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Independent Health and Aged Care Pricing Authority
(IHACPA)
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Independent Health and Aged Care Pricing Authority (IHACPA) Pricing Framework Support at Home Aged Care Services 2027-28

National Seniors Australia (NSA) is a peak consumer body representing the interests of all older Australians, with a community of more than 290,000 consumers. We advocate for an aged care system that prioritises fairness, transparency, affordability and accessibility.

We welcome the opportunity to provide feedback to the Independent Health and Aged Care Pricing Authority (IHACPA) on pricing arrangements for home care services under the Support at Home (SaH) aged care services. It is critical that pricing is grounded in the true cost of delivering home care services while ensuring older Australians can continue to access the care they need. While it is essential for prices to reflect the true cost of care accurately, this does not mean providers should receive a blank cheque.

NSA has consistently advocated for complete transparency from providers regarding the use of public funds, and we maintain that position here. Every dollar flowing through the SaH system and Commonwealth Home Support Programme (CHSP), whether from government subsidy or from an older person's own contribution, should be clearly and openly accounted for. Getting the price right and holding providers accountable for how they use these funds are two sides of the same issue, and we will continue to advocate strongly on both.

Effective communication regarding pricing, inclusions, and anticipated costs for older Australians is crucial. Without it, even a well-designed pricing structure can confuse consumers and undermine trust, complicating their ability to make informed decisions.

NSA urges the IHACPA to recommend that the government expand price transparency obligations beyond provider reporting. This will help consumers receive clear, accessible information. Transparent pricing data enables the government to make informed decisions about care costs, assess provider financial challenges, and identify unnecessary costs to consumers. Transparency is vital for a pricing system that benefits everyone.

Our submission responds to consultation questions (3, 4, and 5) with a particular focus on the cost drivers associated with in-home care delivery and the additional challenges faced in rural and remote communities. We emphasise that pricing decisions will directly influence service availability, provider sustainability and most importantly, consumer access and affordability.

NSA Key Recommendations are as follows:

1. **Ensure that pricing accurately reflects the additional costs** of caring for older people with dementia and complex cognitive needs.
2. **Commission a comprehensive cost study of CHSP services** ahead of the 2027 transition, disaggregated by service type and geographic remoteness to establish a robust evidence base for pricing.
3. **Set new prices from real cost data** rather than carrying forward legacy CHSP grant funding, which may not reflect the true cost of service delivery under a unit pricing model.
4. **Ensure Support at Home prices capture the full cost of care**, including workforce costs, care planning and administration, travel, training, and the additional work required to transition CHSP to the new system.
5. **Maintain block funding or viability funding for thin markets**, particularly in small rural and remote communities where a purely activity-based funding model risks service withdrawal.
6. **Introduce differentiated geographical price adjustments**, recognising that cost pressures vary not only by location but also by service type, rather than applying a single uniform loading.
7. **Collect and incorporate accurate provider-level travel costs data** and consider separate reimbursement mechanisms to ensure travel requirements do not reduce care time available for older Australians.
8. **Apply targeted loadings for clinical services** such as nursing and allied health services in remote areas, where workforce shortages and recruitment costs are most acute.
9. **Ensure that annual price updates begin with a base that reflects actual costs** and fully accounts for recent wage increases for aged care workers.

Pricing settings must be carefully calibrated to prevent unintended outcomes, ensuring that both provider viability and consumer affordability are prioritised, especially for older individuals with greater needs or limited resources.

Should you require further information or input, please contact the NSA Policy Team via policy@nationalseniors.com.au.

Yours sincerely,



Chris Grice
Chief Executive Officer

IHACPA Consultation Survey Questions

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

The system is struggling to keep up

NSA has heard directly from older Australians about the difficulties they are facing since the new aged care laws came into effect in November 2025. Older people reported long waits to have their needs assessed, trouble finding a provider with capacity to take them on, confusion about how the new system works and uncertainty about what will happen to their services.

As at 30 June, more than 838,000 people were relying on CHSP for their everyday support at home¹. Any changes to how services are priced will affect every one of these people. The NSA is concerned that older individuals receiving care through the Commonwealth Home Support Programme (CHSP) are already facing delays in receiving assistance. This issue arises not from ineligibility but from service providers lacking the necessary funding and workforce to accommodate them. If the pricing under the Support at Home (SaH) program is set too low, this predicament could escalate on a larger scale. Conversely, if the prices are set excessively high, older people may find critical clinical care unaffordable. It is essential to find a balance between these two extremes.

