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Current issues in aged care and disability pricing in Australia

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Abstract

The Australian disability, aged care, and health sectors are undergoing significant transformations due to demographic shifts, policy changes, and increasing demand for services. Commonwealth Government spending on these areas is significant and growing – in FY25 expenditure on the National Disability Insurance Scheme, aged care and the Medical Benefits Scheme was expected to be \$48.5 billion, \$37.2 billion and \$32.7 billion respectively, forming 3 of the top 5 programs by expense (Commonwealth of Australia, 2025, p. 119). Effective pricing and scheme design are crucial to ensuring the sustainability and accessibility of these services.

This paper considers recent reviews, recommendations and reforms regarding pricing across aged care and disability in Australia, including the transition of aged care pricing responsibilities to the Independent Health and Aged Care Pricing Authority (IHACPA), the new arrangements for in-home aged care and the report of the Independent Pricing Committee established by the National Disability Insurance Agency (NDIA).

It explores these pricing frameworks and associated policy choices and highlights similarities, differences, overlaps and potential impacts and opportunities.

Keywords: disability, aged care, pricing, costs, reform

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Introduction

Aged care and disability are not the same, but many of the support services provided to older Australians and those living with disability are often very similar, if not identical. The bulk of program spending is on the labour required to support people's activities of daily living, i.e. feeding, washing, toileting, mobility – personal care and domestic assistance – the work of a disability support worker or an aged care worker, whether delivered in-home or in a residential aged care home, sometimes also called 'attendant care'¹.

Fundamentally, it is essential to get prices 'right' across these systems, to enable sufficient, equitable and sustainable access to quality services for those who need support, which requires an adequately remunerated workforce and entities to co-ordinate delivery of care.

But how is the price for this support determined? Despite the similarities in the service provided, significant historical differences in the origins of the systems mean that there is significant diversity in the pricing arrangements – including with respect to means testing, funding arrangements, budget/package amounts and arrangements, consumer contributions, pricing structure, input data including costs and ultimately the price itself.

There is some value in diversity in pricing – it could allow for differential quality for example – but that is not currently the case in these systems. Among other impacts, these differences have created competition for resources between programs and reportedly negatively affected access for those in schemes paying lower prices (for example, Defence Force Welfare Association, 2022).

There is also diversity where it may not be warranted. Given that the skills and qualifications for the attendant care workforce are broadly similar, as are, increasingly, the award arrangements

¹ For example, in the NDIS total expenditure on attendant care supports made up around 65% of the total scheme expenditure for the six months to December (2024 National Disability Insurance Agency. (2025a). *2024-25 Annual Pricing Review*. <https://www.ndis.gov.au/providers/pricing-arrangements/making-pricing-decisions/annual-pricing-review>). For Residential Aged Care (RAC)), personal care workers represented 55% of total care costs in 2023-24 (Department of Health Disability and Ageing. (2025d). *Financial Report on the Australian Aged Care Sector 2023-24*. <https://www.health.gov.au/sites/default/files/2025-07/financial-report-on-the-australian-aged-care-sector-2023-24.pdf>). For the aged care home care programs the author estimates up to 60% of expenditure is on attendant care provided services (Australian Institute of Health and Welfare. (2025). *Commonwealth Home Support Programme aged care services dashboard Supplementary tables, 2023 - 24*. <https://www.gen-agedcaredata.gov.au/resources/dashboards/commonwealth-home-support-programme-aged-care-services>, Ernst & Young. (2023). *Support at Home Costing Study: Study Report*. Independent Health and Aged Care Pricing Authority. https://www.ihacpa.gov.au/sites/default/files/2024-05/20240321_sahcs_-_study_report_-_final.pdf).

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underpinning remuneration, it is reasonable to expect that like services should be priced consistently, this paper will illustrate that this is not necessarily the case.

Actuaries traditionally have a role in scheme design, and pricing is a key actuarial function. Actuaries can contribute to improving outcomes in the aged care and disability sectors, including through getting more involved in design and structure of pricing arrangements.

The scope of this paper is the arrangements for the National Disability Insurance Scheme (NDIS) and the main aged care programs, namely the Commonwealth Home Support Programme (CHSP), the Home Care Package Program (HCP) and Residential Aged Care (RAC), as well as the new in-home program for aged care commencing on 1 November 2025, the Support at Home Program (SAH). The focus is on support work, i.e. attendant care.

While highly relevant, this means that other adjacent Australian schemes which are also providers of attendant care, are not discussed here. This includes Department of Veterans' Affairs (DVA) funded veterans' care and the jurisdiction-based compensation schemes for motor vehicle and workplace accidents, particularly those focused on lifetime care for catastrophic injuries. International schemes and approaches are also not discussed. Also relevant, but not covered here, are other types of support offered in these schemes, such as allied health and other therapeutic services. Lastly, the sufficiency of prices, the policy reasoning for the pricing approaches described and any potential alternative approaches are not addressed here. This is to keep the paper to a digestible length and focussed on reviewing the historical and current settings. These other topics may be covered in future papers.

The remainder of this paper is arranged as follows: after the glossary, which is included because of the many acronyms in this field, there is a brief discussion of the changes introduced during the 2010s, followed by an overview of the reviews and reforms of the first half of the 2020s, touching on the impact of award arrangements. The next section covers the current state as of 2025, before turning to a discussion of similarities, differences and importantly considerations in pricing. The paper concludes with a short summary of impacts and opportunities, with a focus on the potential roles for actuaries.

For the avoidance of doubt, while the author has undertaken work in pricing in both disability and aged care, all material in this paper relies on public sources and no confidential material is referenced. While care has been taken in the preparation and review of this paper, any errors or omissions remain the responsibility of the author.

