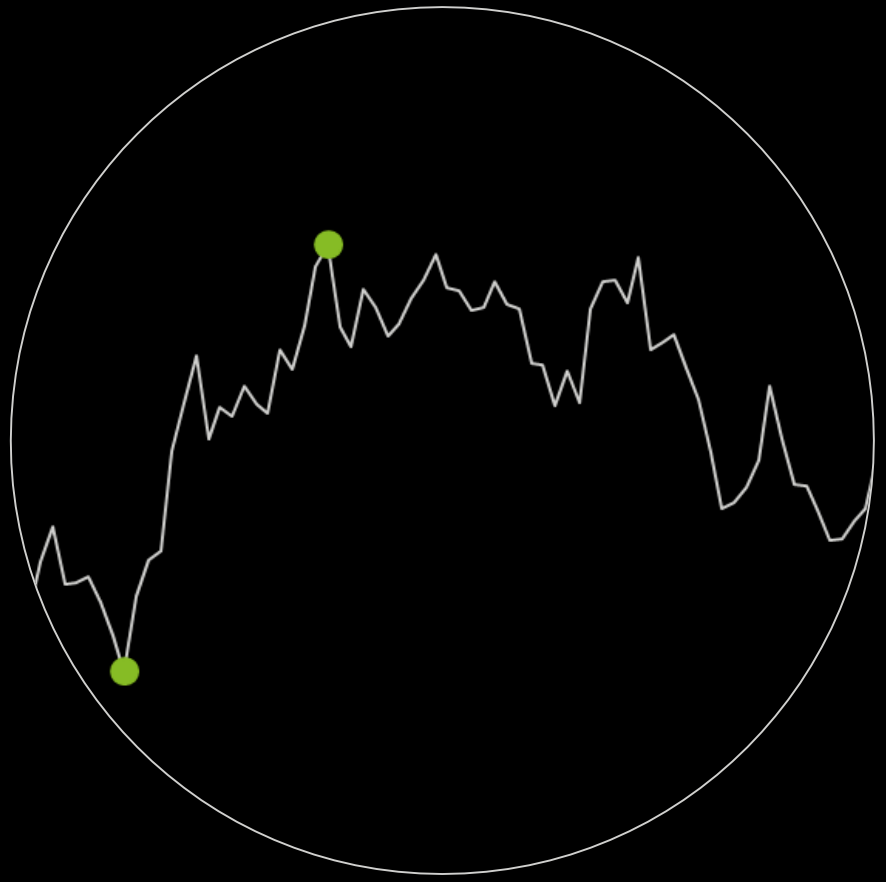


# Commonwealth Home Support Programme Data Study

Department of Health

October 2020

# Contents

# Glossary

| Acronym | Full name |
|---|---|
| ABS | Australian Bureau of Statistics |
| ACAT | Aged Care Assessment Team |
| ACPR | Aged Care Planning Region |
| ACT | Australian Capital Territory |
| ASGS-RA | Australian Statistical Geographic Standard Remoteness Area |
| AWP | Activity Work Plan |
| CALD | Culturally and linguistically diverse |
| CHSP | Commonwealth Home Support Programme |
| DEX | Data Exchange |
| DSS | Department of Social Services |
| DVA | Department of Veterans Affairs |
| FAM | Funding Arrangement Manager |
| HACC | Home and Community Care |
| HCP | Home Care Package |
| LGBTI | An umbrella acronym for clients who have indicated they are non-heterosexual or have a non-binary sex or gender identity |
| IRSD | Index of Relative Socioeconomic Disadvantage |
| NSAF | National Screening and Assessment Form |
| NSW | New South Wales |
| NT | Northern Territory |
| QLD | Queensland |
| RAS | Regional Assessment Service |
| SA | South Australia |
| SA2 | Statistical Area Level 2 |
| SDAC | Survey of Disability, Ageing and Carers |
| SEIFA | Socioeconomic Indexes for Areas |
| TAS | Tasmania |
| VIC | Victoria |
| WA | Western Australia |

# Glossary

| Service type name | Service type abbreviation |
|---|---|
| Assistance with Care and Housing | ACH |
| Allied Health and Therapy Services | AHT |
| Centre-based Respite | CBR |
| Cottage Respite | CR |
| Domestic Assistance | DA |
| Flexible Respite | FR |
| Goods, Equipment and Assistive Technology | GE&AT |
| Home Maintenance | HMa |
| Home Modifications | HMo |
| Meals | M |
| Nursing | N |
| Other Food Services | OFS |
| Personal Care | PC |
| Social Support - Group | SS-G |
| Social Support - Individual | SS-I |
| Specialised Support Services | SSS |
| Transport | T |

# Data quality and limitations

Data quality issues impacted on the analysis that could be undertaken within the CHSP Data Study. While this list is not exhaustive, some specific examples include:

- There were instances of unit prices that were inaccurate, such as an hour of Nursing or Allied Health and Therapy being delivered for less than one dollar per hour. To remove instances of inaccurate unit prices, upper and lower bounds were specified on both the variation in funding and expenditure, and the variation in planned output and delivered output. The optimum range was determined by aggregating the funding and output acquittals nationally and testing ranges that removed outlier unit price values and preserved sample size.

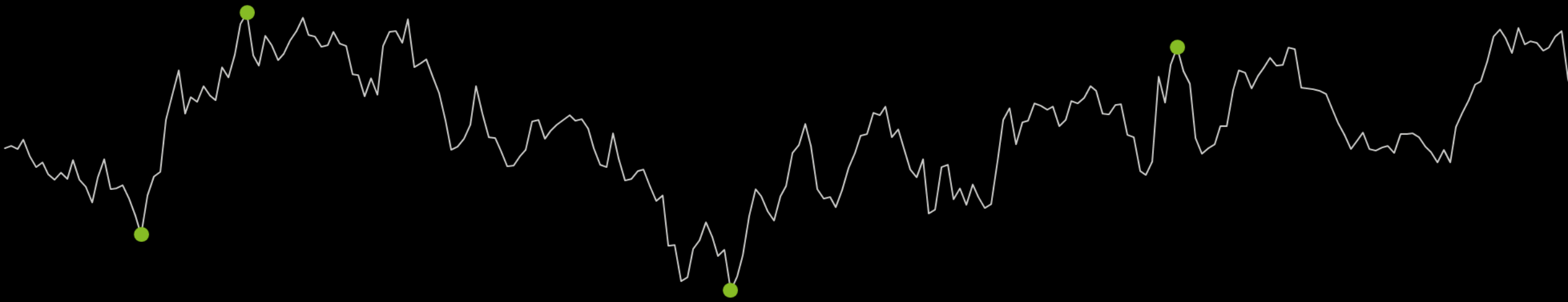
- Coverage of special needs groups in DEX meant that only the characteristics of some special needs groups could be analysed. It is likely that coverage of some special needs groups in DEX and NSAF Assessment data are under-recorded, and therefore the data in this report may not be representative of all clients.

- Further, a substantial proportion of clients were receiving services prior to the change to the nationally consistent screening and assessment process, as implemented in the NSAF Assessment data. Consequently, analyses based on these characteristics are not likely to be representative of all CHSP clients.

- Public reporting by the Aged Care Financing Authority (ACFA) quoted total CHSP funding at approximately $2.6 billion. In this report, analysis has been included based on $2.4 billion of total funding. The reason for the difference is due to the construction of the database used as the source for the analysis in this section. To construct funding and expenditure at an ACPR level, two separate AWP workbooks were merged and then joined to the DEX data. One of these had fewer providers than in the AWP tracking workbook or the DEX data, and consequently some providers were excluded from the analysis where their funding and service delivery could not be matched together.

- Similarly, complete survey data were only available for a subset of all providers (863 out of 1,458 providers funded to deliver services).

Data limitations should be considered when drawing conclusions from the analysis and data presented in this report.



# Executive summary.

Overview of findings

# Executive summary

**Context**
The Commonwealth Home Support Programme (CHSP) is a national aged care service designed to provide entry-level support for people still in their home and community who require either long-term low levels of support or short-term higher levels of support.

The Commonwealth Department of Health engaged Deloitte Access Economics to conduct a data study of the CHSP with a view to better understand the drivers of variation in the CHSP across states and territories, markets and consumer groups. This report presents the highlights and key patterns that emerged from the analysis. The analysis will be used by the Department to inform current and future policy development.

The data used in this study are described in Appendix A. Most of the analysis in the report focuses on 2018-19, which represents the most recent complete year of data available at the time of preparing this report.

**Client profile and demand**
In 2018-19, there were 840,984 clients in the CHSP, or approximately 209 individuals per 1,000 people in the target population. These clients can access 17 different primary types of services, ranging from assistance at home to social supports within the community. The profile of CHSP clients is characterised by:

- The majority (65%) of CHSP clients are women. CHSP has a lower share of clients over 85 years old (32%) relative to the Home Care Package (HCP) Program (42%) and permanent residential care (59%).
- On a per capita basis, clients with special needs may be underrepresented in the CHSP, to the extent data permits analysis for these special needs groups, which comprise: people identifying as Aboriginal and Torres Strait Islander or from culturally and linguistically diverse (CALD) backgrounds; veterans or their spouses; and clients with a disability. It is however noted that there are specific programs such as the National Aboriginal and Torres Strait Islander Flexible Care Program and programs delivered by the Department of Veterans' Affairs which impact on the use of CHSP.
- There is a negative relationship between the number of CHSP clients per 1,000 target population and socioeconomic status. This indicates that areas with relatively low socioeconomic conditions, are associated with higher rates of CHSP use among the target population.
- The top three most common service types used by clients in 2018-19 were Domestic Assistance (330,000 clients), Allied Health and Therapy Services (245,000) and Transport (175,000). However, the services with the highest number of sessions per client were Personal Care (55 per client in 2018-19) and Meals (48 per client) (see Chart i and Chart ii).
- Some services are typically accessed in higher session volumes, driving large differences in the number of sessions by service type (e.g. Meals and Domestic Assistance). Other service types tend to exhibit more short term, non-ongoing use than others (e.g. Assistance with Care and Housing). A session is effectively an instance of service delivery. Clients can receive multiple sessions of a service in a year.

**Chart i Number of distinct clients per service type ('000s), 2018-19**

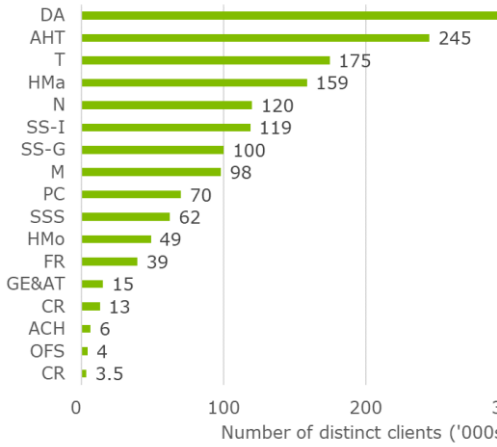
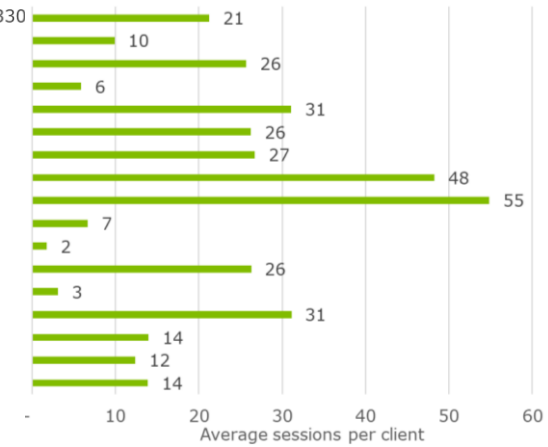



**Chart ii Sessions per client per service type, 2018-19**




Source: Deloitte Access Economics Analysis of DEX (2019).

- CHSP service outputs are measured in terms of hours, quantity or dollars. There is variation in outputs per client across states and territories, whether that be in terms of cost, hours or quantity. Some of the variation is explained by the availability of services in each location.

# Executive summary

- Certain client characteristics are likely to predict the value of services delivered. Functional limitations (e.g. need for assistance with self-care or mobility) and certain primary health conditions (e.g. dementia, cognitive impairment, stroke) are associated with a noticeably higher value of services used in 2018-19. Certain conditions such as sight loss, depression/anxiety, cognitive impairment, frequent falls, brain injury, diabetes, and asthma were not noticeably different. In some cases people with the condition used a lower value of services.

- While there are some limitations in the data for special needs group, the data may suggest Aboriginal and Torres Strait Islander clients receive more services ($3,950 compared to $2,800). On average, women received services worth $2,950 compared to $2,530 for men. As could be expected, the average annual value also increases with age from 65 years old.

- The number of clients requiring CHSP services is expected to grow from around 840,000 people in 2018-19 to around 1.17 million by 2028-29. The way in which they access services is predicted to remain relatively stable over the forecast period.

- In aggregate, 35.4 million hours of care were provided in 2018-19 (noting this excludes output from services measured in either quantity or dollars), which was estimated to increase to 47.3 million hours of care by 2028-29.

**Supplier landscape**

In 2018-19 there were 1,458 providers funded to deliver CHSP services.[1] CHSP services were delivered by a diverse group of service providers: for-profit (8%), not-for-profit (60%) and government (32%), each of whom deliver a unique mix of services. On average, each provider operates between 1.8 and 3.0 outlets, which are the physical locations providers deliver services to clients from, depending on the state or territory where they are located.

NSW had the most providers (447), which was followed by Victoria (369) and Queensland (304). The ACT and NT had 34 and 39 service providers respectively. These patterns reflect the broader distribution of clients across Australia.

**Funding**

In 2018-19, $2.39bn in funding was allocated to providers (where service provision data were also available) across Australia under CHSP funding streams.[2] More than half of funding was for the combination of Domestic Assistance ($488m), Nursing ($271m), Social Support – Group ($271m) and for Allied Health and Therapy Services ($234m). Funding ranged from $4m for Other Food Services at the low end of the range (see chart iii).

By state and territory, 29% of funding was allocated to NSW, 25% to Victoria and 22% to Queensland. SA, Tasmania, ACT and NT, received less than 10%, while WA received 10% (chart iv). Average funding per client ranged from $1,592 in SA to $5,548 in the NT, while funding per unit of output ranged from $22 in NSW to $43 in Victoria in 2018-19.

**Chart iii Funding by service type ($m), 2018-19**

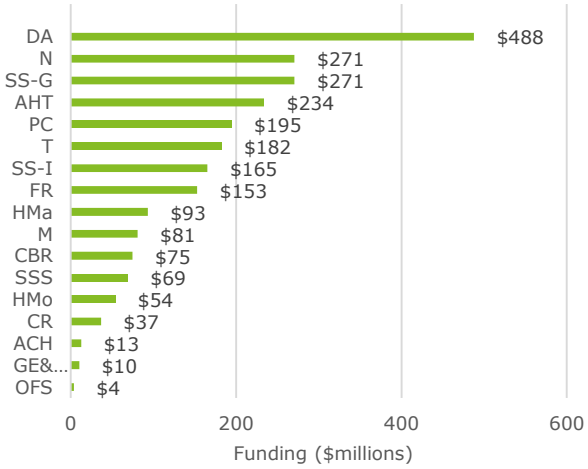
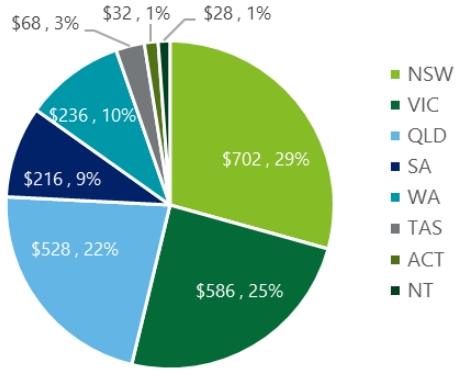



**Chart iv Funding by state and territory ($m), 2018-19**




Source: Deloitte Access Economics Analysis of CHSP funding data.

**Discussion**

The CHSP aims to deliver entry level, nationally consistent aged care services to support people to remain living at home and in their communities. There will always be inherent variability in a program which supports over 800,000 people, with 17 different service types supplied by 1,455 providers across Australia.

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1. 79 providers were excluded from the analysis as it was not possible to link between available expenditure data and service provision data (these linking errors occur because of name and organisation ID discrepancies between datasets). Analyses in the report were therefore conducted for the remaining 1,379 providers in 2018-19.

2. Public reporting by the Aged Care Financing Authority (ACFA) quoted total CHSP funding at approximately $2.6 billion. The reason for the difference is due to the construction of the database used as the source for the analysis in this section.