NSA has also warned that the transition itself creates new costs. Providers will need to manage two different funding models at once, CHSP and SaH, during the changeover period. They will need to invest in new systems, train staff and adapt their administration. These are real costs that need to be reflected in prices².

Getting prices right is not just a technical matter, it directly affects whether older people can get the help they need at home.

Dementia increases the cost and complexity of Care.

One of the most significant cost pressures on the home care system, and one that will only grow, is dementia. The number of Australians living with dementia is projected to grow to around 900,000 by 2050³. The population requiring home care is aging, becoming frailer, and increasingly likely to have dementia. Any pricing framework that does not account for these

¹ [Productivity Commission Report on Government Services 2026](#)

² [NSA, The Transition of the Commonwealth Home Support Program to Support at Home 2026](#)

³ [AIHW \(Australian Institute of Health and Welfare\) \(2025\) Dementia in Australia AIHW](#)

factors will quickly become outdated. Caring for a person with dementia at home is significantly more demanding than caring for someone with the same level of physical dependency but without cognitive impairment. Care workers need more time with each older adult and require specialised skills to manage behavioural symptoms and communication difficulties.

Visits can be less predictable, necessitating flexible scheduling. Continuity of care is crucial for someone with dementia; unfamiliar faces can cause significant distress, limiting the scheduling flexibility that providers would otherwise use to manage costs. All these factors increase the true cost of delivering care, yet they are not always reflected in standard unit cost data.

There is a broader issue beyond the direct costs of home care. When community services cannot adequately support individuals with dementia and complex needs, those individuals may end up in the hospital or remain hospitalised even after they are medically ready for discharge. The Productivity Commission has found that, on average, about 5-10% of all hospital bed days across the nation are occupied by patients who cannot be discharged due to a lack of aged care support⁴. This rate is even higher in rural and remote regions and in low socio-economic areas. People with dementia are disproportionately represented in these groups; they require consistent, familiar support that hospitals are unable to provide. However, the community services that could help keep them at home are under-resourced.

This situation creates a false economy. If home care services for individuals with dementia are underpriced and thus unavailable or of poor quality, the costs do not simply disappear, they shift to the hospital system, which is much more expensive. Ensuring that pricing is appropriate for clients with complex needs is not only the right thing to do for older Australians, but it is also a prudent use of public funds.

NSA Recommendation 1: IHACPA should ensure that pricing explicitly accounts for the additional costs associated with caring for individuals with dementia and other complex cognitive needs. Furthermore, IHACPA should clearly communicate to the government that insufficient funding for high-needs patients with dementia results in standardised patient care in hospitals. This approach ultimately results in higher costs for the public than providing care in the community.

⁴ [Productivity Commission, Report on Government Services 2026](#)

Real Cost Data

IHACPA needs to address the payment amounts currently used in CHSP, which were not worked out from a careful analysis of what services actually cost. They were set years ago and carried forward without proper review. The international report on aged care pricing found this problem in Australia: “There is no publicly available information on how the quantum of care subsidies...were originally set⁵. Currently, there is no study available that shows what it genuinely costs today to deliver a meal, a personal care visit or a nursing service at home. Yet those historically inherited amounts are what current grants are based on.

The Royal Commission into Aged Care Quality and Safety found that for many years, governments had been limiting expenditure without accounting for the actual cost of delivering services, rationing access to services, and neglecting reform of the funding model⁶.

NSA raised the same concern, noting that the draft aged care rules did not include any reference to how payment amounts were determined, or how they would be updated over time to keep pace with costs⁷.

NSA Recommendation 2: IHACPA should commission a dedicated cost study of CHSP services before the 2027 transition. This study should look at what it actually costs to deliver each service type, broken down by service type and by location remoteness. Prices for SaH should be set based on this real cost data, not on the old grant amounts.

IHACPA should recognise first that CHSP is structurally different from SaH. CHSP is an entry-level grant-funded program focused on lower-intensity home support, with some personal care and limited clinical care. In 2023-24, approximately 1.5 million people received some form of aged care and over half were receiving home support through the CHSP (over 835,000 or 56%)⁸.

Staff Costs – Biggest expenditure

Around 70 cents of every dollar spent on aged care services goes on paying staff⁹. This is why wage levels are so important to any pricing framework.