Glossary

Term	Definition
ACFI	Aged Care Funding Instrument
ACFR	Aged Care Financial Report
ACQSC	Aged Care Quality and Safety Commission
ACRC	Royal Commission into Aged Care Quality and Safety
AHSRI	Australian Health Services Research Institute
AN-ACC	Australian National - Aged Care Classification
APR	Annual Pricing Review
CHSP	Commonwealth Home Support Programme
DHDA / DoHAC	Department of Health, Disability and Ageing, previously Department of Health and Aged Care
DRC	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
DSS	Department of Social Services
DSW	Disability Support Worker
DVA	Department of Veterans' Affairs
ERO	Equal Remuneration Order
FOI	Freedom of Information
FWC	Fair Work Commission
HCP	Home Care Package program
IHACPA	Independent Health and Aged Care Pricing Authority
IHPA	Independent Hospital Pricing Authority
IPC	Independent Pricing Committee
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS QSC	NDIS Quality and Safeguards Commission
NWAU	National Activity Weighted Unit
PCW	Personal Care Worker
PM&C	Department of the Prime Minister and Cabinet
QFR	Quarterly Financial Report
RAC	Residential Aged Care
RACCC 2024	Residential Aged Care Cost Collection 2024
RACCPs	Residential Aged Care Pilot Costing Study
RACCS 2023	Residential Aged Care Costing Study 2023
RACDIP	Residential Aged Care Data Insights Project
RUCS	Resource Utilisation and Classification Study
SAH	Support at Home program
SAHCC 2024	Support at Home Cost Collection 2024
SAHCS 2023	Support at Home Costing Study 2023
SAHLDC 2025	Support at Home Live Data Collection 2025
SCHADS	Social, Community, Home Care and Disability Services Award

Brief history - ~2010s

There was a significant period of reform in the early 2010s. Two landmark Productivity Commission reports were published in 2011: *Disability Care and Support* (Productivity Commission, 2011b), which led to the establishment of the NDIS in 2013, and the less well remembered *Caring for Older Australians* (Productivity Commission, 2011a), which led to the 'Living Longer, Living Better' package of aged care reforms also legislated in 2013.

Aged Care

Among other changes, the aged care reforms of this period established the most recent arrangement of aged care programs. The most basic level of support at home, Home and Community Care (known as HACC), was reborn as the Commonwealth Home Support Programme, and the higher levels of home care, Extended Aged Care at Home (EACH) and Community Aged Care Packages (CACP) were brought together as the Home Care Package program (HCP). Residential aged care reform included removing the distinction between low (hostel-style) and high (nursing home-style) care.

From a pricing perspective, the approaches varied by program:

- **CHSP** is a **block-funded grant program**, which is periodically put out to tender. Government subsidies towards unit costs (i.e. the prices paid by government) are set between government and each provider, recorded in the grant agreements and used to support grant acquittal (Department of Health Disability and Ageing, 2025b). Participants may be asked by providers to make an additional 'reasonable contribution' to the cost of services, and these contribution amounts must be published.
- **HCP** provides for higher levels of support and care than CHSP, it is divided into four levels. As the level of need increases, so does the annual 'package amount' available to the care recipient. **Providers have freedom to set unit prices** for each service type offered, within some limits. Providers need to publish their prices and the department has published a *National summary of home care prices* since at least May 2021 (Department of Health and Aged Care, 2025b). Participants draw down on their package as services are consumed, via these unit prices. Participant contributions can be required, but are often waived (Combined Pensioners and Superannuants Association, 2023).
- **RAC** pricing is somewhat more complex as there are several components, namely, accommodation, hotel-type services and care services. Focusing on care services, these were principally funded via department-set **fixed prices** using the **Aged Care Funding Instrument (ACFI)**. This instrument assessed resident needs across three main areas, activities of daily living, cognition and behaviour and complex health care needs. These areas were each divided into levels of acuity and funding in dollars per day was fixed for each of the cells. These funding amounts were summed for the combinations of area of need and acuity level to provide the amount of government subsidy for care in dollars per resident 'bed day'. Residents may contribute via a means tested care fee.

There were no explicit costing exercises conducted to set prices in any of these programs that the author is aware of. It is notable that all of these structures also make it difficult for recipients to understand the total cost of services.

Disability

The **NDIS** was set up to be structurally quite different from the aged care programs, and the pricing approach was also different. Participants are allocated a plan budget (usually annual), divided into support categories (such as support for activities of daily living, assistive technology, therapeutic support). There are no participant contributions, the total cost is paid by government. The NDIS was founded on a number of significant principles, including choice and control for participants, which also lent itself to a more market-based conception of service

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providers. In order to avoid the risk of exploitation of vulnerable participants during the development of the NDIS, before it theoretically transitioned to a sufficiently deep market to allow pricing freedom, unit prices for some support categories, including hours delivered by disability support workers, were **capped**².

The pricing process has been described in the Pricing Strategy (National Disability Insurance Agency, 2019) and is documented in the *NDIS Price Guide* each year (now the *NDIS Pricing Arrangements and Price Limits*). It has been managed via an Annual Pricing Review, which has varying focus areas from year to year.

The unit price for disability support worker time is set using the Disability Support Worker Model (DSW Model, previously known as the Reasonable Cost Model and the Hourly Return Model (Productivity Commission, 2017)). It has been periodically supported by a Financial Benchmarking Survey (FBS, conducted from 2015-16 until 2021-22, with the exception of 2018-19), used to calibrate the inputs to the DSW Model.

The Financial Benchmarking Surveys, while providing useful information, were not comprehensive cost studies. Although the sample size was broadly reasonable, the survey did not directly collect activities and costs, rather it asked a series of descriptive questions regarding provider characteristics, workforce profile, remuneration arrangements, utilisation and some income statement and balance sheet items (National Disability Insurance Agency, 2025d).

In summary, across aged care and disability, there were four distinct approaches to setting prices for what is essentially the same service being provided by a very similar workforce, i.e. provision of attendant care.