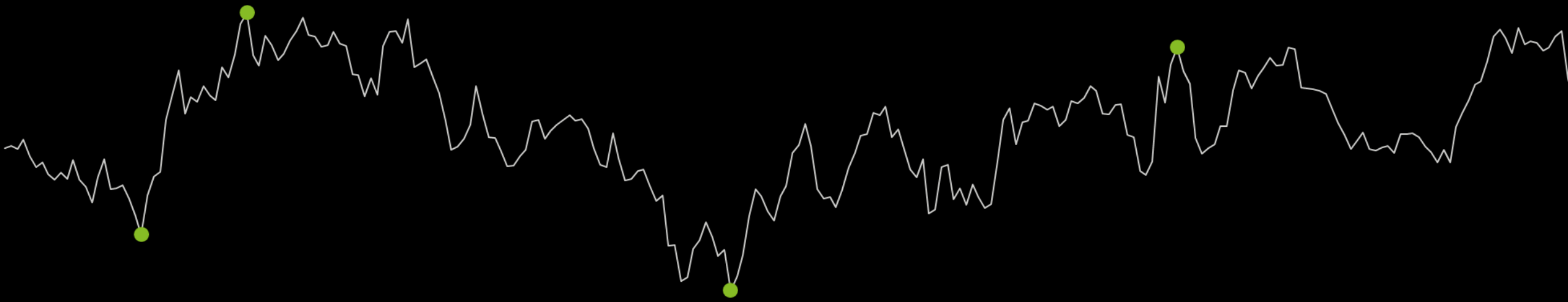
# Executive summary

In November 2019, in response to the Interim Report from the Royal Commission into Aged Care Quality and Safety, the Australian Government announced its intention to establish a single unified system to support care for elderly in the home, which will replace the existing CHSP and HCP. This analysis highlights important areas of consideration for future reform.

Efforts to improve the national consistency in service delivery need to overcome two key limiting factors which were raised by stakeholders during consultations. The HACC Program legacy continues to influence how CHSP services are delivered in regard to wellness and reablement – which maximises clients' autonomy and enables them to remain living independently in their own homes, as well as other factors such as the duration and volume of services, client contributions, and provider knowledge of their supply costs. The analysis in Section 3 highlights the current variation in the volume of services delivered per client between locations and service providers while Section 4 highlights how planned funding relative to output delivered, number of clients and sessions differ between states and territories. Section 5 looks at interaction between supply, demand and prices.

While most service types had a surplus of funding relative to the expended amount, most service providers also reported an output deficit, where delivered output was less than planned output. Furthermore, the available data showed a wide variation in unit prices charged by providers and actual unit price of services delivered was higher than the funded unit price across all service types. This may in part be due to a lack of consistency in how outputs are reported to the Department, for example whether all outputs are being recorded, or just the funded outputs. Further work is required to understand the cost of service delivery in the CHSP, including how it varies across states and territories and small areas.

**Deloitte Access Economics**



# Introduction.

Context and report outline

# Introduction

## History and objectives

The Commonwealth Home Support Programme (CHSP) is a national aged care service designed to provide entry-level support for people still in their home and community who require either long-term low levels of support or short-term higher levels of support. The CHSP offers entry-level support to people aged 65 years and older, and 50 years and older for Aboriginal and Torres Strait Islander people. The objectives of the CHSP are to:

- Support clients to delay (or avoid altogether) the need to move into more complex aged care
- Ensure that all clients have equal access to services
- Facilitate client choice and provide flexible timely services
- Provide a standardised assessment process which encompasses a holistic view of client needs.

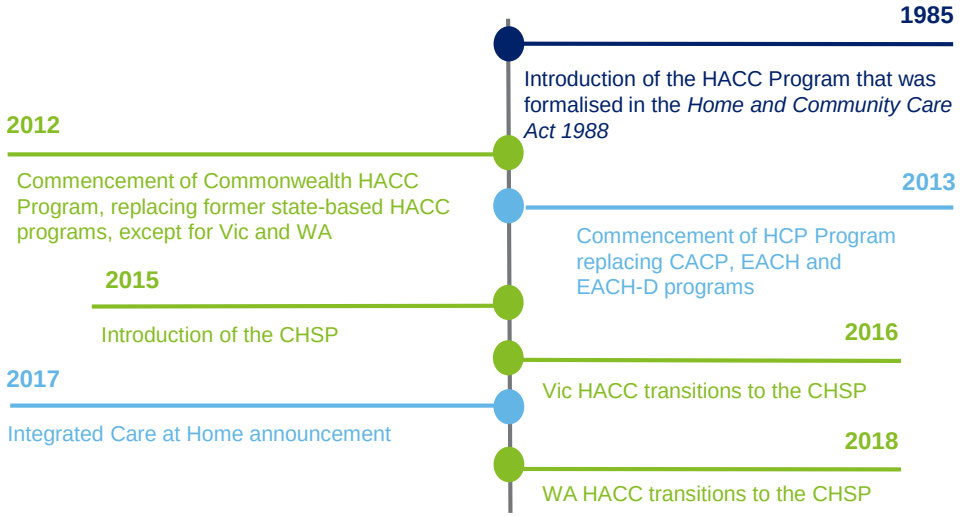
The CHSP commenced operation in July 2015 and arose from an amalgamation of four other aged care programs, including the Commonwealth Home and Community Care (HACC) program, the National Respite for Carers Programme, the Day Therapy Centres Program, and the Assistance with Care and Housing for the Aged Program. Most states and territories transitioned from the HACC in July 2015, except for Victoria transitioning in July 2016 and WA transitioning in July 2018. Since WA's transition, the CHSP has been a national program (see Figure 1).

People who are still able to live in their home but require an additional level of support that the CHSP does not offer are expected to get support through the Home Care Package (HCP) Program, the next tier of support. The HCP Program offers four levels of packages, depending on the level of support required.

In November 2019, in response to the Interim Report from the Royal Commission into Aged Care Quality and Safety, the Australian Government announced its intention to establish a single unified system to support care for elderly in the home, which will replace the existing CHSP and HCP. Funding for CHSP has been extended while Government continues to consider design and transition options for the integrated program.[3]

The CHSP today demonstrates national program standards and guidelines, however, in many ways is still a product of the differentiated way in which the HACC Program was administered in each state and territory. These differences include aspects of service delivery, service access and availability, cost of operations and client contributions. The future design and continued evolution of the program is contingent on developing an evidence-based understanding of these differences and drivers.

**Figure 1 Overview of recent care at home reforms**

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3. While the HCP Program is outside the scope of this report, the interaction between the two programs has also been briefly considered (see page 32).

# Introduction

## Structure of the report

**About the study**
The Commonwealth Department of Health engaged Deloitte Access Economics to conduct a analysis of the CHSP with a view to better understanding the points and drivers of variation in the CHSP across states and territories, markets and consumer groups. The study aims to contribute to the evidence base in relation to the CHSP, its alignment with the Home Care Packages Program, and care at home reform more broadly, and will be used by the Department to inform current and future policy development. This report summarises findings that emerged from the analysis.

The study was conducted primarily through analysis of the large administrative datasets held by the Department. Over the course of the study, the data has been supplemented with primary evidence collected through a survey of providers and consultation with state and territory health and ageing representatives.

**This report**
This report presents a selection of the analysis that was undertaken, and is intended to summarise the key findings that emerged from more detailed data analysis. The report is structured in the following way:

1. **Client profile**: investigates the key characteristics of CHSP clients and how these align with the target population in terms of access to the CHSP.
2. **Demand profile:** analyses demand for entry-level care in the home in Australia, which looks at a summary of which services are recommended and how clients use the CHSP.
3. **Supplier landscape:** investigates the key characteristics of CHSP service providers and the clients they serve; and examines markets where clients experience greater challenges in accessing the CHSP.
4. **Service provider survey results:** outlines the results of the service provider survey, which was a key source of primary data analysed as part of this study. The results of the survey were used to support findings observed through the analysis of the administrative datasets.
5. **Funding, expenditure and unit prices:** investigates the key characteristics of funding, expenditure and unit pricing in the CHSP.

Throughout the report, service types are described as acronyms where appropriate for readability. Most of the analysis in the report focuses on 2018-19, which represents the most recent complete year of data available at the time of preparing this report.

### Report structure

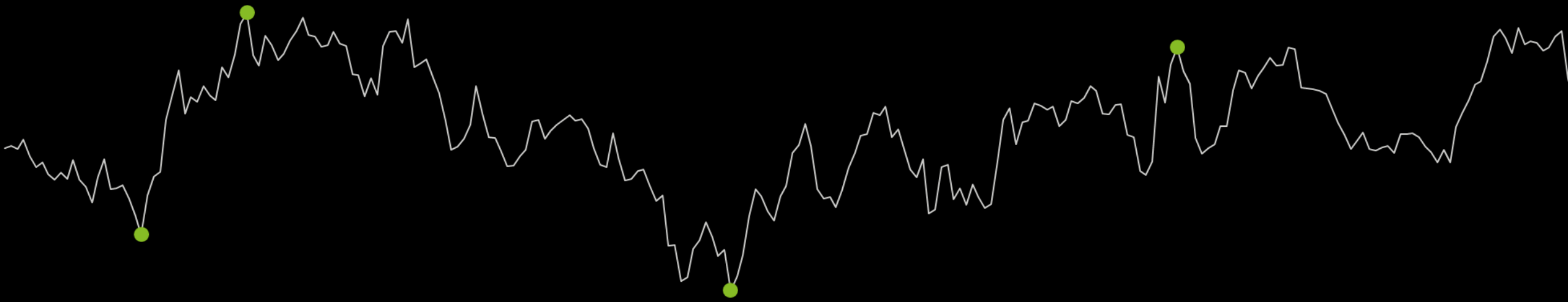
**1 Client profile**

**2 Demand profile**

**3 Supplier landscape**

**4 Service provider survey results**

**5 Funding, expenditure and unit prices**



# 1 Client profile.

Who accesses CHSP services?

# Who is using the CHSP

## Clients by age and sex

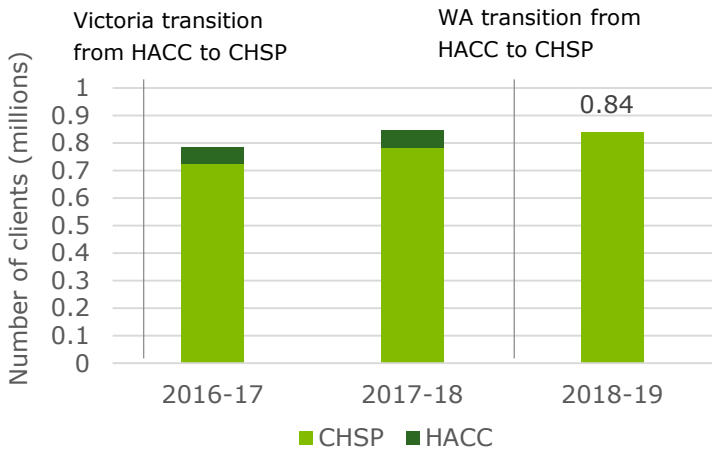
## Analysis

From 2016-17 to 2018-19, the number of people using the CHSP in Australia increased by 7%. As Western Australia (WA) HACC transitioned to the CHSP on 1 July 2018, the total number of CHSP-only clients was comparable to the combined total across the CHSP and the HACC Program in 2017-18.

Of the 840,984 clients who used the CHSP in 2018-19, two thirds were female, and one third were male, largely reflecting the underlying demographics of the population groups.

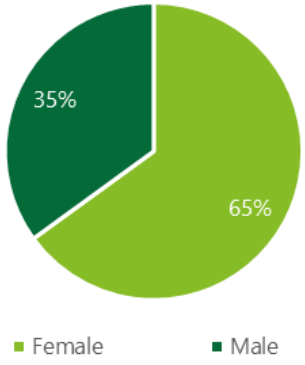
The age distribution* of CHSP clients has remained stable over time. The CHSP has a lower share of clients over 85 years old (32%) relative to HCP (42%) and permanent residential care (59%). This is consistent with the historic trend of clients over 85 accessing higher levels of support on average.

**Chart 1.1 Number of people using the CHSP and HACC (millions)**



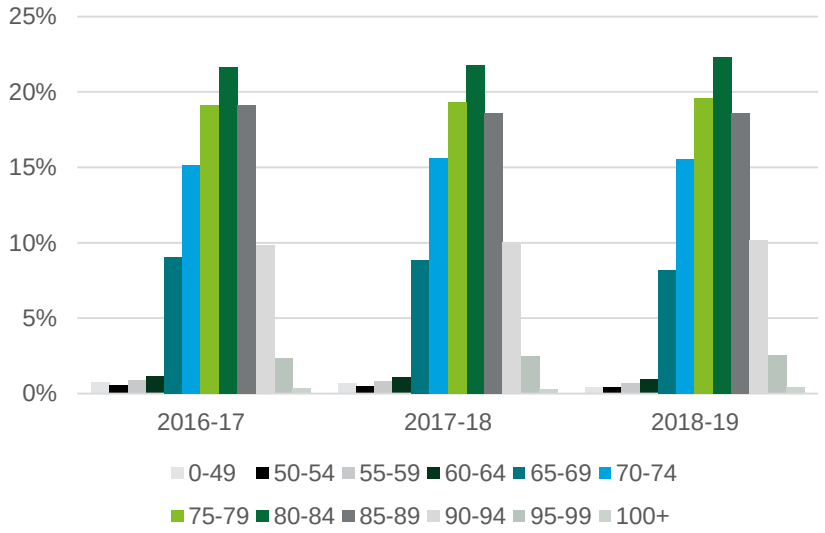

Source: Deloitte Access Economics Analysis of DEX (2019)

**Chart 1.2 Sex of people using the CHSP, 2018-19**




Source: Deloitte Access Economics Analysis of DEX (2019)

**Chart 1.3 Age of people using the CHSP, 2016-17 to 2018-19**




*Note: The CHSP also provides support to prematurely aged people 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) on a low income who are homeless or at risk of homelessness. In exceptional circumstances, CHSP services may also be provided to people outside the target group criteria that need assistance with daily living at home and in the community.

# Who and where

## Clients by state and territory

## Analysis

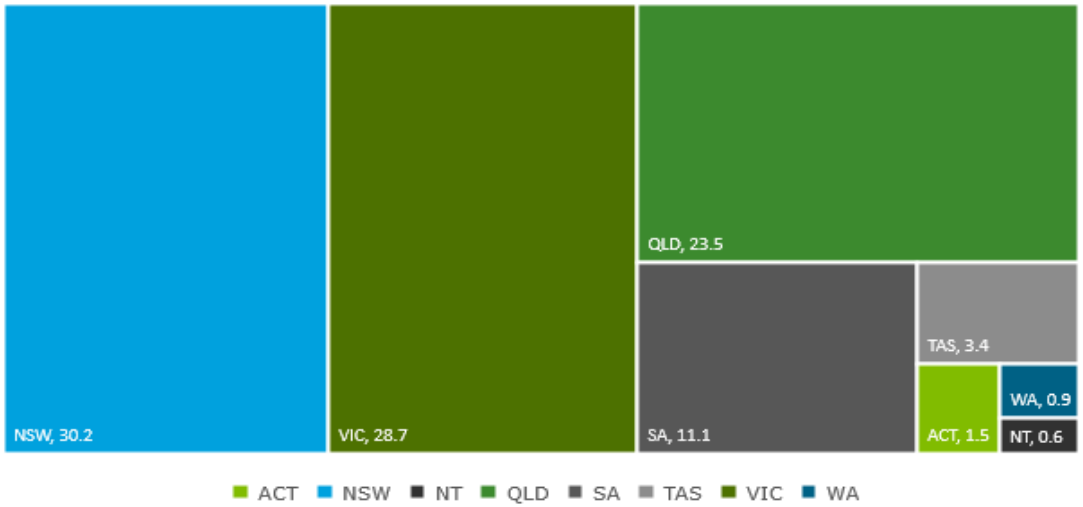
The distribution of CHSP clients across states and territories is reasonably reflective of the distribution of the target population across these regions (Chart 1.4).

The share of NSW CHSP clients (28%) relative to the share of the population aged 65 years and older living in NSW (33%) is noticeably lower than other states.

The age group 65 years and older makes up a larger share of the populations in SA and Tasmania (19% and 21%, respectively) compared to the national average of 16%.

The number of clients declined slightly in ACT, NT and Queensland in 2018-19, but grew in all other locations. The number of clients in WA grew substantially in 2018-19 as new programs were rolled into the CHSP over that year.