In recent years, the Fair Work Commission awarded significant pay increases to aged care workers through the Aged Care Work Value Case¹⁰. These increases were long overdue, but

⁵ [WHO OECD Report Pricing Long Term Care for Older Persons, p87, 2021](#)

⁶ [Royal Commission into Aged Care Quality and Safety, Vol 2, p188.](#)

⁷ [NSA, Aged Care Consultation: Funding for Support at Home Program](#)

⁸ [Commonwealth Home Support Programme Fact Sheet 2023-24](#)

⁹ [WHO OECD Report Pricing Long Term Care for Older Persons, p87, 2021](#)

¹⁰ [Aged Care Award \[2024\] FWCFB 150](#)

they have substantially raised the cost of running services. The formula currently used to update CHSP payments, which is based mainly on movements in the minimum wage, was designed to capture the size of these increases¹¹.

IHACPA has already acknowledged in its 2026-27 Consultation Paper that it will adjust for these wage decisions¹². NSA strongly supports this. But we want to emphasise that adjusting the rate of increase is not enough if the starting point, the base price, is already too low. Indexation applied to an inadequate base will lock in underpayment at a slightly higher level each year.

International evidence shows how serious this can be. When the government froze indexation of residential aged care payments in Australia, sector profits fell from \$1 billion to \$435 million in a single year¹³. More than half of all aged care facilities were already operating at a loss when the OECD report was written (2021), and financial losses in rural and remote areas were even more acute.

NSA Recommendation 3 – IHACPA should ensure that the annual price updates for SaH start from a base that accurately reflects today's service costs, including the full impact of the Fair Work Commission's aged care wage decisions. Simply applying an index to an outdated base will not fix the problem.

Prices to cover the real cost of running a service

Providing a home care service involves much more than the time a worker spends with a client. There are many other necessary costs that prices need to cover:

- Time spent planning and coordinating care, writing up notes and keeping records
- Administration, including managing individual client accounts and reporting to the government
- Training so that workers remain skilled and up to date
- Running a vehicle and covering travel time between clients
- The extra work and costs involved in moving from CHSP to the new SaH system
- Office costs and the infrastructure needed to manage the service.

The shift from block grants in the CHSP to unit-based pricing under SaH will impose new compliance, reporting, and care management overheads on providers, particularly smaller and not-for-profit providers who have not previously operated under individual budget models.

¹¹ [Aged Care Award \[2024\] FWCFB 150](#)

¹² [Consultation Paper on the Pricing Framework for Australian Support at Home Aged Care Service 2027-28](#)

¹³ OECD Report, p82

Other countries have recognised that prices must cover all these costs. In the Netherlands, for example, the government requires that prices include the cost of non-billable hours such as travel time, paid leave, and training, as well as reasonable overhead costs and administrative costs. IHACPA should consider the same principle.

A recent NSA submission to a consultation on Support at Home funding pointed out that the draft rules gave no clear information about what costs were in scope or how payment amounts had been set, making it very difficult for older people and providers to understand whether the amounts were adequate¹⁴.

NSA recommendation 4: IHACPA should confirm that SaH prices will cover all reasonable costs of delivering a service, including care planning, administration, training, travel, and the additional costs of transitioning from CHSP to the new program.

Some communities need a different approach to funding

As this submission is being prepared, reports are indicating that rising fuel prices may lead rural patients to skip medical appointments due to the impact of the war in the Middle East on the global economy¹⁵.

Regional and rural health services depend heavily on staff who travel long distances to deliver care to patients and clients. In rural and remote communities, home care services often rely on a single provider. This provider may serve only a small number of clients, but still has to cover fixed costs, such as vehicle maintenance, office rent, coordinator salaries, and telecommunications management.

Under the CHSP, many services receive a block grant, which is a fixed amount of money allocated to run community services. This funding provides providers with the certainty needed to plan and maintain services, even during slow periods.