Further Reviews

Two external reviews were conducted towards the end of this period, namely the Productivity Commission's report into NDIS costs (Productivity Commission, 2017) and the Independent Pricing Review commissioned by the NDIA and conducted by McKinsey (McKinsey and Company, 2018).

The 2017 Productivity Commission report was focussed on broad questions of NDIS sustainability, but touched on pricing in ways that reinforced the perspectives of the time, that '*Prices should be set with market development [i.e. increasing supply] as the primary focus*' (Productivity Commission, 2017, p. 34). There was clear support for transition away from price caps to market-based pricing freedom, and concern that having the NDIA set prices would constrain supply by erring in favour of budgetary restraint. The study recommended moving price setting responsibility gradually from NDIA to the NDIS Quality and Safeguards Commission (NDIS QSC), which was in the process of being established.

The McKinsey review was focussed on providing advice regarding improved pricing effectiveness and 'recommendations in relation to the potential early deregulation of price in more mature sub-markets and the glide path for the eventual deregulation of price more generally' (McKinsey and Company, 2018, p. 4). The review did not find shortages in availability of attendant care, and in fact, in its benchmarking, found that prices were in line with those of other schemes. However, it noted financial pressure on providers and recommended transition support along with additional documentation and process, which likely led to the development of NDIA's Pricing Strategy noted above.

² Self-managed participants can use registered or unregistered providers and are not subject to the pricing arrangements, payments for self-managed participants were approximately 10% of total NDIS payments in Q4 of 2024-25, National Disability Insurance Agency. (2025f). *Table E.91, Supplement E National 2024-25 Q4.xlsx*. <https://dataresearch.ndis.gov.au/reports-and-analyses/quarterly-report-supplements>

Royal Commissions and NDIS Review

This period broadly concluded with the calling of two Royal Commissions, the Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission or ACRC), established in October 2018 and reporting in March 2021, and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission or DRC), established in April 2019 and reporting in September 2023.

The other major review of relevance was the NDIS Review, announced in October 2022 and reporting in December 2023.

Recent reviews, recommendations and reforms - ~2020s

Driven primarily by these Royal Commissions and the NDIS Review, the period since 2018 has seen a significant wave of reforms, which have included a number of changes to pricing approaches both implemented and planned.

RAC Funding Reform

Firstly, in a reform that commenced prior to the ACRC, funding for care in RAC was moving from ACFI to a new model, AN-ACC: the Australian National – Aged Care Classification. This new classification system was established following a suite of studies, including cost studies, conducted by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong, known as the Resource Utilisation and Classification Study (or RUCS) (Eagar K et al., 2019).

The RUCS developed National Weighted Activity Units (NWAUs) to represent the relative cost of care as a function of resident and facility characteristics, but did not produce an actual price per NWAU. The Department developed the initial price per NWAU to represent 'the cost of a standard day of care' when providers transitioned from ACFI to AN-ACC in October 2022 (Department of Health and Aged Care, 2022a), but no cost study was undertaken at this time.

Aged Care Royal Commission recommendations and reforms

The ACRC made 148 recommendations, a number of which either related directly to pricing or impacted pricing arrangements in some way. Recommendation 115 was that the responsibilities of the Independent Hospital Pricing Authority (IHPA) be expanded to include aged care pricing, firstly for RAC and then home care. This was accepted and August 2022, IHPA became the Independent Health and Aged Care Pricing Authority (IHACPA). The activities they have undertaken since this transition are described in the following section.

The ACRC also heard that, in some cases, up to 50% of HCP funding was being used for administration and management costs, because there were no effectiveness caps on what providers could charge (Department of Health and Aged Care, 2022b). Following a Department review (Department of Health and Aged Care, 2022c) changes were introduced from 1 January 2023 that limited the amount a provider could charge for Care Management and Package Management at 20% and 15% of the package level respectively (Aged Care Quality and Safety Commission, 2022) and required additional transparency from providers in terms of publishing their prices.

Another key recommendation was the creation of a new program for in-home care, now known as Support at Home (**SAH**), to replace the existing programs. The main features of SAH in relation to pricing are the creation of a new specific service list, which divides services into three types: clinical (such as nursing and allied health), independence (including personal care) and

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everyday living (such as domestic assistance). Also, *'Initially, Support at Home providers will set their own prices for services. From 1 July 2026, government-set price caps will apply. Prices must include the entire cost of delivering a service (e.g. administrative costs, staff travel and third-party charges).'*' (Department of Health Disability and Ageing, 2025c) This brings SAH closer to the operation of NDIS price limits, although consumer contributions, now differentiated by service type, will continue in SAH.

As part of preparation for the move to SAH, the Department of Health and Aged Care (DoHAC, now DHDA) noted that unit prices for CHSP were nationally inconsistent and moved to developing National Unit Price Ranges which underpin the grant agreements and are now published in the CHSP Manual (Department of Health Disability and Ageing, 2025a) 'to drive more consistency in prices across Australia'. They are based on work conducted by ACIL Allen (Department of Health and Aged Care, 2021), and are informed by assessment of unit price information, examination of comparable pricing approaches for other programs and consideration of market implications of funding design.

Disability Royal Commission recommendations

The Disability Royal Commission didn't really touch on pricing except to recommend that pricing reviews be undertaken in respect of services in remote areas and for accommodation arrangements (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability, 2023a). It also considered views from providers that pricing arrangements did not sufficiently allow for training and development of staff (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability, 2023b).