**Chart 1.4 State and territory proportion (%) of total clients, 2017-18**




Source: Deloitte Access Economics Analysis of DEX (2019)

**Table 1.1 Distribution of target population and client population by state, 2018-19**

| State or territory | Target population ('000s) | % of Australian population (aged 65 yrs+) | % of state/territory population (aged 65 yrs+) | % of total CHSP clients |
|---|---|---|---|---|
| NSW | 1,350 | 33% | 17% | 28% |
| VIC | 1,023 | 25% | 16% | 27% |
| QLD | 818.7 | 20% | 16% | 22% |
| SA | 332 | 8% | 19% | 11% |
| WA | 397.8 | 10% | 15% | 7% |
| TAS | 110.4 | 3% | 21% | 3% |
| ACT | 56.1 | 1% | 13% | 1% |
| NT | 28.8 | 1% | 12% | 1% |
| **AUS** | **4,116** | **100%** | **16%** | **100%** |

Source: Deloitte Access Economics analysis of ABS Census (2016) and DEX (2019)

# Who and where

## Variation in CHSP uptake by state and territory

## Analysis

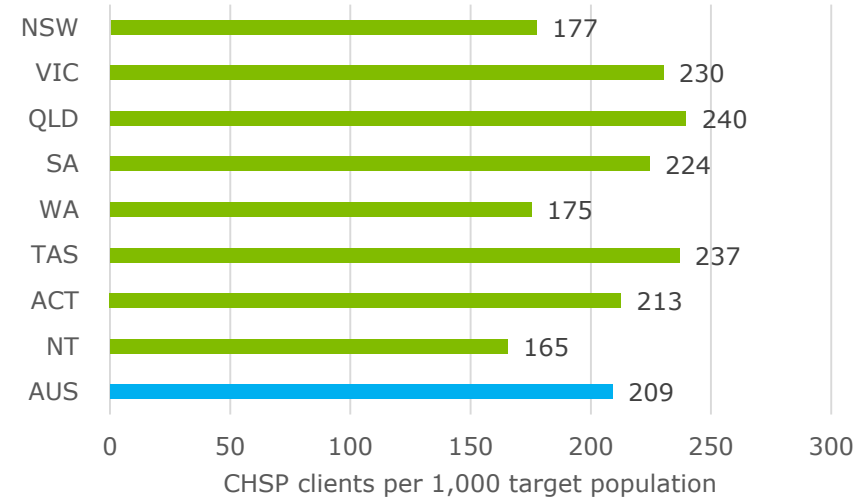
Those who were in the target population – comprising all people aged 65 and over, and Aboriginal and Torres Strait Islander people aged 50-64 years – made up 98% of clients.[4] There are approximately 209 CHSP clients per 1,000 people in the target population.

There is some variation in the rate of CHSP use across states and territories (Chart 1.5). In 2018-19, the rate was highest in Queensland, at 240 per 1,000 people, or 15% above the national average. The lowest coverage was in the NT (165 per 1,000 people), 21% below the national average. The availability of other programs and differences in population characteristics are likely contributing to the variation across states and territories.

There are more Aged Care Planning Regions (ACPRs) that have coverage above the national average (38 ACPRs compared to 30 below) and these ACPRs are more often in regional and remote areas (Chart 1.6).

The highest CHSP client per 1,000 target population are in the Eyre Peninsula, SA and York, Lower North and Barossa, SA, at 312, 44% above the national average. The lowest is in South West, Queensland at 47, 78% below the national average.

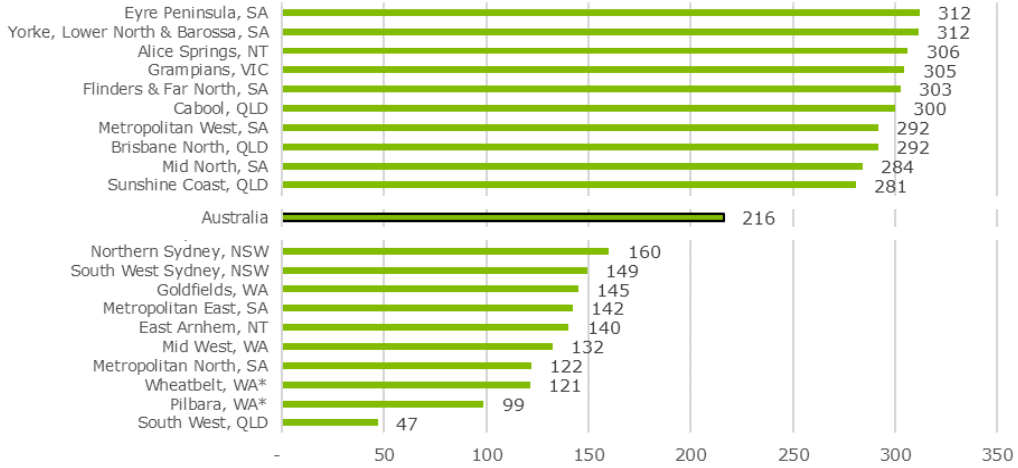
**Chart 1.5 Proportion of target population using the CHSP, 2018-19**




Note: The target population is defined as the ABS Estimated Residential Population in 2018-19 for +65 year old Australians in each state and territory plus the estimated Aboriginal and Torres Strait Islander population for +50 years old in the Aboriginal and Torres Strait Islander Population Projections: Persons by Age by Sex by State/Territory (2016-2031).

Source: Deloitte Access Economics analysis of DEX (2019) and ABS (2019)

**Chart 1.6 CHSP clients per 1,000 target population by ACPR (top 10, bottom 10 and national average), 2017 18**




Note: The time period presented in this chart is for the DEX 2017-18 clients for all ACPRs other than for those in WA, which only entered the program in 2018-19. These ACPRs are highlighted by an asterix (*).DEX 2017-18 data is used (except for ACPRs in WA) to better align with ABS Census (2016) data. Therefore Chart 1.6 is not directly comparable

Source: Deloitte Access Economics analysis of DEX (2018) and ABS Census (2016)

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4. There are exceptional circumstances (for example, the use of CHSP in emergency circumstances or where CHSP services are provided to ensure continuity of support) where CHSP is provided to clients outside of this target group, representing 2% of all clients in 2018-19.

# Complexity profile

## CHSP uptake in special needs client groups

## Analysis

The CHSP aims to meet the diversity of care needs across the population. The representation of four special needs groups were considered in this study including people from Aboriginal and Torres Strait Islander and CALD backgrounds, veterans, rural or remote populations and those who are identified as having a learning, physical, psychiatric or sensory disability.

For most special needs groups, the rate of coverage is lower than the national rate of coverage of 195 CHSP clients per 1,000 target population in 2017-18, except for clients in regional and remote areas (see Table 1.2), where the coverage (196 per 1,000) is approximately equal to the national rate.

Table 1.2 also provides a comparison of several characteristics of the special needs groups and target population which provides insights into why these groups may be underrepresented. For example, CALD clients are more likely to be living with a carer, which could reduce their need for CHSP services while nearly 70% of CHSP clients who are veterans are over 85 years old and may be better served through the HCP Program and residential aged care facilities.

**Table 1.2 CHSP coverage of target population for special needs groups and comparison of characteristics, 2017-18**

| Characteristics | National CHSP | Aboriginal and Torres Strait Islander | Disability[5] | CALD[6] | Veterans[7] | Regional/ remote[8] |
|---|---|---|---|---|---|---|
| **CHSP coverage of target population** | | | | | | |
| Number of clients | 783,044 | 21,443 | 179,291 | 155,486 | 21,837 | 99,014 |
| Target population ('000) | 4,023 | 123 | 1,952 | 828 | 190 | 505 |
| CHSP clients per 1,000 target population | 195 | 175 | 92 | 187 | 115 | 196 |
| **Characteristics** | | | | | | |
| Share female | 65% | 64% | 65% | 65% | 69% | 62% |
| Average age | 79 | 66 | 79 | 80 | 86 | 79 |
| Share over 85+ years | 31% | 8% | 33% | 31% | 69% | 27% |
| Regional/remote | 13% | 92% | 23% | 10% | 27% | 100% |
| Share living with carer | 16% | 16% | 21% | 21% | 16% | 14% |

Source: Deloitte Access Economics Analysis of ABS (2019), ABS SDAC (2018), ABS Census (2016) and DVA Annual Report (2017-18)

The national CHSP clients per target population of 195 in 2017-18 differs from the 209 CHSP clients per target population in 2018-19. These comparisons largely rely on 2017-18 as it enables better comparison with other data (e.g. the latest Survey of Disability, Ageing and Carers was also from 2017-18).

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5. Disability status is self-identified by clients in DEX as those who have a learning, physical, psychiatric or sensory disability, as recorded by their service provider. In the ABS Survey of Disability, Ageing and Carers (SDAC), disability is defined as any limitation, restriction or impairment which restricts everyday activities and has lasted, or is likely to last, for at least six months.

6. ABS Census (2016) definition of CALD target population is respondents 65 years and older who were born overseas and speak at least one language other than English. This does not perfectly match the categorisations found in DEX, where certain country and language combinations outside of this definition are considered CALD and non-CALD respectively, possibly at the discretion of the client or the provider.

7. The Veteran population was defined as the number of Department of Veterans Affairs (DVA) clients aged 65 years. Veteran status is identified in DEX as those listed as having access to a DVA Gold Card, White Card or Orange Card, as recorded by their service provider.

8. Remoteness based on ASGS Remoteness Structure. major cities, inner regional, outer regional, remote, and very remote. Rural and remote includes all people living in outer regional, remote and very remote areas were classified as living in rural and remote areas.

# Complexity profile

## Relationship between CHSP uptake and socioeconomic status

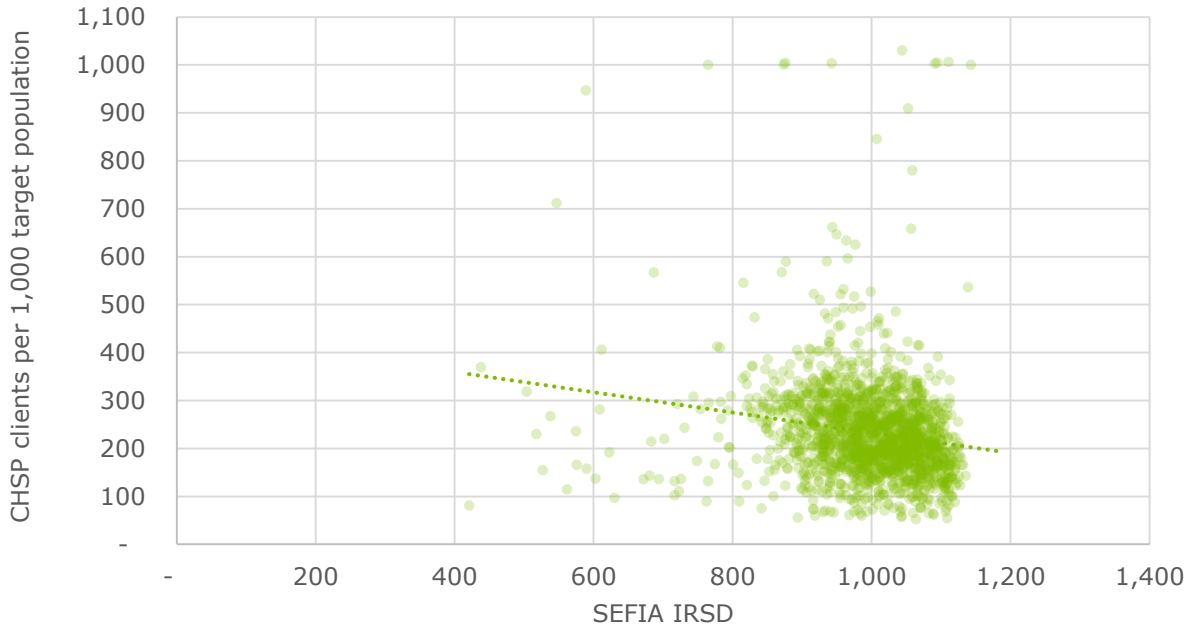
## Analysis

There appears to be a relationship between the number of CHSP clients per 1,000 target population at the Statistical Area Level 2 (SA2) level (Chart 1.7) and socioeconomic status. This indicates that areas with relatively low socioeconomic conditions are associated with higher rates of CHSP use among the target population. This is consistent with findings for HCP and Residential Care.

In the absence of client-level information of socioeconomic status in the DEX data, the Socioeconomic Indexes for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSD) was used to provide an indication of the possible socioeconomic conditions of the communities in which CHSP clients live. The lower the SEIFA IRSD, the relatively greater the disadvantage in general. For example, an SA2 with a low score could have many households with low incomes, many people with no qualifications or many people in low skilled occupations.

It should be noted that, as was found in Chart 1.6, there is some evidence that regional and remote SA2s have more CHSP clients per 1,000 target population compared to urban areas. These regions also tend to have lower SEIFA IRSD scores than those in metropolitan SA2s.

**Chart 1.7 Relationship between CHSP clients per 1,000 target population by SA2 and SEIFA index of relative disadvantage, 2017-18**




After removing outliers, for every 100-point increase in SEIFA IRSD there are 21 fewer CHSP clients per 1,000 population. The estimated linear relationship between CHSP clients per 1,000 target population and the SEIFA IRSD is significant at the <1% level.

Note: All WA SA2s have been removed from the chart above, CHSP had not been rolled out in 2017-18 and their CHSP clients per 1,000 target population were much lower than the rest of Australia. There are several outliers at the SA2 level, where there are many more CHSP clients than the target population. This is driven primarily by the fact that these SA2s have low populations and that given the target population data are based on the Census (2016) and the client numbers are from 2017-18, a small increase in clients has a large effect on this ratio.

Source: Deloitte Access Economics analysis of DEX (2018 and ABS (2016)

# Duration and client turnover

Average duration of clients who received CHSP services between 2017-18 and 2018-19

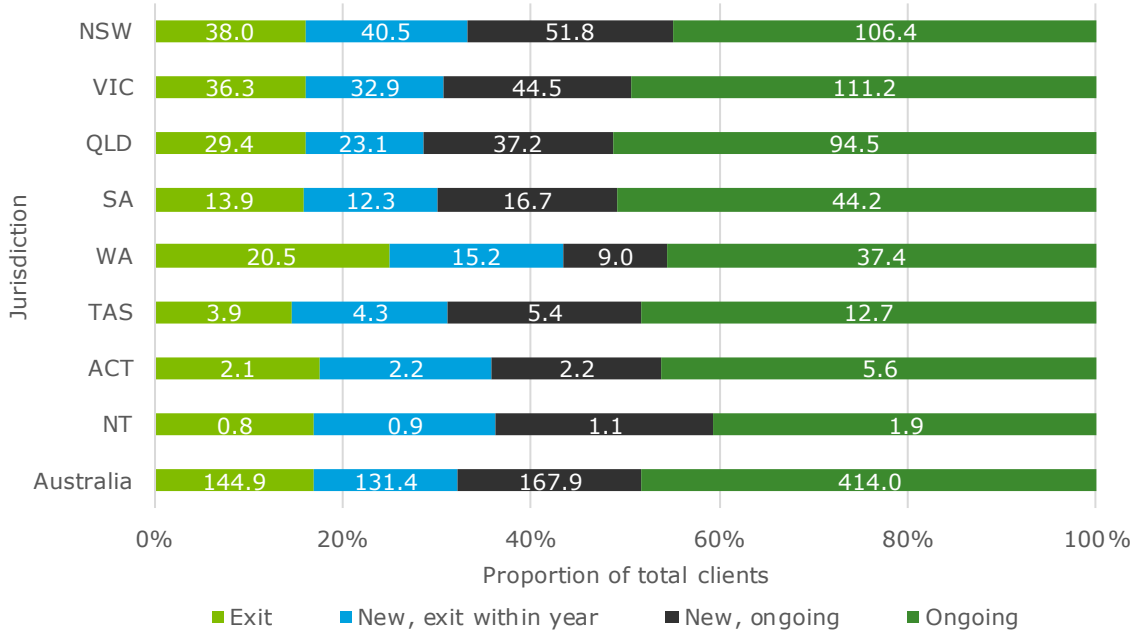
## Analysis

Of the 858,200 clients using CHSP (or HACC in WA) in 2017-18, approximately 167,900 were new clients who continued to receive services in 2018-19. A further 131,400 clients received services for the first time in 2017-18 and did not continue to receive services in 2018-19.

Almost 414,000 clients continued to receive services in 2017-18 and received some services either for part of, or for the full year in 2016-17 and 2018-19. Of note, approximately 144,900 clients discontinued CHSP in 2017-18. It is likely that a number of these clients received one-off or short-term services through CHSP (or HACC in WA).