The new SaH program has shifted towards a model that pays providers for each unit of service delivered, such as per hour of care. This change can create significant challenges for small communities. If fewer clients than anticipated require services in a given week, the provider's income decreases while their fixed costs remain unchanged. International evidence clearly indicates that a pay-per-service model is not effective in remote and rural areas. There is often

¹⁴ [NSA, Aged Care Consultation: Funding for the Support at Home Program](#)

¹⁵ [ABC News Rising fuel prices potentially forcing rural patients to forgo medical appointments, experts warn.](#)

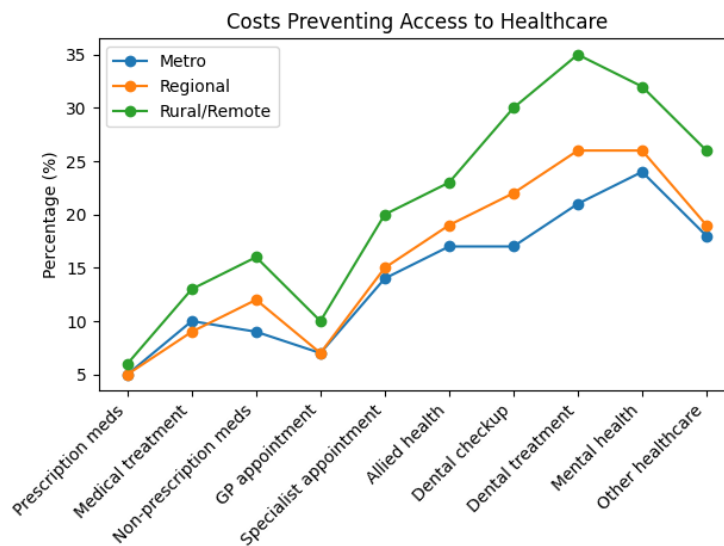
limited choice among providers, and travel costs account for a large share of an individual's care budget¹⁶.

NSA's submission regarding the CHSP transition highlighted a significant concern. Providers in certain locations incur higher transportation and outreach costs, limited economies of scale, and increased expenses for telecommunications and service-delivery infrastructure. Many of these services have relied on block funding to remain viable, and transitioning to individual budgets without a viable model to address costs could jeopardise sustainability in some communities.

NSA Recommendation 5: IHACPA should advise the government that block-funding arrangements should remain available for rural and remote communities alongside the new per-service pricing model. A single national pricing approach cannot adequately support services in all parts of Australia.

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

NSA research indicates that a higher percentage of people in rural, remote, and regional areas found healthcare inaccessible or unaffordable than in metropolitan areas¹⁷. This has implications for how adjustments should be structured.



¹⁶ OECD Report, p90.

¹⁷ [National Seniors Australia, The Regional, rural and remote experience in National Seniors Social Surveys 2025](#)

Costs that prevent access to healthcare

One NSSS-2023 question asked about the affordability of 10 common types of healthcare appointment or treatment.

For each, the question asked respondents whether the cost had affected their access in recent years.

They could select:

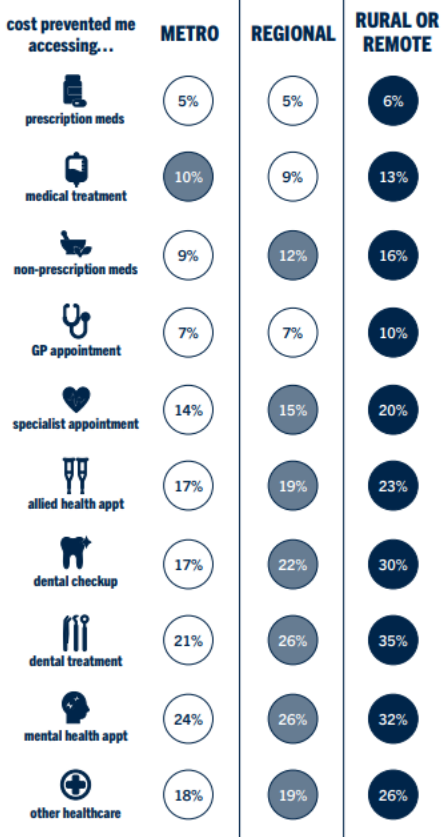
- Yes, the cost prevented me from accessing this.
- The cost made me hesitate about accessing it.
- No, the cost has not stopped me at all.
- Not applicable.

This graphic shows the percent who selected 'yes, the cost prevented me from accessing this' for each item.

For every item, a greater proportion of rural and remote respondents were impacted by cost compared to other respondents.

Regional people were also impacted more than metro respondents for most items.

'Not applicable' answers were excluded prior to calculations.



National Seniors Australia: The regional, rural, and remote experience in the NSSS 2025

In a city, a home care worker might drive five minutes between clients. In a rural or remote area, that same journey could take an hour or more. The care worker still needs to be paid for that time, which comes out of their budget, but this does not count as care time the older person receives, leaving them worse off than people in metropolitan areas.