NDIS Review recommendations and government response

However, the NDIS Review commissioned a specific paper on pricing issues in the NDIS, *'The role of pricing and payment approaches in improving participant outcomes and scheme sustainability'* published in May 2023 (NDIS Review, 2023). This paper made the following observations:

- *'Governments have relied on price caps to incentivise providers to operate 'efficiently' in the NDIS market.*
- *'Fee-for-service payments in the NDIS are easy to administer and understand, but reward providers for each hour of service they deliver, regardless of the 'value' for participants.*
- *'Previous reviews suggested in the long-term replacing price caps with 'light touch' price monitoring and greater transparency on prices and quality'*

And findings:

- *'There are opportunities to improve NDIS pricing arrangements over the short- to medium-term*
- *'The fee-for-service payment approach rewards NDIS providers for the volume of supports they deliver, rather than for supporting participants to achieve outcomes*
- *'A lack of transparency around prices, volume, quality and outcomes is restricting the effectiveness of NDIS service delivery*
- *'Removing price caps could place pressure on scheme costs. Instead, the focus should be on foundational market reforms that help align incentives for participants, providers and governments'*

The paper also noted that *'In the NDIS, most transactions occur at the price cap. Of those supports subject to a price cap, 82% of the total value for supports between March 2022 and March 2023 were charged at or close to the price cap.'* (NDIS Review, 2023, p. 27)

The Review used these to support consultation that then fed into the final report (Department of the Prime Minister and Cabinet, 2023). The final report found that there was little incentive for providers to compete on price and that concerns remained about the inherent conflict of interest for the NDIA in setting prices while also being responsible for NDIS sustainability. The Review recommended redesigning a new pricing and payments framework (Action 11.1) and transitioning responsibility for advising on NDIS pricing to IHACPA to strengthen transparency, predictability and alignment (Action 11.3).

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In response, government commissioned IHACPA to undertake initial work to identify opportunities for future reforms to NDIS pricing. This included public consultation, reviewing existing pricing approaches and developing a pricing data strategy. IHACPA identified principles to guide a new NDIS pricing framework; explored pricing model options to improve NDIS pricing; and looked for opportunities for pricing harmonisation across the care and support sector (Independent Health and Aged Care Pricing Authority, 2024a). This work was conducted over 2024 but has not been published.

In September 2024, government also established a new Independent Pricing Committee (IPC) to review NDIS pricing approaches and recommend changes designed to lead to a higher quality and sustainable disability provider market (National Disability Insurance Agency, 2024). The final report was published in June 2025 (Anthony et al., 2025). It explicitly did not make recommendations, but rather proposed a new framework and approach along with a four-year implementation plan. The Committee worked from a conceptual basis and focussed on a more precise specification of service types, which appears to be an alternative disaggregation of the current support services. They also suggested complementary reforms to give full effect to these changes.

During this time, the NDIA's Financial Benchmarking Study was paused and has not been conducted since 2021-22 (National Disability Insurance Agency, 2025d). The most recent Annual Pricing Review 'rolled forward' the DSW Model by updating for increases in the SCHADS award and superannuation guarantee. In response to the IPC Report, the NDIA has committed to publishing a roadmap in the coming months outlining how future pricing reforms will be delivered (National Disability Insurance Agency, 2025a).

Care and support harmonisation initiatives

Also during this time, a number of initiatives started to consider broader issues of harmonisation across the 'care and support economy', such as a Cross-Agency Taskforce on Regulatory Alignment made up of the Department of Health and Aged Care (representing aged care), the Department of Social Services (DSS) (representing disability services), DVA (for veterans), the NDIS QSC and the Aged Care Quality and Safety Commission (ACQSC). Established in 2021, it reported generally favourable views towards having more common approaches, including for pricing arrangements (Care and Support Harmonisation Taskforce, 2022). This was followed by the establishment of the Care and Support Economy Taskforce (now Reform Unit) within PM&C which produced a Draft National Care and Support Economy Strategy in May 2023, where they specifically called out the impact of differential prices across sectors:

*'Government programs are, in effect, **competing with each other** [author's highlight] to secure services for their target cohorts. For example, the policy and program settings for the NDIS and aged care, especially the pricing of services, put pressure on the market for veterans' services. The unintended consequence of this misaligned pricing can be underservicing of the veteran population.'* (Care and Support Economy Taskforce, 2023, p. 45)

However, what reform there has been since then has tended to be led by individual departments and agencies.

Finally, after the most recent Federal election in May 2025, machinery of government changes moved the majority of the disability functions of the Commonwealth from DSS to the Department of Health and Aged Care, renamed the Department of Health, Disability and Ageing (DHDA). Ministerial responsibilities were also reorganised. This was motivated in part by immediate pressure to resolve aspects of NDIS reform such as Foundational Supports (including the recently announced Thriving Kids program), by bringing together Commonwealth responsibility for the NDIS and the National Health Reform Agreement negotiations for public hospital funding, all of which are to be negotiated with the States and Territories. But it may also be a move towards bringing major parts of the care and support sector closer together, a theme reinforced

during the recent Economic Reform Roundtable and preceding Health, Disability and Ageing Economic Reform Roundtable, both held in August 2025.

The impact of award arrangements

At this point it is worth highlighting the significant impact reviews by the Fair Work Commission (FWC) of the applicable awards have had on the major component of input costs and hence prices. Because these have been uneven between disability and aged care over time, this has also likely influenced the flow of workers between sectors and hence ease of access to services or otherwise.

The first review was the Equal Remuneration Order (ERO) of 2012 which introduced phased-in wage increases of up to 45% over eight years for community sector workers under the SCHADS Award, including disability support workers (Fair Work Commission, 2012). This was reflected in the DSW Model and hence NDIS price caps, but led to a significant gap in wages between disability support workers and personal care workers in aged care (both residential and home care).

Following the ACRC, a Work Value Case (Fair Work Commission, 2024) for aged care was lodged by the Health Services Union in 2020, which led to an initial 15% increase in wages for workers under both the Aged Care Award for residential aged care workers and the SCHADS Award for aged care home care workers. This was followed by a final determination in March 2024 which provided for further increases in January and October 2025.