Table 1.3 summarises the average elapsed time between a client's first and last recorded service between 1 July 2016 and 30 June 2019. Nationally, the average elapsed time exceeded 100 weeks, which supports the data in Chart 3.10 showing that approximately half of all clients were receiving ongoing services during this period.

**Chart 1.8 Client entry and exit status by jurisdiction, 2017 18**




Source: Deloitte Access Economics analysis of DEX (2019) and HACC MDS for WA (2017, 2018)

Using an imperfect measure of entry and exit, there is preliminary evidence of a significant amount of entry and exit into and out of CHSP every year. This analysis however is constrained to data available from 2017 to 2019. Data covering a longer time period beyond the three financial years available for this analysis are required to analyse transitions into and out of the CHSP over time

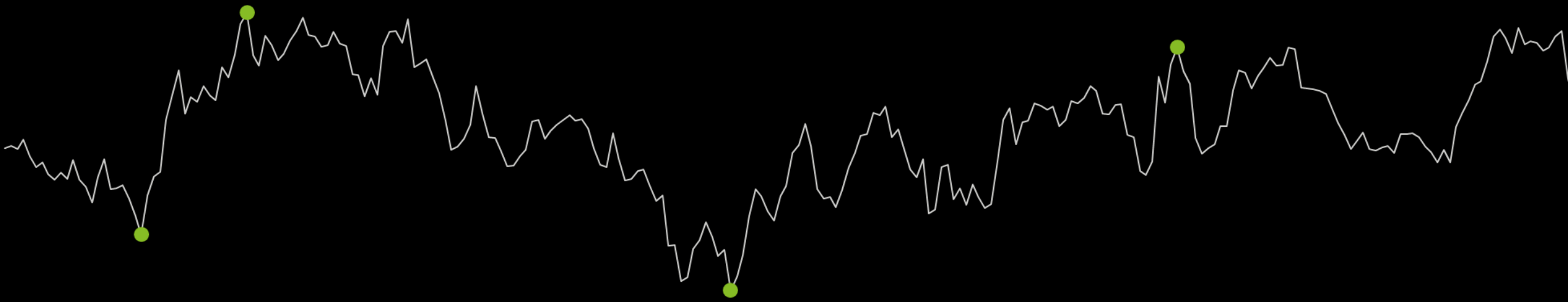
According to the CHSP provider survey, the main reasons for clients exiting CHSP services were clients requiring additional assistance transitioning into residential care or to the HCP Program (49.9% of respondents), death of the client (23.2% of respondents), or client wellbeing improves and they no longer need any CHSP services (8.7%).

**Table 1.3 Average duration (in weeks) of clients in CHSP between 2016-17 and 2018-19**

| STATE | Average duration |
|---|---|
| NSW | 97 |
| VIC | 101 |
| QLD | 108 |
| SA | 105 |
| TAS | 102 |
| ACT | 97 |
| NT | 91 |
| **Australia*** | **102** |

Source: Deloitte Access Economics analysis (2019)

There are some minor differences across the states and territories, where the average elapsed duration was higher in Queensland at 108 weeks compared to 91 weeks in the NT. Data for WA was not available for the full period, nor were detailed client service records showing the date of each service made available for the WA HACC program prior to 1 July 2018: consequently, WA was removed from the analysis.



# 2 Demand profile.

How are services used?

# What CHSP services are required?

Recommendations by service type and state and territory

## Analysis

Nationally, there were more than 1 million recommendations for CHSP services in the data available for analysis in 2018-19. The number of recommendations ranged from 3,600 in the NT to approximately 81 times that in NSW (293,200).

The most common recommendations were for Domestic Assistance (14.8% of total recommendations) and Allied Health and Therapy Services (14.8% of total recommendations) (Table 2.1). There are some notable differences in the relative importance of each service type across states and territories, including but not limited to:

- Transport is the most commonly recommended service in NSW (43,000 recommendations, 14.8%), but the third most commonly recommended service nationally (11.0%).
- About one third (47,500) of all Allied Health and Therapy Services recommendations occur in Victoria.

**Table 2.1 Number of recommendations by state and territory and service type ('000s), 2018-19**

| Service types | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | AUS |
|---|---|---|---|---|---|---|---|---|---|
| Allied Health and Therapy Services | 35.9 | 47.5 | 33.3 | 16.2 | 6.5 | 1.9 | 0.3 | 2.6 | 151.0 |
| Assistance with Care and Housing | 0.8 | 0.3 | 0.4 | 0.3 | 0.1 | 0.0 | 0.0 | 0.1 | 2.2 |
| Centre-based Respite | 3.1 | 1.3 | 3.3 | 0.8 | 0.7 | 0.2 | 0.1 | 0.3 | 10.2 |
| Cottage Respite | 2.5 | 1.2 | 1.9 | 0.6 | 0.7 | 0.1 | 0.0 | 0.3 | 7.7 |
| Domestic Assistance | 40.3 | 38.0 | 34.2 | 12.3 | 13.1 | 4.4 | 0.7 | 2.1 | 151.3 |
| Flexible Respite | 21.6 | 11.8 | 10.5 | 3.4 | 2.3 | 1.6 | 0.1 | 1.5 | 55.2 |
| Goods, Equipment and Assistive Technology | 5.1 | 0.5 | 3.8 | 7.2 | 4.6 | 0.1 | 0.5 | 1.2 | 24.5 |
| Home Maintenance | 21.9 | 26.7 | 29.2 | 11.3 | 6.9 | 3.4 | 0.2 | 1.4 | 104.2 |
| Home Modifications | 22.0 | 19.9 | 18.2 | 9.0 | 4.6 | 0.9 | 0.0 | 1.1 | 80.1 |
| Meals | 16.6 | 11.9 | 9.7 | 5.1 | 2.5 | 1.4 | 0.4 | 0.9 | 50.5 |
| Nursing | 15.7 | 14.6 | 12.7 | 4.3 | 1.6 | 1.3 | 0.0 | 0.9 | 53.1 |
| Other Food Services | 1.6 | 0.8 | 2.3 | 0.5 | 0.5 | 0.0 | 0.0 | 0.2 | 6.1 |
| Personal Care | 17.9 | 16.2 | 12.7 | 5.1 | 4.5 | 2.1 | 0.2 | 1.1 | 62.8 |
| Social Support - Group | 13.3 | 13.0 | 8.0 | 4.8 | 3.9 | 0.9 | 0.1 | 0.8 | 46.6 |
| Social Support - Individual | 26.1 | 13.6 | 18.3 | 6.7 | 5.6 | 2.4 | 0.3 | 1.5 | 77.5 |
| Specialised Support Services | 5.3 | 8.3 | 8.2 | 1.4 | 0.7 | 0.6 | 0.0 | 0.6 | 26.1 |
| Transport | 43.4 | 15.0 | 25.9 | 9.2 | 8.6 | 3.9 | 0.5 | 2.1 | 112.9 |
| **Total** | **293.2** | **240.7** | **232.3** | **98.0** | **67.6** | **25.2** | **3.6** | **18.5** | **1,021.9** |

Source: Deloitte Access Economics analysis of NSAF assessment data (2019)

# What CHSP services are required?

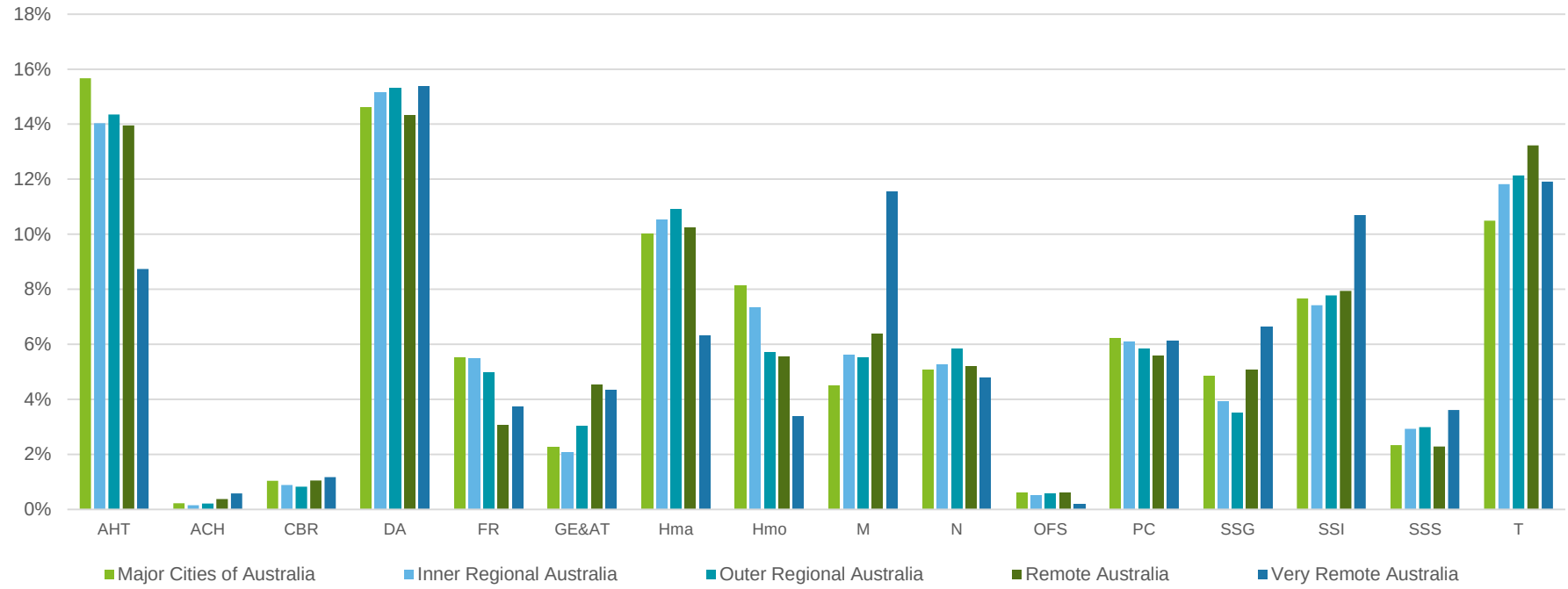
Service type recommendations by remoteness area of clients

## Analysis

There were differences in which services were recommended when comparing urban areas of Australia and regional and remote locations. For example, Allied Health and Therapy Services were recommended less frequently in remote areas compared to urban areas of Australia in 2018-19 (Chart 2.1). This variance is explained by the difference in service recommendations across jurisdictions as well as the relative availability of each service. Some other notable observations include:

- Goods, Equipment and Assistive Technology, Meals, and Transport tend to be recommended at a higher rate in remote communities.
- Home Maintenance is recommended less frequently in remote regions, and Home Modification recommendations are relatively more common in urban regions.
- Social Support (either Group or Individual) tends to be recommended less in regional areas, and more in capital cities and remote communities.

**Chart 2.1 Distribution of recommendations by service type and remoteness, 2018-19**




Note: The figures presented are a percentage of the total number of recommendations made within each type of region (i.e. the percentage of total recommendations made to each service type).

Source: Deloitte Access Economics analysis of NSAF assessment data (2019).

# What is being accessed?

Number of clients and average sessions per client by service types

## Analysis

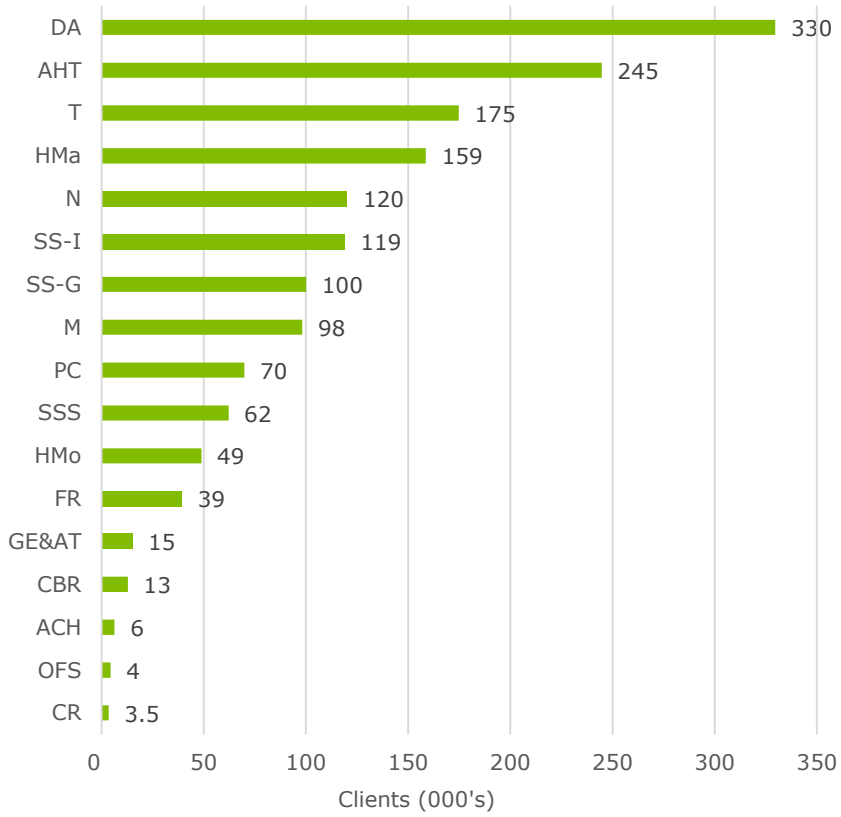
Domestic Assistance was the service type used by the highest number of clients in 2018-19, with around 330,000 people using this service type (Chart 2.2). This was followed by Allied Health and Therapy Services, which provided services to almost 245,000 clients, and Transport (175,000 clients).

Chart 2.3 shows the relative intensity with which clients use sessions, as measured by sessions per client as well as the share of total sessions per service type.

There were 35m sessions in total in 2018-19. The top five service types by sessions were Domestic Assistance (19.9% of total sessions), Meals (13.5%), Transport (12.8%), Personal Care (10.9%) and Nursing (10.6%).

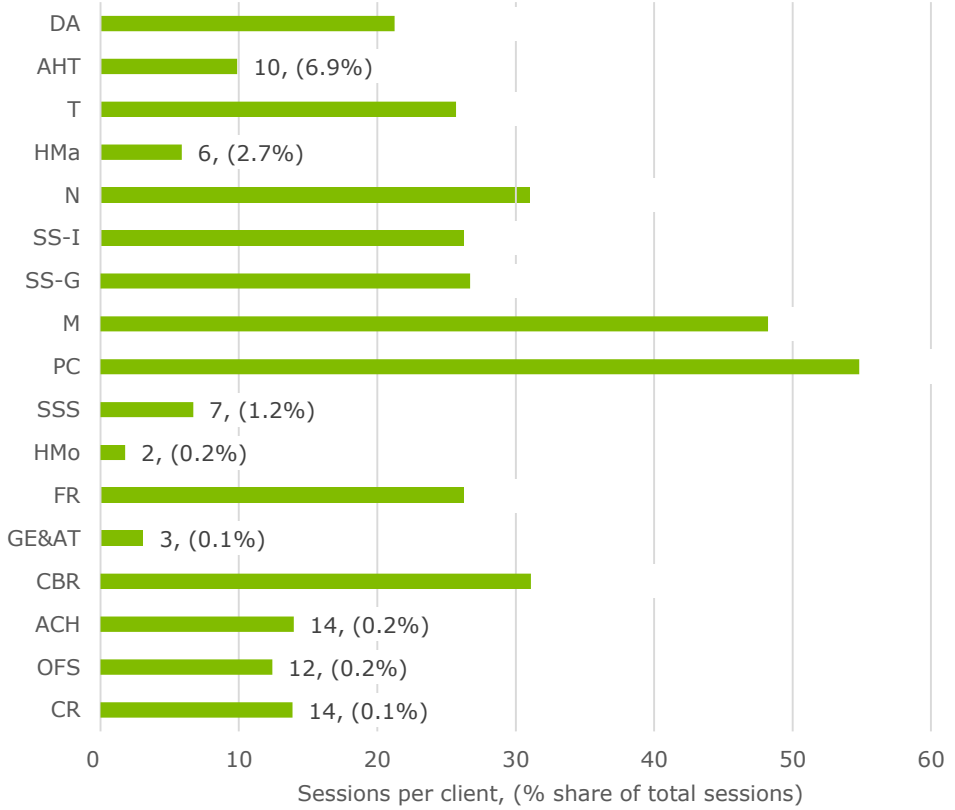
Service intensity and frequency can vary substantially between service types. For example, 245,000 distinct clients used Allied Health and Therapy Services in 2018-19, with each client using 10 services on average for the year. At the higher end, 70,000 clients used Personal Care, but on average each client used 55 sessions for the year.