The evidence confirms that in-home care “travel costs can consume much of a home care package budget¹⁸. This is not a minor inconvenience, it is one of the biggest structural differences between running a service in the city and in the country.

¹⁸ OECD report, p90-91.

IHACPA acknowledged that sector submissions identified travel distance as a key cost pressure in rural and remote areas. Ageing Australia, the peak body for aged care providers, described travel as “one of the most significant cost drivers in rural and remote care”¹⁹, including fuel, vehicle maintenance, and non-billable travel time for staff driving long distances.

We raised this issue directly in our CHSP transition submission, noting that “providers in these locations face higher transportation and outreach costs” as a structural feature of operating in thin markets²⁰.

In some programs, travel costs have been deducted directly from a client's care budget, meaning that an older person in a remote area ends up receiving fewer hours of actual care than someone in a city with the same assessed needs, simply because their care worker had to drive further.

Speech Pathology Australia told IHACPA that travel should be paid for separately, “scaled to reflect real costs and not deducted from therapy budgets²¹”.

NSA Recommendation 6: IHACPA should collect real data on the costs providers incur to travel to older people across different parts of Australia. Travel should be paid for separately and should not be deducted from the time an older person receives care.

Economies of Scale

A large city provider might have hundreds of clients. If they have a quiet week, they can absorb it. A small provider in a remote area might have 20 or 30 clients. If a handful of patients cancel or go to the hospital, the provider’s income can drop sharply, while their fixed costs remain the same.

Remote aged care facilities with over 40 beds can generally achieve economies of scale, but 70 per cent of facilities in rural and remote areas have fewer than 40 beds²². The same applies to home care providers; a small provider with few clients has to recover all their fixed overheads from a much smaller number of service hours.

The financial situation for service providers in rural and remote areas is already critical. We have consistently emphasised in our submissions that if providers do not receive adequate payment to cover their costs, they will be forced to reduce service volumes, eliminate certain types of services, or prioritise higher-funded programs. This directly impacts older individuals

¹⁹ [Ageing Australia IHACPA 2026-27 Pricing Framework Consultation for Support at Home \(SaH\)](#)

²⁰ [NSA, The Transition of the Commonwealth Home Support Program to Support at Home 2026](#)

²¹ [Speech Pathology Submission IHACPA NDIS Pricing 15 November 2024](#)

²² OECD Report, p90.

who depend on these services. In thin markets with only one provider, even a single closure can leave an entire community without access to care.

NSA Recommendation 7: IHACPA should apply pricing adjustments for rural and remote areas that separately address each type of extra cost. A single flat loading across all areas and services is inadequate.

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

The evidence from the OECD Report, NSA submissions, and IHACPA's own consultations indicates that cost pressures in rural and remote areas are not uniform across service types. They are substantially more pronounced for some categories, and the nature of the cost driver also differs by service type.

Services such as nursing, physiotherapy, occupational therapy, speech pathology, and psychiatry are provided by qualified health professionals who must hold recognised registration or qualifications. These professionals are harder to attract to remote areas and the most expensive to recruit from outside. The extra costs come from three directions at once:

- Workforce scarcity: there are very few registered nurses or allied health professionals living in remote communities, so providers often recruit from cities and cover relocation, housing or travel costs.
- Higher travel cost between clients, clinical visits tend to be spaced further apart from personal care visits, so travel time represents a larger share of the working day.
- Telehealth infrastructure: where face-to-face care is not always possible, providers need reliable technology to deliver clinical services remotely and that technology costs money to set up and maintain.

Key Cost Pressures in Rural & Remote Healthcare

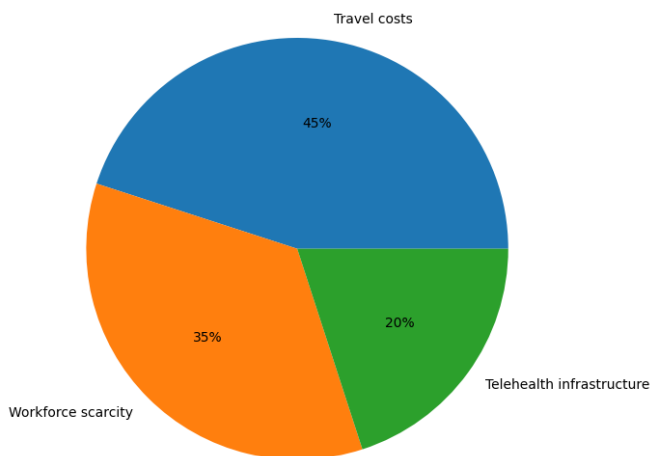


Figure X: Key cost drivers for service delivery in rural and remote areas. Note: “Percentage weightings are indicative and used for illustrative purposes to reflect relative cost pressures identified in OECD evidence. The OECD does not prescribe quantitative weightings between cost drivers.”