While this went some way to addressing the gaps between disability and aged care wages, a further review, the Gender Equity Review (Fair Work Commission, 2025), is in the process of assessing five awards, including SCHADS, and found in April 2025 that the minimum wages for disability support workers and aged care home care workers do not accurately reflect the value of work undertaken, due to gender-based undervaluation of female dominated workforces. Final decisions on further changes to pay rates are expected in late 2025 or early 2026, but the FWC has recommended replacing the current classification structures with a single, simplified classification and wage rate structure, based on a “Caring Skills” benchmark rate. This should reduce award-based pay differentials for workers with similar qualifications doing similar work.

Current approaches

Aged Care

With IHACPA having taken on responsibilities for pricing aged care services, they have adapted their **activity-based costing** process for pricing public hospital services to residential and home-based aged care.

This broadly consists of developing a pricing framework, including pricing principles, regular consultation, cost and activity collection and then provision of pricing advice, usually on an annual cycle. As part of their commitment to transparency, most of the documents are publicly available, allowing stakeholders to understand how pricing advice has been arrived at.

In the case of **RAC**, their remit in respect of care costs and setting the AN-ACC price and NWAUs has led to a sequence of activities, the Residential Aged Care Data Insights Project (RACDIP) and Costing Pilot Study (RACCPs) followed by the Costing Study (RACCS 2023) and Cost Collection (RACCC 2024)³. The AN-ACC price, which remains **fixed**, as its predecessor the ACFI was, represents the average, sector-wide, cost per day to provide care for a resident. The Cost Collection activity includes a time and motion survey of a sample of residents in RAC facilities which is used to support the NWAUs that adjust that average cost to allow for the intensity of care needs of residents in each AN-ACC class. IHACPA have regularly provided Pricing Advice since 2023. While the underlying cost input information is broken down by workforce type, including capturing time spent with residents, it is not examined directly in terms of cost per hour of support. This information can be inferred from data supplied to the Department as part of mandatory reporting for RAC providers, such as the annual Aged Care Financial Report (ACFR) and the Quarterly Financial Report (QFR), which reports both costs and hours worked by workforce type.

For the forthcoming **SAH** program, IHACPA has followed the same cycle, conducting a Costing Study (SAHCS 2023) and Cost Collections (SAHCC 2024, SAHLDC 2025)⁴. They are also in the process of conducting their second round of consultation on the pricing framework (Independent Health and Aged Care Pricing Authority, 2025b). While the introduction of the Aged Care Act, and hence the SAH program, was delayed from 1 July 2025 to 1 November 2025, it is still currently intended that pricing will **transition from the current pricing freedom to capped unit prices**, based on IHACPA's pricing advice, from 1 July 2026 (Department of Health Disability and Ageing, 2025c).

CHSP will continue as a block-funded grant program until at least 1 July 2027, when it may be merged into the SAH program.

Disability

NDIA continues to apply their Annual Pricing Review cycle, although they have indicated they are *'committed to publishing a roadmap in the coming months outlining how future pricing reforms will be delivered'* as a result of the work of the Independent Pricing Committee (National Disability Insurance Agency, 2025b). There has been no explicit response to IHACPA's review of disability pricing – the report has been withheld from publication despite FOI requests (Independent Health and Aged Care Pricing Authority, 2025c). However, in his address to the National Press Club on 20 August announcing the Thriving Kids program, Minister Butler did allude to the prospect of further reform:

³ The RACCPs and RACCS 2023 reports are available on the IHACPA website. RACDIP and RACCC 2024 have not been published but are referenced on these sites respectively: [2022 National Conference Sessions](#) and [Aged care cost collection](#)

⁴ Similarly, The SAHCS23 report is available on the IHACPA website. SAHCC 2024 and SAHLDC 2025 are referenced here: [Consultation Paper on the Pricing Framework for Australian Support at Home Aged Care Services 2026–27](#)

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'There is real potential to introduce more pricing discipline within the scheme, drawing on the independent pricing experience in hospitals and aged care. As much as possible, the pricing of services across health and those 2 big care sectors should be aligned – to maximise efficiency and prevent distortion.' (The Hon Mark Butler MP, 2025)

Benchmarking

Complementary benchmarking continues to be a feature of the landscape, providing additional sources of data. IHACPA notes in the current SAH consultation *'Many stakeholders supported benchmarking of prices as a method to help bring equity in access, consistency and fairness across the in-home aged care, NDIS and DVA sectors.'* (Independent Health and Aged Care Pricing Authority, 2025b, p. 16). Organisations outside government publish benchmarking based on surveys of their own, such as the work of StewartBrown, an accounting firm, for both aged care and disability (StewartBrown, 2024, 2025a), and of Ability Roundtable, a disability services benchmarking group (Ability Roundtable, 2025).

In anticipation of the need for providers to reset prices for services to be provided under the forthcoming SAH program, DHDA surveyed providers regarding the prices they proposed to charge and published results in early 2025 (Department of Health and Aged Care, 2025b). At the same time DHDA published guidance for providers (Department of Health and Aged Care, 2025a) advising that *'Prices should correspond to your costs of delivering services. If they don't, government may consider your prices to be unreasonable'* and *'The Commission [ACQSC] may take action where you cannot demonstrate that pricing is reasonable.'* Following the delay of the transition from July to November, StewartBrown published their own survey of proposed prices in September 2025 (StewartBrown, 2025c).

Current price comparison

In the end, for one hour of someone coming to your home to help, current and near-term prices are summarised in the following table. In general, the prices shown are for weekday, daytime services provided to clients of 'standard' complexity/intensity in a metropolitan location. There are frequently loadings for non-standard hours, non-metropolitan service locations and for higher complexity service recipients, as a reflection of additional costs of service delivery.

It is notable that, for the current programs providing care at home, prices are in the same range, given the completely different methodologies used to determine them.