**Chart 2.2 Number of clients by service type ('000s), 2018-19**




Source: Deloitte Access Economics analysis of DEX (2019)

**Chart 2.3 Average sessions per client by service type (% share of total sessions), 2018-19**




Source: Deloitte Access Economics analysis of DEX (2019)

**Session:** CHSP services are recorded against "sessions". A session represents the provision of services to **one or more** clients by an outlet, for a particular day, and for a particular service type. A session may be counted more than once at a client level (e.g. as in chart 2.3).

# What is being accessed?

Services are principally measured in one of three units: hours, dollars and quantity

## Analysis

Another measure of service use is provided by outputs: hours, quantity and dollars. Table 2.2 summarises the total number of outputs by service type as well as the outputs per client in 2018-19. Domestic Assistance, and Social Support – Group represented the largest output based on total hours (9.1m and 8.6m respectively), making up half of all the hours in 2018-19.

However, average hours per client was highest for Centre-based Respite and Cottage Respite: 123 and 270 hours respectively. On the lower end, on average, clients accessed 7 hours of Specialised Support Services, and 9 hours of Allied Health and Therapy Services, and Home Maintenance.

More than 7m meals were provided in 2018-19, resulting in an average of 77 meals per client. More than $35m worth of Home Modifications were provided, costing $723 per client on average.

**Table 2.2 Outputs (hours, quantity and dollars ) per client, 2018-19**

| Service type | Principal output measure | Total output (millions) | % of total hours | Output per client |
|---|---|---|---|---|
| Allied Health and Therapy Services | Hours | 2.1 | 6.1% | 9 |
| Assistance with Care and Housing | Hours | 0.1 | 0.4% | 19 |
| Centre-based Respite | Hours | 1.6 | 4.5% | 123 |
| Cottage Respite | Hours | 1.0 | 2.8% | 270 |
| Domestic Assistance | Hours | 9.1 | 26.3% | 28 |
| Flexible Respite | Hours | 2.0 | 5.8% | 51 |
| Goods, Equipment and Assistive Technology | Quantity | 0.2 | -* | 12 |
| Home Maintenance | Hours | 1.5 | 4.2% | 9 |
| Home Modifications | Dollars | 35.3 | -* | $723 |
| Meals | Quantity | 7.6 | -* | 77 |
| Nursing | Hours | 2.3 | 6.6% | 19 |
| Other Food Services | Hours | <0.1 | 0.2% | 11 |
| Personal Care | Hours | 2.9 | 8.3% | 41 |
| Social Support - Group | Hours | 8.6 | 24.6% | 85 |
| Social Support - Individual | Hours | 3.1 | 9.0% | 26 |
| Specialised Support Services | Hours | 0.4 | 1.3% | 7 |
| Transport | Quantity | 5.2 | -* | 30 |

Note: Quantity refers to the number of meals, number of one-way trips and/or number of items purchased or loaned (e.g. a communication or mobility aid) in each of the three service types measured in terms of quantity above. The quantity per client may not be directly comparable to other service types and not all output may be captured: for example, Goods, Equipment and Assistive Technology may also be reported as a contribution towards the cost of a mobility aid.

* These services are measured in terms of "quantity" or "dollars" delivered.

Source: Deloitte Access Economics Analysis of DEX (2019)

**Principal measure of output:** Each CHSP service type is able to be measured as three kinds of output: hours, quantity and dollars. To simplify reporting, each service type has a *principal measure*, which most providers record their output in.

# What is being accessed?

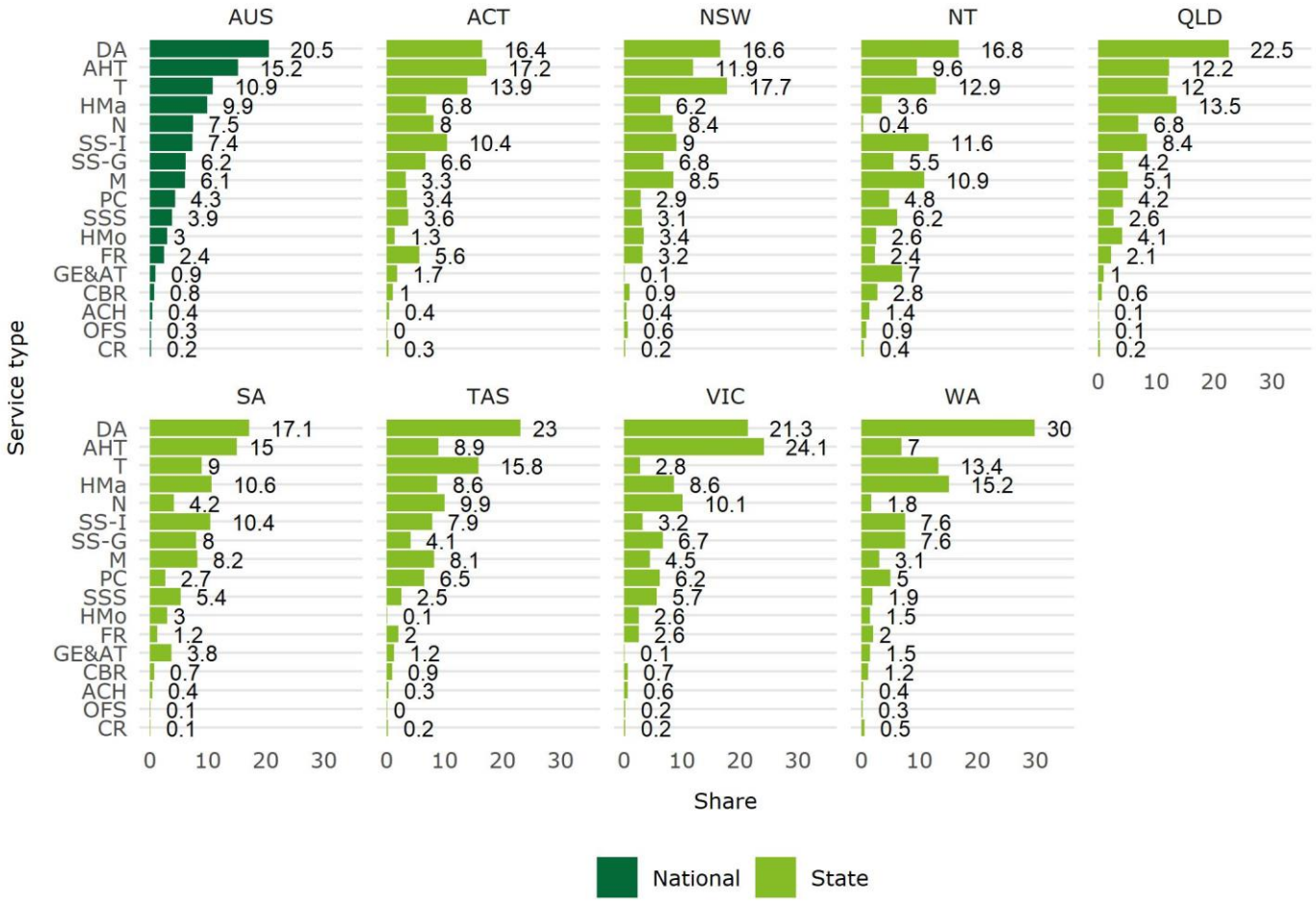
## CHSP uptake by location

## Analysis

Service use patterns differ by states and territories. Chart 2.4 shows the distribution of clients across service types by state or territory. Domestic Assistance has the highest proportion of clients at the national level and for most state and territories, except in NSW, Victoria and the ACT. Other key trends include:

- The proportion of clients using Allied Health and Therapy Services varies from approximately 9% in Tasmania to more than 24% in Victoria. clients. Almost one quarter of CHSP clients in Victoria use Allied Health and Therapy Services, more than all other service types.
- Nursing clients make up more than 10% of Victoria's clients, compared to almost no clients accessing Nursing in the NT in 2018-19 (less than 1%).
- Entering the CHSP in 2018-19, WA has the highest share of clients using Domestic Assistance services as a proportion of all clients.
- Only 2.8% of clients in Victoria access Transport services, which is substantially lower than other states and territories.

**Chart 2.4 Proportion of clients using different service types for each state and territory, 2018-19**




Note: Clients can use more than one service in a year. Overseas Territories (OT) are not shown in the above. In 2018-19 there were 28 clients in OT. There were 4 clients who did not have a state/territory associated with their entry.

Source: Deloitte Access Economics analysis of DEX (2019)

# What is being accessed?

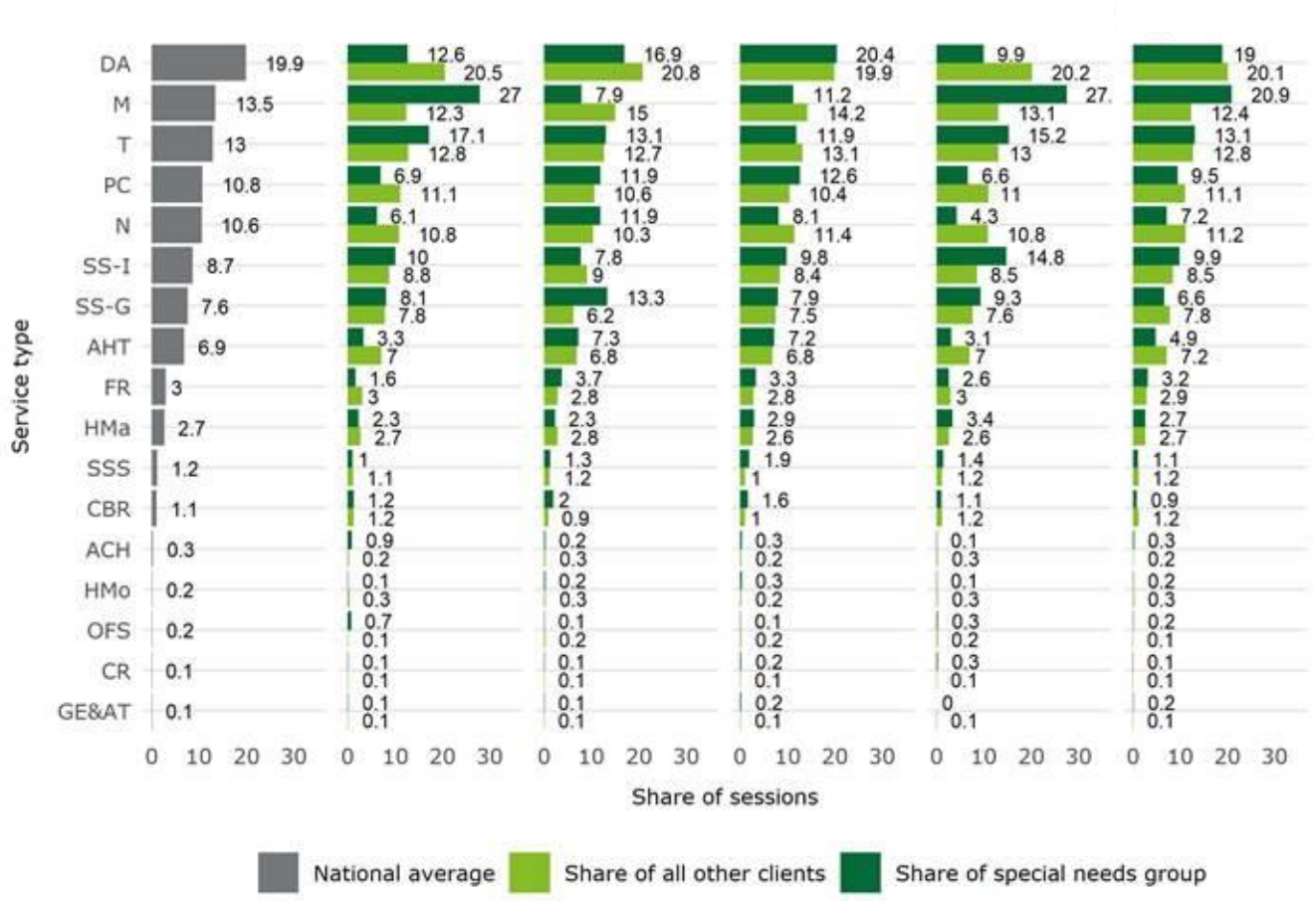
## Service consumed by special needs groups

## Analysis

The distribution of clients and sessions across service types within states and territories can partly be explained by the variation in client characteristics and the resulting care needs of these individuals as shown in Chart 2.5. For example:

- Aboriginal and Torres Strait Islander clients have a noticeably lower share of services provided at home such as Home Maintenance and Domestic Assistance sessions, compared to the rest of the population. However, the share of Meals and Transport were much higher.
- CALD clients consume a lower share of Domestic Assistance Service and Meals but a higher share of Social Support – Group compared to the rest of the population.
- There is no clear difference between clients with a disability and clients living in rural and remote communities compared to the rest of the population, with the exception of higher proportion of Meals for rural and remote communities.
- Veterans use a larger share of Meals and Social Support – Individuals but a lower share of support at home including Personal Care and Domestic Assistance as well as Nursing.

**Chart 2.5 Proportion of sessions consumed by special needs groups, 2018-19**




Client characteristics across states and territories do not explain all of the variation in service type use described. Some variation is also driven by the design legacies of jurisdictionally based HACC programs.

Note: Proportion of sessions represents number of sessions consumed by special needs group for each service type divided by total sessions consumed by that special needs group, compared to number of sessions consumed for each service type for all other clients, divided by total sessions consumed.

Source: Deloitte Access Economics Analysis of DEX (2019)

# Use of CHSP by output volume

Outputs delivered by location and service type

## Analysis

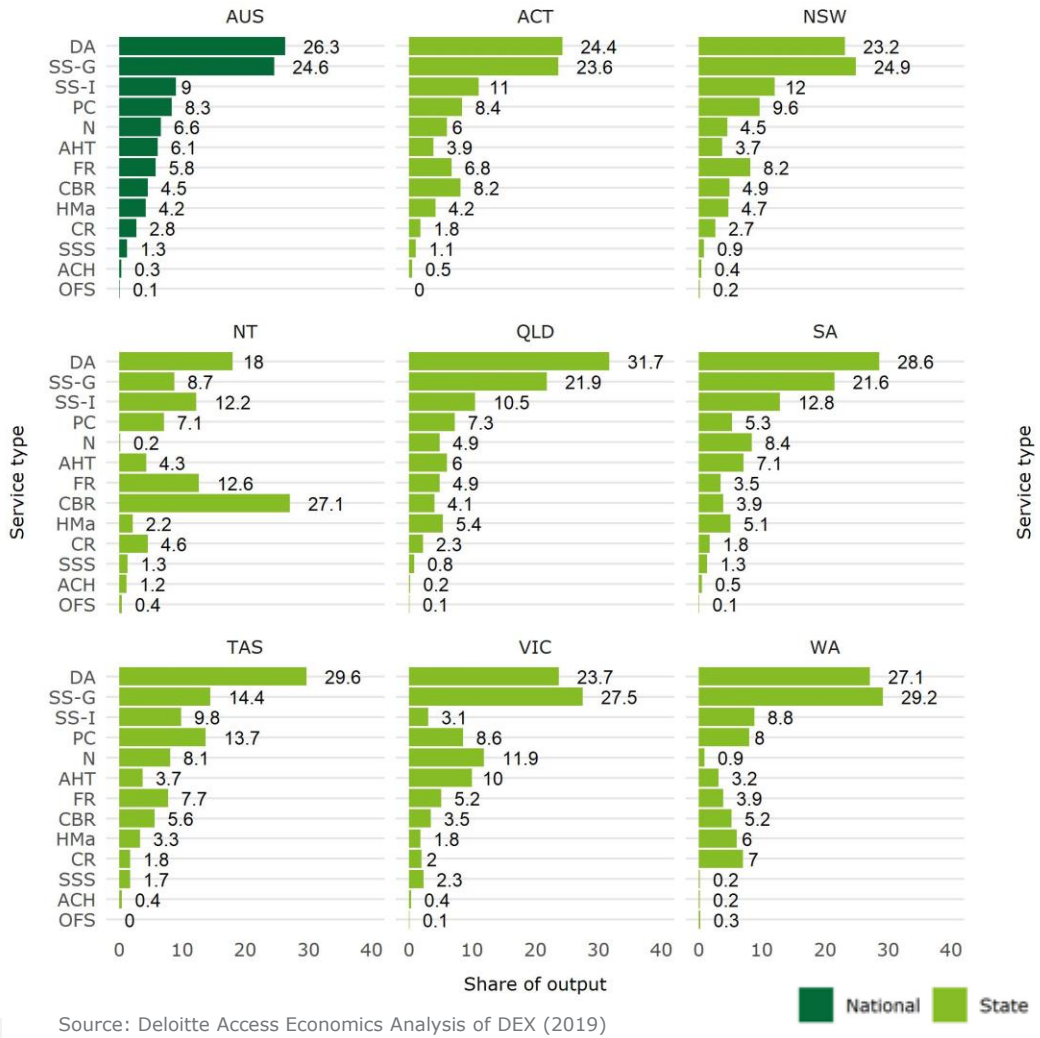
In addition to the number of clients and sessions accessed, outputs delivered, in terms of hours, dollars and quantity provides another measure of CHSP use. Chart 2.6 and Chart 2.7 presents output for 13 of the 17 service types that are recorded in hours.