Evidence indicates that the cost of home-based care reveals that the expenses for nursing and clinical care are significantly higher than those for personal care and household assistance. Additionally, when a rural and remote surcharge is added to these higher base prices, the overall dollar difference compared to metropolitan services becomes quite substantial.

Speech Pathology Australia has already raised concerns about the current rate under CHSP, “barely covers the cost of hiring allied health professionals at minimum wage, even in the city. The government already recognises that residential aged care needs different price categories for different levels of remoteness. When IHACPA set prices for aged care facilities in 2024-25, it found that “existing funding categories did not adequately address differences in costs” across locations and restructured the categories accordingly²³. The same logic should apply to home-based care.

NSA Recommendation 8: IHACPA should treat nursing and allied health services in remote communities as a distinct pricing category requiring higher adjustments than other service types. These services face a compound cost challenge, workforce scarcity, higher travel costs, and infrastructure investment needs, which a general rural loading does not adequately address.

²³ IHACPA Residential Aged Care Pricing Advice 2024-25.

Personal Care, Household and Social Services

Personal care services, such as assisting with showering, dressing, and taking medication, are generally provided by aged care workers who hold a Certificate III or IV qualification. These workers are more likely to be available locally in rural and remote areas than registered nurses or allied health professionals, so the workforce scarcity cost premium may likely be lower. However, the travel-cost premium remains real and significant.

Services like meal delivery, help with housework, home modifications and transport face a rural and remote cost premium too. Still, the main driver is freight and logistics rather than workforce or travel. Because the base price for these services is generally lower than for clinical services, the absolute premium over metropolitan pricing tends to be smaller, even though the percentage increase may be similar or higher.

A single flat adjustment applied to all services in all remote areas will not reflect the actual cost. It will:

- Underpay for nursing and allied health in remote areas, where the cost gap is biggest, and where there are no available specialist services, the situation is most serious
- Does not reflect that the costs are higher for different types of services.

Adjustments should be set for the type and length of the home care service to recognise legitimate and unavoidable cost differences among providers, rather than as a single supplement applied equally across all services.

NSA Recommendation 9: IHACPA should design pricing adjustments for rural and remote areas as a matrix that combines the type of service (clinical, personal care, household/social) with the location's remoteness (using the government's Modified Monash Model classification system, MMM1-7). Nursing and allied health services in very remote areas should attract the highest adjustments. This approach is consistent with how IHACPA already sets prices for residential aged care.

Conclusion

NSA's goal is to ensure that the home care system is adequately funded to provide the services older individuals need, as determined by their assessments.

The transition from the CHSP to the Support at Home SaH program presents an opportunity to establish fair pricing. If the IHACPA bases its recommendations on the actual costs of delivering care in remote areas and accurately reflects the different types of services, the new system can genuinely improve on what has existed in the past. This will require providers to open their books and be transparent about the true costs of delivering care, facilitating more mature discussions on appropriate profit margins and equipping the government with the evidence needed to set pricing that genuinely reflects the cost of quality care.

If prices are set too low or are based on outdated assumptions, older Australians will face significant consequences. They may struggle to access essential services that are not available in their communities. Additionally, service providers may struggle to sustain their operations.

Equally, if prices are set too high, this will reduce the number of services a person can receive within their budget, unfairly increase user contributions, and undermine overall trust in and the sustainability of the aged care system.

IHACPA's pricing framework should ensure that both the government and individuals only pay for the actual cost of delivering quality services. This means that prices should be based on accurate, audited cost data rather than what the market might tolerate or historical negotiations between providers. **There should be strong public reporting requirements to allow older Australians, their families, and the government to understand exactly what they are paying for, ensuring that funds are being allocated appropriately.**

NSA looks forward to continuing our collaboration with IHACPA as this important work progresses. We are more than happy to provide additional information on any of the issues raised in this submission.