	10%
Direct Care (DC)	29%	50%	25%	32%
Care Hrs (CM & DC)	2.97	3.84	2.53	3.10
Care Hrs (DC only)	2.28	3.45	1.7	2.45

Level 2 Home Care Packages	Not For Profit	For Profit	Government	Total
Number of HCPs	22,211	3,242	1,782	27,234
Total Receipts per HCP	$579	$664	$507	$585
Unspent Funds	18%	26%	19%	19%
Average Expenditure per HCP	$474	$491	$413	$472
Package Management	15%	11%	18%	15%
Care Management (CM)	15%	9%	18%	15%
Direct Care (DC)	52%	54%	45%	51%
Care Hrs (CM & DC)	5.66	5.83	5.66	5.68
Care Hrs (DC only)	4.79	5.42	4.72	4.86

Level 3 Home Care Packages	Not For Profit	For Profit	Government	Total
Number of HCPs	7,947	1,521	505	9,973
Total Receipts per HCP	$1,136	$1,109	$1,015	$1,126
Unspent Funds	21%	24%	19%	21%
Average Expenditure per HCP	$901	$843	$757	$885
Package Management	16%	11%	18%	15%
Care Management (CM)	14%	10%	17%	13%
Direct Care (DC)	49%	55%	45%	51%
Care Hrs (CM & DC)	10.25	10.31	9.22	10.20
Care Hrs (DC only)	8.69	9.66	7.35	8.77

Level 4 Home Care Packages	Not For Profit	For Profit	Government	Total
Number of HCPs	11,567	2,152	674	14,394
Total Receipts per HCP	$1,965	$1,774	$1,869	$1,932
Unspent Funds	15%	25%	29%	16%
Average Expenditure per HCP	$1,648	$1,432	$1,334	$1,622
Package Management	15%	11%	16%	15%
Care Management (CM)	13%	9%	16%	13%
Direct Care (DC)	57%	56%	39%	56%
Care Hrs (CM & DC)	17.52	18.18	15.42	17.52
Care Hrs (DC only)	15.36	17.27	12.41	15.51

Appendix 2

Tables 24-27. Percentage distribution of average care costs for each HCP level by ownership type as a proportion of total HCP level program expenditure (with unspent funds excluded) per fortnight for FY18-19.[13]

Level 1 Home Care Packages	Not For Profit	For Profit	Government	Total
Average Expenditure per HCP	$226	$278	$157	$231
Package Management	19%	15%	29%	21%
Care Management (CM)	17%	13%	22%	19%
Direct Care (DC)	64%	62%	49%	60%
Care Hrs (CM & DC)	2.97	3.84	2.53	3.10
Care Hrs (DC only)	2.28	3.45	1.70	2.45

Level 2 Home Care Packages	Not For Profit	For Profit	Government	Total
Average Expenditure per HCP	$474	$491	$413	$472
Package Management	18%	15%	22%	19%
Care Management (CM)	18%	13%	22%	19%
Direct Care (DC)	64%	73%	56%	63%
Care Hrs (CM & DC)	5.66	5.83	5.66	5.68
Care Hrs (DC only)	4.79	5.42	4.72	4.86

Level 3 Home Care Packages	Not For Profit	For Profit	Government	Total
Average Expenditure per HCP	$901	$843	$757	$885
Package Management	20%	14%	23%	19%
Care Management (CM)	18%	13%	21%	16%
Direct Care (DC)	62%	73%	56%	65%
Care Hrs (CM & DC)	10.25	10.31	9.22	10.20
Care Hrs (DC only)	8.69	9.66	7.35	8.77

Level 4 Home Care Packages	Not For Profit	For Profit	Government	Total
Average Expenditure per HCP	$1,648	$1,432	$1,334	$1,622
Package Management	18%	14%	23%	18%
Care Management (CM)	15%	12%	22%	15%
Direct Care (DC)	67%	74%	55%	67%
Care Hrs (CM & DC)	17.52	18.18	15.42	17.52
Care Hrs (DC only)	15.36	17.27	12.41	15.51

Please contact LASA if you would like to know more about us and how we can assist you in the age services industry. We look forward to hearing from you.

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