The proportion of hours across service type for NT, WA, and Tasmania varies the most compared the other states and territories in 2018-19.

The average hours per client differ noticeably for ACT, NT and WA compared to the national average. In the NT, the average hours of Home Maintenance and Domestic Assistance is much lower than the national average, while hours of respite support was much higher.

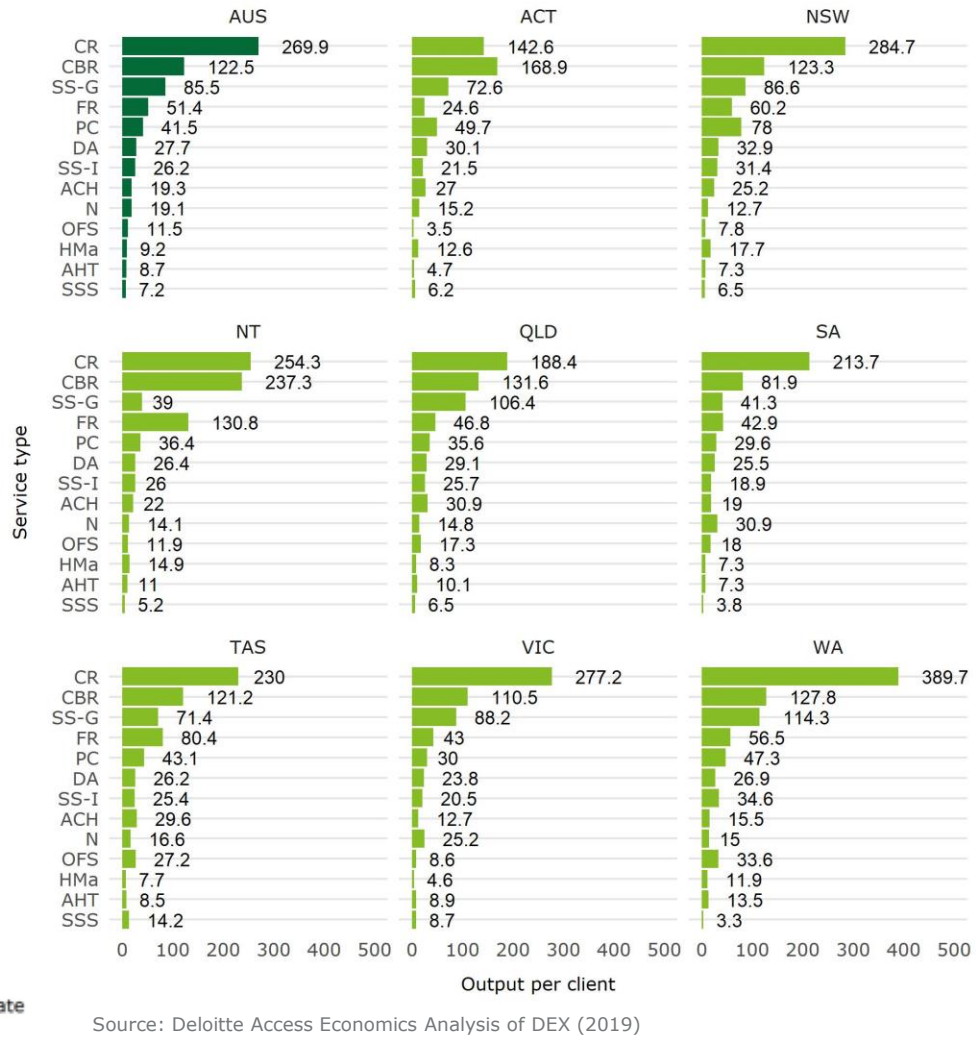
The average hours per client of Social Support – Individual services were one third in Victoria (3.0 hours) of the national average (9.0), while Nursing was on the higher end. This is the opposite for WA, where only 1.0 hour of Nursing and 3.3 hours of Allied Health and Therapy services were used per client.

**Chart 2.6: Proportion of hours used by service type for each state and territory, 2018-19**




Source: Deloitte Access Economics Analysis of DEX (2019)

**Chart 2.7: Average hours per client for each state and territory, 2018-19**




Source: Deloitte Access Economics Analysis of DEX (2019)

# Use of CHSP by output and sessions

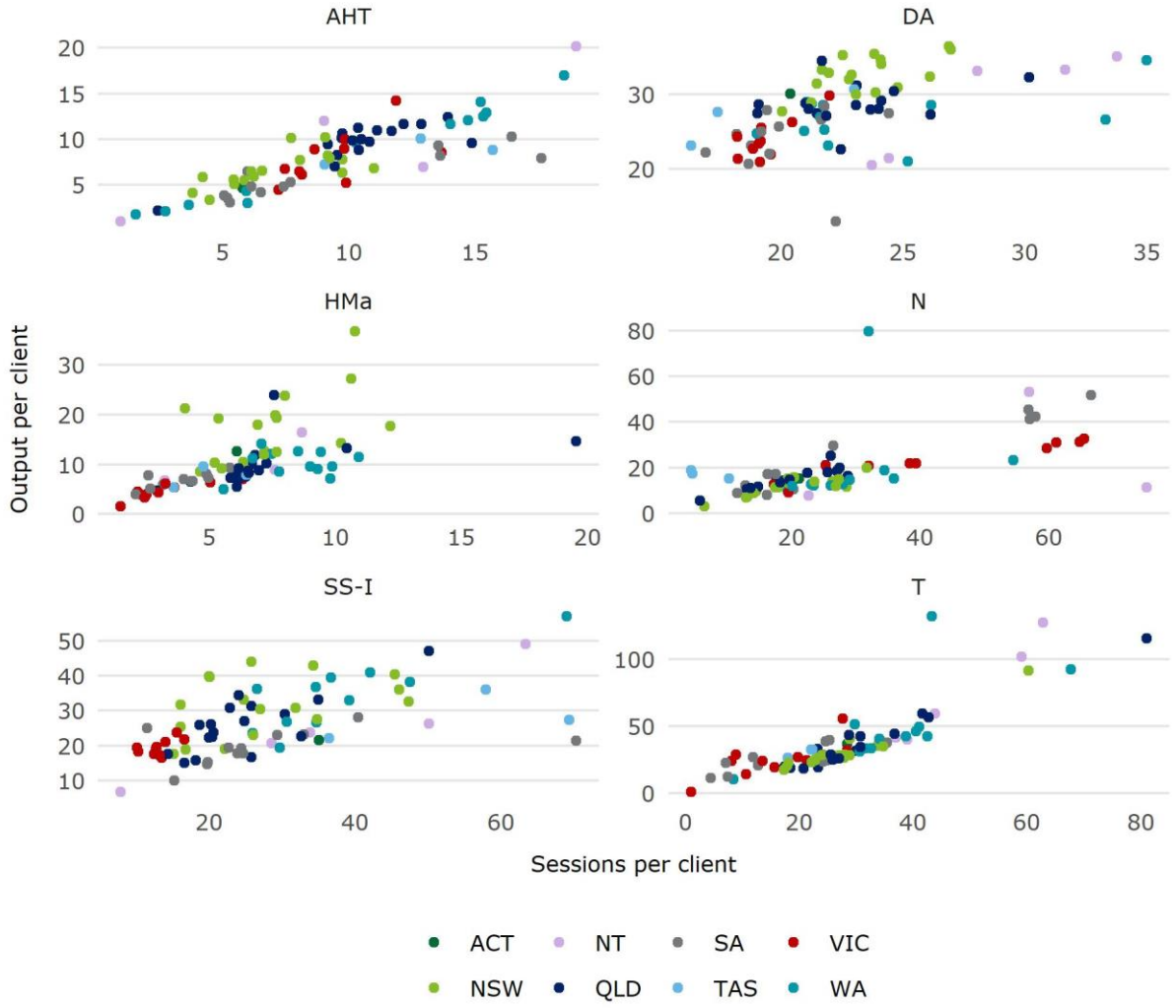
The relationship between output and sessions per client

## Analysis

Chart 2.8 shows the relationship between output per client and sessions per client, for the top six service types by client numbers in 2018-19. The points represent ACPRs and are coloured according to state or territory in which the ACPR is located. Note that the principal measure of output for each service type is used. Other than Transport, which is measured in quantity, all service types in the Chart are principally measured in hours.

There is significant regional variation in the intensity of service use. Points that are further from the origin – such as the ACPR where the hours and sessions per client average 20 hours and 19 sessions for Allied Health and Therapy Services – represent ACRPs where there are more clients, and each client uses these services relatively more intensively. These will often also be regions with lower client populations.

**Chart 2.8 Output per client on sessions per client for each ACPR, 2018-19**




The ACPRs tend to cluster together by jurisdiction for most service types. Victoria, Queensland and WA, in particular, exhibit similar patterns of ACPR service use within each state. There is greater variation between each state.

In the case of Nursing and Transport, there are two distinct groups of ACPRs: a group clustered around lower usage and intensity of services, and a group of ACPRs clustered around higher usage and intensity of services.

Source: Deloitte Access Economics Analysis of DEX (2019)

# How much is accessed?

## Variation in frequency of use by service type

## Analysis

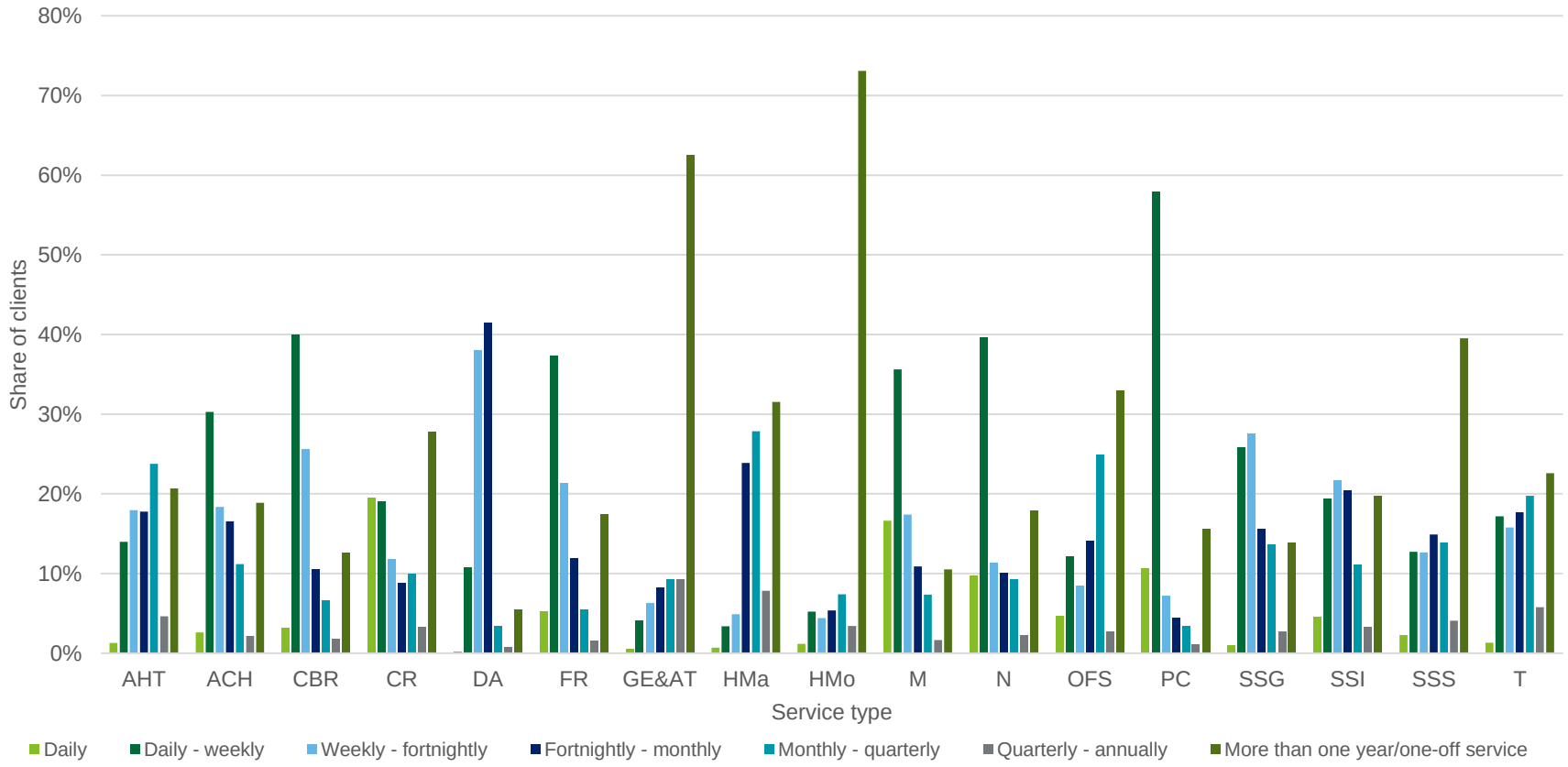
There is expected variation in how regularly clients access each service type. Chart 2.9 illustrates the average amount of time between each session for each service type.

Assistance with Care and Housing, Centre-based Respite, Flexible Respite, Meals, Nursing, Personal Care and Transport are skewed to frequent usage, and are typically used every week to every couple of weeks. Domestic Assistance is typically used between fortnightly and monthly.

Goods, Equipment and Assistive Technology, Home Modifications, Other Food Services and Specialised Support Services are mostly used on an annual basis or may be delivered as one-off services. The distribution across clients for Allied Health and Therapy Services and Social Support - Individual are relatively flat, compared to other service types.

The frequency of service access for service types aligns with the intended objectives of the CHSP - either long-term low levels of support or short-term higher levels of support.

**Chart 2.9 Share of clients by frequency ranges by service type, 2018-19**




Note: the upper bound of each category is inclusive, e.g. a client accessing services weekly is grouped in 'Daily-weekly'. In the reported data, some clients may receive multiple services on the same day (e.g. a client receiving multiple assistive aids on the same day). Services delivered on the same day have been grouped together as a single service.

Source: Deloitte Access Economics analysis of DEX (2019).

# What services are typically accessed together?

Patterns in service types used together are observed

## Analysis

Table 2.3 presents the pairwise combinations of service types used together in 2018-19. Each of the cells represent the count of clients who used both services at least once as well as the client counts in relative terms – the share of all clients who used each service type individually, in 2018-19.

For example, there were roughly 245,000 clients who used Allied Health and Therapy services in 2018-19. The value in the Allied Health and Therapy-Home Maintenance cell, shows that there were 16.4% Allied Health and Therapy clients who also used Home Maintenance services.

There are number of prevalent service type pairs. For example, of those who use:

- Allied Health and Therapy Services, 33% also use Domestic Assistance
- Social Support – Group, 43% also use Transport
- Flexible Respite, 24% also use Personal care
- Home Maintenance, 23% also use Domestic Assistance
- Goods, Equipment and Assistive Technology, 35% use Nursing.