The outlier would seem to be the future SAH program. While the treatment of travel may seem to be a significant difference, travel is often not charged for the shift of an NDIS support worker, as the home where the care is delivered is effectively the usual place of work and the provider may not be required to pay for travel time in that case. This may be different for an aged care home care worker if it is more likely that they move between locations during a shift. The more significant driver of the price differential may be the changes in treatment of Package Management and Care Management in moving from HCP to SAH.

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Table 1 - Summary of current and near-term prices for one hour of support in the home (inclusive of consumer contribution where applicable)

Program	Effective Date	Price for one hour of support	Service Definition	Basis	Treatment of Management / Co-ordination	Treatment of Travel
NDIS	FY26	\$70.23	<i>Assistance With Self-Care Activities - Standard - Weekday Daytime</i>	Price limit (Base)	Doesn't include Plan Management or Support Co-ordination	Can be charged if to/from usual place of work and provider must pay the worker
CHSP	FY26	\$77.73	<i>Personal Care</i>	Average of upper and lower range (Unit Price and Client Contribution)	Not stated	Not to be reported in grant acquittal
HCP	30/06/2025	\$78.00	<i>Personal Care</i>	National Median	Doesn't include Care Management (up to 20% of package value) or Package Management (up to 10% of package value)	Can be charged in addition as Staff Travel 'if reasonable'
SAH (DHDA)	FY26	\$100.00	<i>Assistance with Self-care and Activities of Daily Living</i>	Indicative - median - survey	Includes Package Management and allows for Care Management being capped at 10%	Included in the Unit Price
SAH (StewartBrown)	from 1/11/2025	\$115.00	<i>Assistance with Self-care and Activities of Daily Living</i>	Indicative - median - survey	Includes Package Management and allows for Care Management being charged separately and capped at 10%	Included in the Unit Price

Sources: NDIS (National Disability Insurance Agency, 2025e); CHSP (Department of Health Disability and Ageing, 2025a; Department of Social Services, 2023); HCP (Department of Health and Aged Care, 2024); SAH (Department of Health and Aged Care, 2025a; Department of Health Disability and Ageing, 2025e; StewartBrown, 2025c)

Similarities, differences and considerations

Similarities and differences

There are increasing similarities in the services provided, the workforce and organisations providing the services, and some of the pricing arrangements. There are still meaningful differences, for example in service definitions as well as pricing approaches and governance of price setting policy.

Similarities include increasing alignment in the types of support provided (attendant care, personal care, domestic assistance), a broadly similar base workforce and types of qualifications required (for example the Certificate III in Individual Support has common core modules with elective disability or aged care specialisations) and increasingly harmonised award arrangements. The move to capped unit prices in SAH also increases alignment with NDIS arrangements.

However, differences remain. As shown above, service definitions are similar, but not the same. While unit price caps will be common across NDIS and SAH, prices for care are fixed in residential aged care (via the AN-ACC arrangements). Cost collections are taking place across residential aged care and Support at Home, but the NDIS pricing processes are not currently founded on cost collections. Governance of price setting arrangements for the NDIS and aged care are separate, with responsibility resting with the NDIA Board in case of the NDIS and with the Minister for Health in respect of aged care, based on advice from IHACPA. There are informal opportunities for disability and aged care pricing to be benchmarked against each other, but no formal obligation to do so.

Pricing considerations

There are many issues that warrant consideration in the pricing process that apply across both aged care and disability. A selection of these issues is briefly discussed in the following table. It is far from exhaustive, for example indexation of historical costs to determine a future price is not discussed, as this is covered in some detail in IHACPA's published pricing advice.

Table 2 – Some issues and considerations in the pricing process

Issue	Considerations
Unit of service	There are multiple considerations when establishing the unit of a service to be priced. Is it an 'all-in' price, such that an hour of face-to-face service delivery includes all non-direct associated activity (such as travel, administration, record keeping), or can each of these components be charged separately? Is the unit always an hour, or other time unit (such as a day, a week), or should it be a 'session' or appointment, to allow for some variation in duration around a standard period of service? What is the relationship between session time and any fixed overhead costs? Should the unit for a travel component be time or distance, or some combination of both?
Overall scope of costs	The scope of costs to be included in the price must be carefully defined. For episodes of care in public hospital IHACPA provides the Australian Hospital Patient Costing Standards (Independent Health and Aged Care Pricing Authority, 2025a) which guide contributors on standards, business rules and

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Issue	Considerations
	costing guidelines. For RAC and HCP, the items included in the scope tend to be defined with reference to the line items in the ACFR. This level of reporting does not exist for CHSP or NDIA. For CHSP, the initial costing study conducted by IHACPA (SAHCS 2023) included a Data Request Specification, which guided providers on the costs to be included. For NDIA, total in-scope costs are not collected due to the different methodology adopted. The general intention across all programs is for the costs to be the ‘fully loaded’ cost of delivery. One of the key challenges has been determining the share of administrative and corporate overheads that should be attributed to the in-scope service costs to determine the price. A variety of methods are used, and approaches change over time, which means to date there has been limited consistency overall.
Methodology	The choice of pricing methodology is fundamental. Where costing is undertaken, we have seen two main approaches: survey-based ‘activity based costing’ where activity and costs are collected in respect of units of service (an hour, a bed day) for different classes/types and a more bottom up (or normative) approach, where a model is constructed and input parameters calibrated to survey data. The ‘activity-based costing’ approach adopted by IHACPA for RAC also uses the sector-wide administrative data to weight the survey results to be nationally representative. Differences in methodology can make results difficult to directly compare. For example, the NDIA DSW uses the SCHADS award rates as a base input, whereas the IHACPA method captures actual costs, including both award and above award rates (such as those in Enterprise Bargaining Agreements (EBAs)). In the RAC process, IHACPA also explicitly ‘trims’ out providers that appear to be paying extremely high or low hourly rates. (Independent Health and Aged Care Pricing Authority, 2025d; National Disability Insurance Agency, 2025a, 2025c)
Cost and activity collections	The methodologies for the cost and activity data collections are also fundamental. For RAC, the methods used since RUCS have attempted to capture time spent by different staff types with individual residents, using various technologies such as barcode scanning and proximity beacons, as well as direct observation and manual recording. Manual recording is relatively expensive and intrusive, but may be more reliable than the automated technology (Eagar K et al., 2019; Scyne Advisory, 2023). For HCP and SAH the unit to be priced is the service and is not differentiated by the individual receiving the service. This means that the key challenge is attributing costs to activities delivered. For all collections, data quality becomes a key concern, and approaches need to be developed to deal with apparently anomalous data.
Treatment of Care Management and Package Management	We noted above some of changes in treatment of Package Management and Care Management costs in the current HCP arrangements and forthcoming SAH program. Although not a perfect analogy, Plan Management in the NDIA could be considered comparable to Package Management, as it deals with review and processing of invoices and payments. The broad equivalent of Care Management in the NDIA could be Support Co-ordination, which sources and