**Table 2.3 Interaction between service type use for CHSP users, client count (share of total clients who use each service type %), 2018-19**

| | AHT | ACH | CBR | CR | DA | FR | GE&AT | HMa | HMo | M | N | OFS | PC | SS-G | SS-I | SSS | T |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # clients using each service type (000) | 244.8 | 6.3 | 12.9 | 3.5 | 329.7 | 39.4 | 15.1 | 158.7 | 48.8 | 98.3 | 120.2 | 4.5 | 69.9 | 100.1 | 118.9 | 62.2 | 174.7 |
| AHT | | | | | | | | | | | | | | | | | |
| ACH | 911 (0.4%) | | | | | | | | | | | | | | | | |
| CBR | 3,018 (1.2%) | 21 (0.3%) | | | | | | | | | | | | | | | |
| CR | 919 (0.4%) | 6 (0.1%) | 1,288 (10%) | | | | | | | | | | | | | | |
| DA | 80,155 (32.7%) | 811 (12.9%) | 3,166 (24.6%) | 766 (21.6%) | | | | | | | | | | | | | |
| FR | 12,173 (5%) | 183 (2.9%) | 2,908 (22.6%) | 1,029 (29%) | 14,217 (4.3%) | | | | | | | | | | | | |
| GE&AT | 7,525 (3.1%) | 72 (1.1%) | 250 (1.9%) | 96 (2.7%) | 6,256 (1.9%) | 859 (2.2%) | | | | | | | | | | | |
| HMa | 40,145 (16.4%) | 292 (4.6%) | 1,335 (10.4%) | 348 (9.8%) | 76,575 (23.2%) | 5,474 (13.9%) | 2,681 (17.8%) | | | | | | | | | | |
| HMo | 30,529 (12.5%) | 73 (1.2%) | 564 (4.4%) | 153 (4.3%) | 19,627 (6%) | 2,954 (7.5%) | 2,867 (19%) | 16,778 (10.6%) | | | | | | | | | |
| M | 20,652 (8.4%) | 446 (7.1%) | 3,019 (23.4%) | 435 (12.3%) | 34,882 (10.6%) | 5,132 (13%) | 2,059 (13.6%) | 13,711 (8.6%) | 4,798 (9.8%) | | | | | | | | |
| N | 41,502 (17%) | 368 (5.9%) | 1,481 (11.5%) | 507 (14.3%) | 37,874 (11.5%) | 7,413 (18.8%) | 5,306 (35.1%) | 14,840 (9.4%) | 7,710 (15.8%) | 12,827 (13.1%) | | | | | | | |
| OFS | 865 (0.4%) | 60 (1%) | 96 (0.7%) | 29 (0.8%) | 1,853 (0.6%) | 262 (0.7%) | 53 (0.4%) | 623 (0.4%) | 206 (0.4%) | 2,659 (2.7%) | 526 (0.4%) | | | | | | |
| PC | 25,492 (10.4%) | 205 (3.3%) | 1,617 (12.6%) | 619 (17.5%) | 41,596 (12.6%) | 9,418 (23.9%) | 2,573 (17%) | 12,772 (8%) | 5,816 (11.9%) | 11,620 (11.8%) | 21,358 (17.8%) | 801 (18%) | | | | | |
| SS-G | 22,893 (9.4%) | 342 (5.4%) | 4,694 (36.4%) | 1,361 (38.4%) | 31,051 (9.4%) | 6,291 (16%) | 1,396 (9.2%) | 15,464 (9.7%) | 3,610 (7.4%) | 25,053 (25.5%) | 9,925 (8.3%) | 699 (15.7%) | 8,938 (12.8%) | | | | |
| SS-I | 28,582 (11.7%) | 642 (10.2%) | 2,602 (20.2%) | 758 (21.4%) | 60,079 (18.2%) | 7,499 (19%) | 3,310 (21.9%) | 24,280 (15.3%) | 7,150 (14.6%) | 23,920 (24.3%) | 16,554 (13.8%) | 1,245 (27.9%) | 17,023 (24.4%) | 27,371 (27.4%) | | | |
| SSS | 19,958 (8.2%) | 373 (5.9%) | 1,411 (11%) | 399 (11.3%) | 18,951 (5.7%) | 4,187 (10.6%) | 1,944 (12.9%) | 8,734 (5.5%) | 3,573 (7.3%) | 6,662 (6.8%) | 8,898 (7.4%) | 315 (7.1%) | 6,381 (9.1%) | 8,128 (8.1%) | 9,012 (7.6%) | | |
| T | 32,248 (13.2%) | 562 (8.9%) | 4,876 (37.9%) | 921 (26%) | 58,331 (17.7%) | 7,439 (18.9%) | 3,034 (20.1%) | 29,317 (18.5%) | 7,991 (16.4%) | 27,949 (28.4%) | 16,669 (13.9%) | 1,109 (24.9%) | 12,805 (18.3%) | 43,021 (43%) | 43,749 (36.8%) | 9,179 (14.8%) | |

Note that the columns and rows will not add to 100%, because clients can use more than two services in a year.

Source: Deloitte Access Economics analysis of DEX (2019)

# What services are typically accessed together?

Most common service bundle types ranked by count of clients

## Analysis

Table 2.4 shows the 20 most common bundle types (ranked by count of distinct clients) in 2018-19 where a client accesses more than one single service type in a given month.

Allied Health and Therapy Services, Domestic Assistance and Transport are the services that appear most often out of the top 20 bundles. Domestic Assistance and Home Maintenance bundles totalled $59.2m in value with a combined number of sessions of 592,000 sessions, while Allied Health and Therapy Services and Domestic Assistance bundles amounted to $56.7m, with a combined number of sessions of 567,000.

As could be expected, there is evidence that clients tend to increase their service consumption following a subsequent assessment. The value of service consumption increases by $209 per person per year, or close to 95%, after an assessment. The average client may access an additional 0.1 distinct service types (increasing from 1.3 to 1.4). There are 24% of clients who increase the number of service types they access following an assessment.

**Table 2.4 Interaction between service type use for CHSP users, 2018-19**

| Rank | Bundle | Number of clients | Value per client ($) | # sessions ('000s) | Total value of bundle ($m) |
|---|---|---|---|---|---|
| 1 | DA, HMa | 45,270 | 1,309 | 592 | 59.2 |
| 2 | AHT, DA | 40,904 | 1,387 | 567 | 56.7 |
| 3 | DA, SS-I | 29,797 | 2,068 | 838 | 61.6 |
| 4 | DA, T | 24,037 | 1,347 | 543 | 32.4 |
| 5 | DA, PC | 19,355 | 3,112 | 953 | 60.2 |
| 6 | SS-G, T | 16,646 | 3,683 | 794 | 61.3 |
| 7 | DA, M | 14,835 | 2,108 | 760 | 31.3 |
| 8 | DA, N | 14,428 | 2,256 | 405 | 32.6 |
| 9 | AHT, N | 14,061 | 1,890 | 311 | 26.6 |
| 10 | SS-I, T | 11,551 | 1,697 | 296 | 19.6 |
| 11 | DA, SS-G | 10,182 | 2,238 | 224 | 22.8 |
| 12 | DA, SS-I, T | 8,306 | 2,367 | 296 | 19.7 |
| 13 | AHT, HMa | 7,963 | 767 | 53 | 6.1 |
| 14 | M, SS-G | 7,337 | 1,670 | 220 | 12.3 |
| 15 | AHT, HMo | 7,284 | 1,516 | 35 | 11.0 |
| 16 | AHT, DA, HMa | 7,140 | 1,234 | 85 | 8.8 |
| 17 | DA, SSS | 6,714 | 898 | 53 | 6.0 |
| 18 | M, SS-G, T | 6,343 | 4,013 | 371 | 25.5 |
| 19 | N, PC | 6,115 | 3,097 | 312 | 18.9 |
| 20 | AHT, SS-G | 5,864 | 2,168 | 107 | 12.7 |

Note: The total value is based on 2018-19 financial data.

Source: Deloitte Access Economics analysis of DEX (2019)

The value of the bundle was derived by multiplying the weighted average unit price per unit of output for each service type by the total outputs for each service type. The weighted average unit price includes the Department's funding and any average client contributions.

A key area of change from the transition away from the HACC Program is the increased focus that CHSP has on wellness and reablement. Reablement services are time limited interventions that are targeted towards a client's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Several of the top bundles (e.g. Allied Health and Therapy Services and Domestic Assistance) are associated with clients who received recommendations to services for a period of reablement. In 2018-19, there were approximately 27,560 clients who received such recommendations. The most common reason for receiving this support was for mobility (37.5%).

More than a third (37.1%) of the 1,025 providers who responded to the Department's Wellness and Reablement Survey (2018) reported that wellness and reablement approaches were successfully increasing clients' independence and reducing reliance for ongoing services.

# What factors drive the annual value of services?

Average annual value of services by various client characteristics

## Analysis

The relationship between client characteristics and service use was assessed by comparing the average total value of services consumed between those who do and do not have certain characteristics. The characteristics analysed are broadly grouped into special needs groups (Aboriginal and Torres Strait Islander, Homeless, CALD and LGBTI), functional limitations, primary health conditions (Table 2.5) and age (Chart 2.10).

All of the functional limitations and some of the primary health conditions are associated with a noticeably higher value of services used in 2018-19. However, some conditions such as eyesight, depression/anxiety, frequent falls, brain injury, diabetes, and asthma were not noticeably different. In some cases people with the condition used a lower value of services compared to all clients.

The average total value is higher for all special needs groups, and this difference is most pronounced for Aboriginal and Torres Strait Islander ($3,950 compared to $2,800) and LGBTI clients ($3,200 compared to $2,800). On average, women received services worth $2,950 compared to $2,530 for men. The average annual value also increases with age from 65 years old.

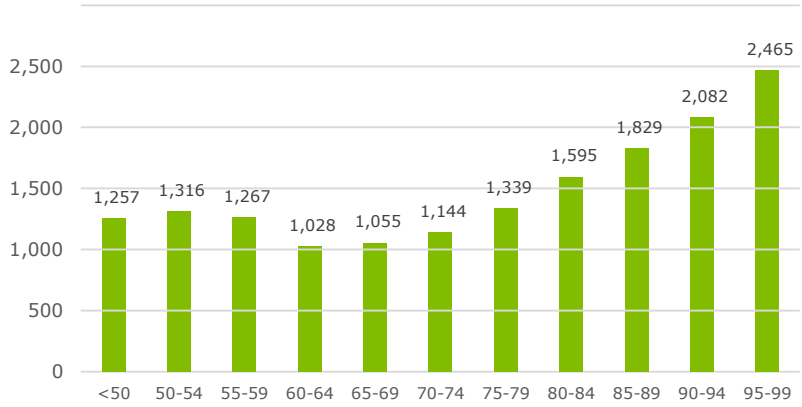
**Table 2.5 Average annual value of services by client characteristics, 2018-19**

| | Characteristic | Clients with characteristics | | | All other clients | | |
|---|---|---|---|---|---|---|---|
| | | Value ($) | Sessions | Clients | Value ($) | Sessions | Clients |
| Demographic | Female | 2,956 | 37 | 163,122 | 2,529 | 32 | 95,547 |
| | Aboriginal and Torres Strait Islander | 3,953 | 53 | 5,164 | 2,775 | 35 | 253,509 |
| | CALD | 3,019 | 38 | 80,320 | 2,699 | 34 | 178,353 |
| | Veteran | 2,724 | 44 | 2,604 | 2,799 | 35 | 256,069 |
| | LGBTI | 3,186 | 38 | 314 | 2,798 | 35 | 258,359 |
| | Homeless | 2,363 | 25 | 264 | 2,839 | 36 | 189,625 |
| Functional limitations | F.L Communication | 4,114 | 48 | 43,634 | 2,529 | 33 | 214,608 |
| | F.L Housework | 2,987 | 38 | 224,532 | 1,551 | 20 | 34,043 |
| | F.L Medicine | 5,146 | 59 | 6,125 | 2,286 | 29 | 177,533 |
| | F.L Meals | 3,407 | 44 | 139,394 | 2,085 | 26 | 119,187 |
| | F.L Sitting | 3,433 | 43 | 64,940 | 2,585 | 33 | 193,623 |
| | F.L Walking | 3,223 | 42 | 122,730 | 2,414 | 30 | 135,849 |
| | F.L Daily tasks (e.g. dressing) | 3,393 | 43 | 123,413 | 2,254 | 28 | 135,167 |
| | F.L Shopping | 3,255 | 41 | 178,159 | 1,785 | 23 | 80,421 |
| | F.L Travel | 3,215 | 41 | 161,405 | 1,888 | 23 | 84,864 |
| Primary health conditions | Arthritis | 2,868 | 37 | 40,160 | 2,785 | 35 | 218,251 |
| | Asthma | 2,922 | 38 | 36,396 | 2,778 | 35 | 222,015 |
| | Brain injury | 3,580 | 44 | 1,367 | 2,794 | 35 | 257,044 |
| | Cancer | 2,593 | 34 | 41,964 | 2,838 | 36 | 216,447 |
| | Cognitive impairment | 5,496 | 79 | 399 | 2,794 | 35 | 258,012 |
| | Depression/anxiety | 3,436 | 40 | 36,952 | 2,692 | 35 | 221,459 |
| | Dementia | 5,364 | 53 | 17,640 | 2,610 | 34 | 240,771 |
| | Diabetes | 3,038 | 40 | 56,206 | 2,732 | 34 | 202,205 |
| | Eyesight | 3,056 | 40 | 30,049 | 2,764 | 35 | 228,362 |
| | Frequent falls | 3,536 | 47 | 16,043 | 2,749 | 35 | 242,368 |
| | Heart condition | 3,069 | 40 | 44,608 | 2,742 | 34 | 213,803 |
| | Memory | 5,368 | 52 | 8,340 | 2,713 | 35 | 250,071 |
| | Parkinson's disease | 3,392 | 39 | 7,375 | 2,781 | 35 | 251,036 |
| | Stroke | 3,986 | 42 | 18,307 | 2,708 | 35 | 240,104 |
| | Urine trouble | 3,316 | 44 | 32,528 | 2,724 | 34 | 225,883 |

Note: missing data varied for each characteristic so components will not sum to consistent total.

Source: Deloitte Access Economics analysis of DEX (2019) and NHS data (2019).

**Chart 2.10 Average annual value by age group, 2018-19**




The average value of services received was derived by applying the weighted average price per unit of output for each service type to the total output each client received.

# Interaction with the HCP Program

## Clients accessing both the CHSP and HCP Program

## Analysis

The number and characteristics of clients who were accessing the HCP Program in March 2019 and had a CHSP session date in the same month (clients transitioning to HCP are entitled to access CHSP), are shown in Table 2.6. During 2018-19, 13,359 CHSP clients transitioned from CHSP-only to both the CHSP and the HCP Program.

In March 2019, nearly 23,700 clients were accessing both the CHSP and the HCP Program. While this figure represents slightly less than 5% of total CHSP clients, it made up nearly a quarter of all HCP clients.

At a state and territory level, a higher proportion of CHSP clients in NSW were also accessing the HCP Program, while the identified overlap was comparatively lower in WA.

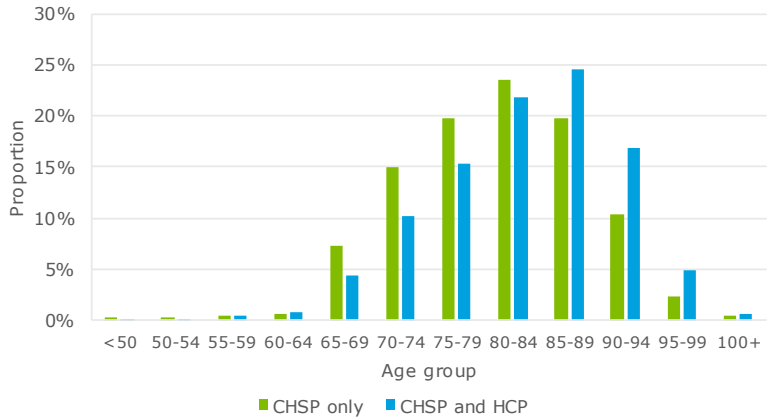
**Table 2.6 Number of clients accessing both CHSP and HCP Program services, March 2019**

| | CHSP only | CHSP and HCP | Total CHSP clients | Total HCP clients | CHSP and HCP as a % of total CHSP clients | CHSP and HCP as a % of total HCP clients |
|---|---|---|---|---|---|---|
| ***National*** | 457,468 | 23,653 | 481,121 | 99,110 | 4.9% | 23.9% |
| **State / territory** | | | | | | |
| NSW | 120,569 | 8,375 | 128,944 | 33,692 | 6.5% | 24.9% |
| VIC | 120,269 | 6,359 | 126,628 | 24,819 | 5.0% | 25.6% |
| QLD | 108,543 | 4,677 | 113,220 | 19,715 | 4.1% | 23.7% |
| SA | 48,741 | 1,861 | 50,602 | 8,360 | 3.7% | 22.3% |
| WA | 38,449 | 1,171 | 39,620 | 7,188 | 3.0% | 16.3% |
| TAS | 12,753 | 786 | 13,539 | 2,402 | 5.8% | 32.7% |
| NT | 2,533 | 119 | 2,652 | 600 | 4.5% | 19.8% |
| ACT | 5,593 | 305 | 5,898 | 1,466 | 5.2% | 20.8% |
| **Special needs** | | | | | | |
| Aboriginal and Torres Strait Islander | 10,910 | 858 | 11,768 | 3,023 | 7.3% | 28.4% |
| CALD | 92,228 | 5,397 | 97,625 | 26,286 | 5.5% | 20.5% |
| Disability stat. | 105,051 | 6,074 | 111,125 | - | 5.5% | - |

Note: The total CHSP clients will not sum to what is published in DEX as data are only presented for March 2019

Source: Deloitte Access Economics analysis of HCP client data (2019) and DEX (2019)

**Chart 2.11 Age distribution of CHSP-HCP and CHSP only clients, March 2019**




Source: Deloitte Access Economics analysis of HCP client data (2019) and DEX (2019).