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Issue	Considerations
	arranges providers of different services as well as support and co-ordination of assessment of changes in circumstances. Plan Management and Support Co-ordination each only represent 2.3% of total spending for plan managed participants (National Disability Insurance Agency, 2025f), so, given the significant difference in the magnitude of these costs compared to HCP, there may also be issues related to different approaches to the allocation of administrative overheads to the cost of direct service delivery which means these are not comparable. There may also be differences in the business models of the organisations delivering in the two systems.
Treatment of overheads	As raised above, this is a key question in developing prices, irrespective of methodology. Accurate recording of overheads that are attributable to the activity being priced can be challenging, especially where an entity offers both in-scope and out-of-scope services, which is not unusual in the disability and aged care sectors. <i>StewartBrown notes ‘The individual residential and home care segment results are more variable due to the extent of the data provided and the methodology around making segment allocations being inconsistent between providers as there is [sic] no strict criteria for determining segment revenue and expense allocations. This is also relevant in relation to the allocation of corporate administration between segments, with some providers allocating all corporate costs to each business segment and others only allocating a portion, with the balance being included in the “Other” segment. The allocation methodology between segments is also inconsistent.’ (StewartBrown, 2025a, p. 20)</i>
Allocation methods	This is another foundational question in costing processes. Once you have determined what needs to be allocated, the selection of cost drivers to drive the allocation is required. In RAC, IHACPA has used time but, where appropriate, occupied bed days or available bed days, to drive most allocations (Scyne Advisory, 2023). While staff time is the major component of costs, allocation methods may be required for enabling costs, such as vehicles, IT, finance and the like, as well as administrative and corporate overheads.
Utilisation and the ‘billable hour’	The ‘fully loaded’ or ‘billable’ hour of service must also incorporate an allowance for ‘utilisation’ of staff. Attendant care worker time, after allowance for training and leave, may not be fully utilised in service delivery, but some staff will still need to be paid, depending on their employment arrangements. Some providers may be more efficient at scheduling, or be busier overall, and so operate with higher utilisation than other providers. Depending on the pricing approach, care needs to be taken not to unintentionally incentivise poorer performance in this regard, as it may lead to a cycle of increasing cost per hour of service delivered.
Treatment of capital costs	In RAC, costs and funding are separated into three main streams, care, labelling and accommodation. Capital costs are addressed in the accommodation stream⁵. So care costs funded through AN-ACC are exclusive of capital costs (with the possible exception of what might get passed through as part of ‘corporate recharge’).

⁵ Notably, capital costs are excluded from IHACPA’s work on public hospital funding (Create Health Advisory, & Duckett, S. (2025). *The Growth and Drivers of Australian Public Hospital Costs and Prices*. A. B. o. Treasurers. https://www.treasury.sa.gov.au/_data/assets/pdf_file/0006/1191165/Duckett-Report-Growth-Drivers-Australian-Public-Hospital-Costs-Prices.pdf) and this approach has been carried over to RAC.

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Issue	Considerations
	This is not feasible for the home-based care programs, as they don't have other in-scope revenue streams from which to recover capital costs. While their capital costs are likely substantially lower (office accommodation, vehicles and the like), the costs are or will need to be incorporated into the relevant prices.
Treatment of margin	When IHACPA took on aged care pricing responsibilities, they had not previously had to deal with a mix of public, for profit and not for profit providers. Their work for public hospitals meant that price could be set in line with cost, with no explicit allowance for a margin between the two. Currently the AN-ACC price in residential aged care is also set equal to cost, with no allowance for margin. The implication is that required margins (such as return on capital) can be earned in the hotelling and accommodation streams, which, as noted above, is where the vast majority of capital costs lie. The NDIS has had a mixed provider market since inception, and the NDIA has made explicit allowance for a margin in the DSW set at 2% which equates to a rate of return of 8.0% against working capital that has been estimated to be equivalent to three month's wages and entitlements (National Disability Insurance Agency, 2025c). While cost collection for Support at Home has commenced, prices have not yet been published, IHACPA guidance to date is silent on what the approach to determining margin might be. However, DHDA has stated in current guidance to providers on price setting that they can include '<i>a margin to cover the cost of capital used in delivering the service</i>' (Department of Health and Aged Care, 2025a). StewartBrown has reported (StewartBrown, 2025b) that a more significant margin will be required to make the respective sectors 'investable'.
Tax issues: the example of payroll tax	A related issue in a mixed provider market, is the treatment of payroll tax, as only some providers will be liable to pay this. Payroll tax is excluded from both NDIA's DSW Model and IHACPA's approach to pricing RAC. NDIA has noted this disadvantages for-profit providers but hasn't proposed a change to their practice (National Disability Insurance Agency, 2021, p. 79). IHACPA has noted that '<i>The state and territory governments remain responsible for the policies regarding payroll tax, and thus [it] remains out of scope for IHACPA's pricing advice.</i>' (Independent Health and Aged Care Pricing Authority, 2024b, p. 29)
Pricing features	Finally, in addition to the type of service, there will be additional features of service delivery, such as the location or time of day of service delivery, the complexity of the client, staff-to-client ratio that may warrant additional pricing factors to allow for the increased/decreased cost of delivering a unit of service.
Setting the price point within the range	On the other hand, once warranted differentials have been allowed for, there will still be variation in the unit cost data for a given service type, due to variation in business practices and efficiencies. If a single price point is to be determined (whether as a fixed price, a cap or otherwise) a basis for this must be determined. IHACPA sets the 'efficient price' in public hospitals as the average weighted cost for the activity, and this method has been applied in RAC pricing advice (Independent Health and Aged Care Pricing Authority, 2025d). NDIA historically considered that an 'efficient' price for DSW services could be at 25th percentile (National Disability Insurance Agency, 2020). To encourage

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Issue	Considerations
	supply, NDIA has also used a strategy of setting price at the 75 th percentile, in the case of therapy supports for example (NDIS Review, 2023, p. 29).

Data considerations

A further key area for consideration is data – sources, availability and quality. Each of the current programs currently collects different types of data in different ways and to different extents.

Table 3 – Comparison of data sources and availability for current programs

Program	Costs to deliver	Activity levels	Activity based costing
CHSP	Not universally collected. Surveys have been conducted (e.g. IHACPA SAHCS23).	Collected at unit level via the Data Exchange (DEX) by DSS.	Undertaken in the SAHCS 2023, but out of scope in subsequent cost collections.
HCP	Collected by line item at provider level through ACFR and QFR. Surveys and benchmarking have been conducted.	Reported to clients via Monthly Care Statements. Not universally reported to government. Surveys have been conducted (DHDA and IHACPA).	Undertaken by IHACPA on a sample.
RAC	Collected by line item at facility level through ACFR and QFR. Surveys and benchmarking have been conducted.	Represented by resident AN-ACC class days.	Undertaken by IHACPA on a sample.
NDIS	Not universally collected. Surveys and benchmarking have been conducted (e.g. FBS, Ability Roundtable etc).	Represented by line item claims reported to NDIA.	Not undertaken by government.

Legend:

Data availability assessment	Good	Reasonable	Partial	Not available
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This means that for CHSP there is a detailed record of activity, but limited visibility of costs. Whereas for HCP government receives financial statements at Approved Provider level in some line item detail, but no meaningful record of activities, even though this exists, and is provided to care recipients via the Monthly Care Statements. For RAC similarly, government receives financial statements at Approved Provider level in some line item detail but also has a record of bed days by AN-ACC class – the time & motion data collections make the connection between costs and activities at an individual resident level. Finally for NDIS, the NDIA has a detailed record of activity (with some gaps, e.g. self-managed participants), but has very limited visibility on costs, and doesn't explicitly undertake activity-based costing.

Impacts and opportunities

This diversity of approaches likely has a number of impacts.

Firstly, while it is reasonable for government to have different funding arrangements for like services, it is more problematic if government fails to exercise its buying power effectively and pays (or subsidises) different prices for identical, or at the least, very similar services.

As a result, providers and their workforce will likely respond to differing price signals from the different programs and direct capacity to the program that is most remunerative, which is a reasonable response. However, this could lead to government effectively competing against itself, resulting in the potential for a cycle of upward pressure on prices.

Anchoring is also likely to have an impact. It has already been noted that price caps operate as an anchor in the NDIS. Given the planned pricing for SAH reported by DHDA (\$100 per hour) and Stewart Brown (\$115 per hour), compared to the median cost reported for Personal Care in IHACPA's SAHCS 2023 of \$82 (Ernst & Young, 2023, p. 27), there is a risk that there is pressure for these higher prices to become the anchor when capped unit pricing is implemented for SAH from 1 July 2026.

Each of these impacts could further threaten the sustainability of the schemes.

This review has also identified a number of opportunities. The potential benefits arising from harmonisation across other aspects of the 'care economy' – workforce, quality and safety, compliance, IT systems – also apply to pricing.

For example, with the SAH program moving to capped unit prices with billing in arrears, the program may retain the cost reporting requirements of HCP while being enhanced by the unit-level activity reporting approach of NDIA, to produce an administrative dataset that could support potentially direct activity-based costing.

Within the current policy settings for pricing, each program could work towards combining aspects that are already in existence, such as sector-wide cost collection (for a representative sample or for all providers), activity based costing and 'normative' modelling on 'typical' providers and case-mix/service mix (of which the DSW Model is an example), along with holistic market monitoring of service availability⁶.

This may enable the integration of data across programs and, by drawing on multiple, complementary methods, drive a comprehensive understanding of costs in a consistent way across sectors, allowing for differences where appropriate. From this base, pricing consistency for government can be better assured, whichever pricing or funding model is applied.

In addition, the reduction in duplication (avoiding each program benchmarking against the others) and in data collection (collecting once and using many times) should reduce the overall administrative expenditure on costing and pricing for government.

Pricing holistically across the care economy should minimise the risk of perverse outcomes, unintended drivers of excessive cost inflation and cannibalisation of a workforce where demand continues to exceed supply (Jobs and Skills Australia, 2024). Actuaries should have a significant role to play in deeply understanding these costs and also designing the features of these or any alternative pricing arrangements that can influence good outcomes and minimise perverse incentives.

⁶ The Care Sector Demand Map is an example of both the possibilities and the current constraints. It brings together service usage data from NDIS and aged care to help providers plan in a more joined up way, but each program still needs to be searched separately ([Care Sector Demand Map | Department of Social Services, Australian Government](#)).

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