In March 2019, clients accessing CHSP and HCP together were much more likely to be aged 80 years or older, with an unadjusted odds ratio of 1.7 (Chart 2.11). The odds ratio is the ratio of probability of a client having a certain characteristic, compared to the probability of a client not having this characteristic. Clients accessing both programs were also more likely to be from at least one of the special need client groups: the unadjusted odds ratios were 1.5, 1.2 and 1.2 for Aboriginal and Torres Strait Islander, CALD and Disability respectively.

# Projecting demand for CHSP services

Discussion of the quantitative demand model developed for CHSP services

## Analysis

Future demand for CHSP services were also projected as part of the CHSP Data Study.

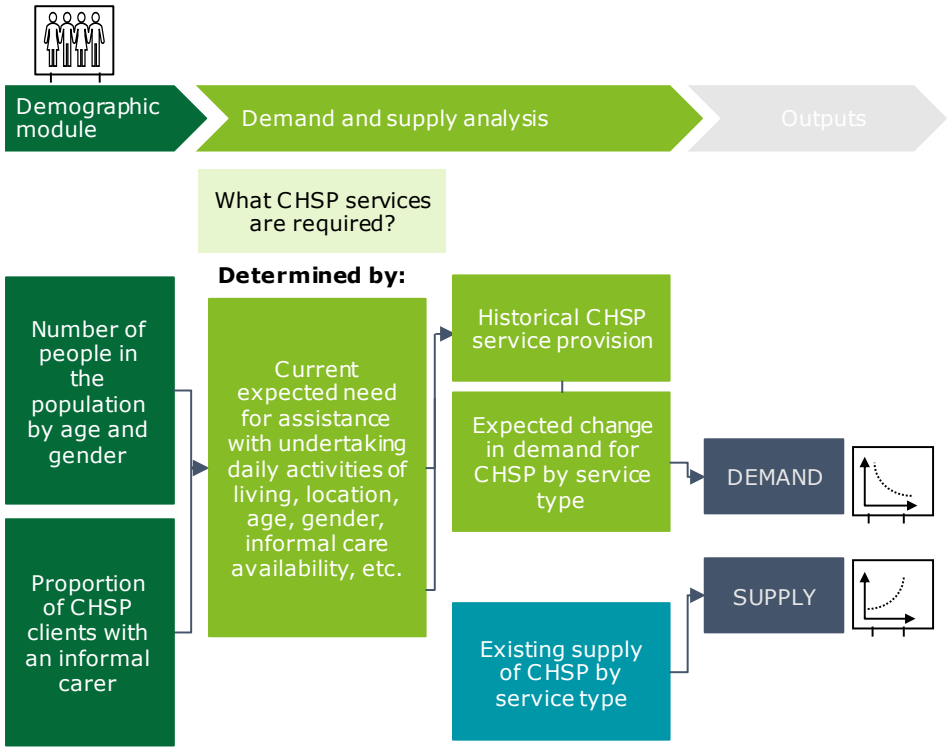
To estimate the future demand for CHSP services, NSAF assessment data were combined with expected trends in a number of key population characteristics (such as age, gender, disability, etc) in the community, based on data from the Survey of Disability, Ageing and Carers (SDAC).

Logit models were used to analyse the likelihood of a particular group of people receiving a recommendation for each service type. The final model specifications included:

- Baseline model variables: age group, gender, state, remoteness
- Number of functional limitations and health conditions
- Special needs groups: Aboriginal or Torres Strait Islander, veterans, CALD and LGBTI
- Carer status: classified as whether an individual received assistance from a carer.

The outputs from the logit model were then incorporated in an Excel model composed of population demographics by age, gender and region, disability and informal care availability, and also current service provision and unit prices. Figure 2.1 presents a visual overview of the model.

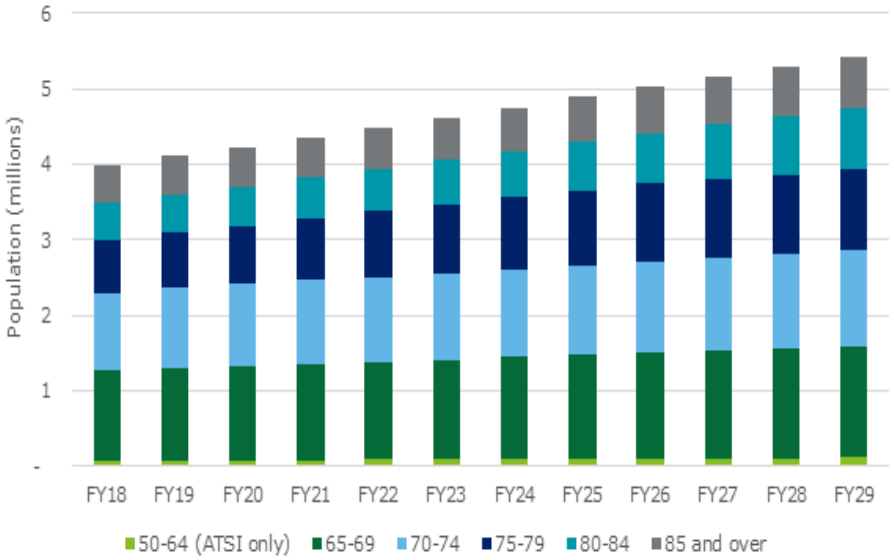
**Figure 2.1 Overview of the model**




Source: Deloitte Access Economics.

The CHSP target population is expected to grow at a relatively constant rate over the next decade, as shown in Chart 2.12. It is expected to grow from nearly 4 million in 2017-18 to just over 5.4 million in 2028-29.

**Chart 2.12: CHSP target population by age, 2017-18 to 2027-29**




Source: Department of Health (2019) Population projections, 2017 (base) to 2032 for all states and territories at Statistical Area Level 2 (SA2) by sex and age <https://www.gen-agedcaredata.gov.au/Resources/Access-data/2019/September/Population-projections,-2017-(base)-to-2032-for-al>.

# CHSP clients over time

The CHSP service mix is expected to remain reasonably stable over time

## Analysis

The current demand model incorporates measures of disability in the form of activity limitations, health conditions, and the number of people receiving informal care in current projections of CHSP demand. These factors will each play a role in the future use and demand for CHSP services. Similarly, the interaction between these factors can also impact future CHSP use and need.

The demand model has incorporated information from trends in SDAC data from 2009, 2012, and 2015 as well as data on disability from the Australian Burden of Disease study (ABDS) from 2003, 2011 and 2015 to inform future trends in disability, health and caring over the next 10 years.

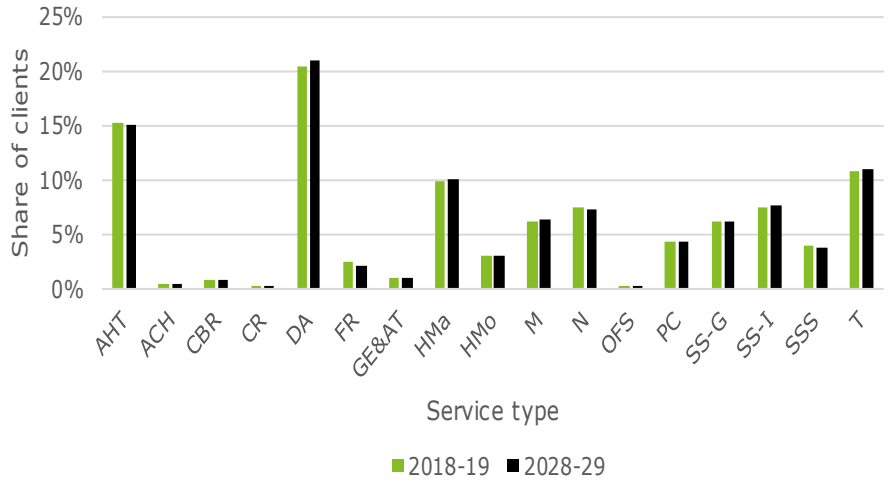
The number of clients requiring CHSP services is expected to grow from around 840,000 people in 2018-19 to around 1.17 million by 2028-29. The service mix at the aggregate level is predicted to remain relatively stable over the forecast period (Chart 2.13).

**Table 2.7: Predicted demand by client count by state and territory, '000s, 2018-19 to 2028-29**

| State/ territory | FY19 | FY21 | FY23 | FY25 | FY27 | FY29 |
|---|---|---|---|---|---|---|
| NSW | 235.6 | 248.7 | 264.1 | 280.4 | 298.6 | 316.9 |
| VIC | 229.7 | 243.7 | 260.0 | 277.0 | 296.2 | 315.3 |
| QLD | 189.6 | 204.6 | 221.6 | 239.4 | 258.7 | 277.8 |
| SA | 86.9 | 91.3 | 96.5 | 102.0 | 108.2 | 114.2 |
| WA | 58.8 | 63.2 | 68.4 | 73.9 | 80.2 | 86.7 |
| TAS | 25.6 | 27.1 | 29.0 | 30.8 | 32.9 | 34.8 |
| ACT | 11.6 | 12.5 | 13.6 | 14.7 | 16.0 | 17.1 |
| NT | 4.8 | 5.3 | 5.7 | 6.2 | 6.7 | 7.1 |
| **Total** | **842.6** | **896.4** | **959.0** | **1,024.5** | **1,097.5** | **1,169.9** |

Note: When counted for each service type, there were 1.61 million clients in 2018-19, which is estimated to increase to 2.18 million in 2028-29.
Source: Deloitte Access Economics analysis.

**Chart 2.13: Service mix as a share of total client count by service type, 2018-19 and 2028-29**




Note: In aggregate, 35.4 million hours of care were provided across the services types shown in chart 2.13 in 2018-19, which was estimated to increase to 47.3 million hours of care by 2028-29.
Source: Deloitte Access Economics analysis.

# Projected expenditure

If trends in demand continue, CHSP expenditure is projected to increase to approximately $4.5 billion by 2028-29

## Analysis

Table 2.8 shows the estimated expenditure (in nominal terms) by service type between 2018-19 and 2028-29. Expenditure was estimated by multiplying the average unit prices by the predicted output, noting the national average unit price was applied to services in each region and these were indexed by 1.3% per annum in line with the WCI-3 in 2018-19.

Overall, expenditure on the CHSP was estimated to increase from $2.6 billion in 2018-19 to $4.5 billion in 2028-29, growth of approximately 71% over the period.

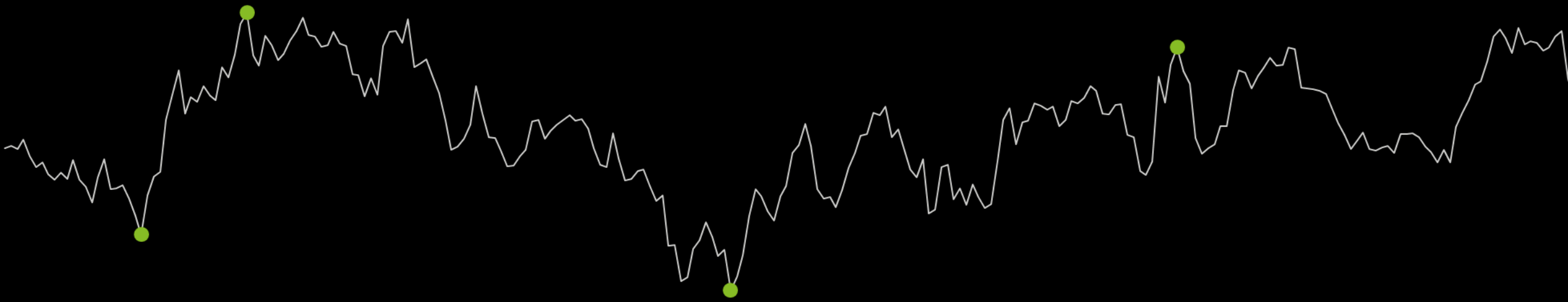
Domestic Assistance, Meals and Other Food Services are expected to be some of the fastest growing service types, with real growth exceeding 3.3% per annum. Cottage Respite, Centre-based Respite and Flexible Respite are expected to be the slowest growing services with real growth of around 1.7% to 2.1% per annum.

**Table 2.8: Predicted CHSP expenditure in nominal terms by service type at the national level, 2018-19 to 2028-29, $ millions**

| Service type | FY19 | FY21 | FY23 | FY25 | FY27 | FY29 |
|---|---|---|---|---|---|---|
| Allied Health and Therapy Services | 261.0 | 290.9 | 324.6 | 362.0 | 404.2 | 448.7 |
| Assistance with Care and Housing | 22.6 | 25.2 | 28.0 | 31.3 | 35.0 | 38.7 |
| Centre-based Respite | 83.1 | 90.4 | 99.0 | 108.4 | 119.1 | 130.3 |
| Cottage Respite | 40.0 | 43.1 | 46.8 | 50.9 | 55.7 | 60.8 |
| Domestic Assistance | 538.6 | 603.5 | 678.2 | 760.8 | 854.6 | 954.7 |
| Flexible Respite | 155.1 | 167.5 | 181.7 | 197.4 | 215.3 | 233.9 |
| Goods, Equipment and Assistive Technology | 27.1 | 29.8 | 32.6 | 35.8 | 39.5 | 43.5 |
| Home Maintenance | 105.4 | 118.0 | 132.4 | 148.3 | 166.2 | 185.2 |
| Home Modifications | 65.4 | 72.6 | 80.8 | 89.8 | 100.0 | 110.8 |
| Meals | 99.6 | 111.3 | 125.1 | 140.6 | 158.7 | 178.3 |
| Nursing | 275.4 | 304.9 | 339.0 | 376.9 | 420.6 | 466.4 |
| Other Food Services | 4.2 | 4.8 | 5.3 | 6.0 | 6.8 | 7.6 |
| Personal Care | 232.7 | 256.7 | 284.2 | 315.1 | 350.9 | 389.1 |
| Social Support - Group | 286.9 | 318.8 | 355.7 | 396.6 | 443.4 | 493.2 |
| Social Support - Individual | 187.3 | 209.2 | 234.6 | 263.3 | 296.7 | 332.9 |
| Specialised Support Services | 70.1 | 77.7 | 86.4 | 95.9 | 106.4 | 117.4 |
| Transport | 190.8 | 213.1 | 239.0 | 267.8 | 301.0 | 336.5 |
| **Total** | **2,645.3** | **2,937.4** | **3,273.5** | **3,646.9** | **4,074.3** | **4,527.9** |

Note: unit prices for each unit of output were indexed at 1.3% per annum, in line with the WCI-3 for 2018-19.

Source: Deloitte Access Economics analysis.



# 3 Supplier landscape.

Who is providing CHSP services and how are they being provided?

# Provider demographics

## Provider characteristics by location

## Analysis

In 2018-19, there were 1,458 providers funded to deliver CHSP services. Analyses were conducted on 1,379 of these providers, representing those providers who could have their service provision and expenditure data linked.[9]

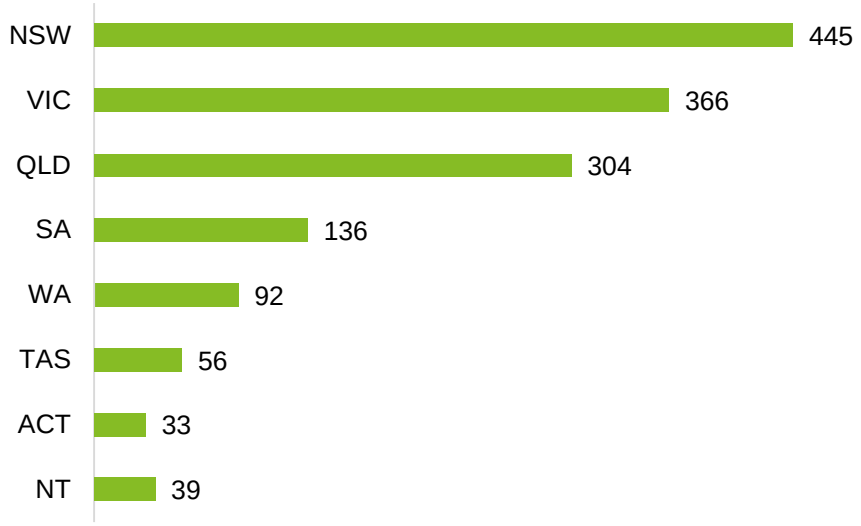
As outlined in Chart 3.1, NSW had the most providers operating at 445, closely followed by Victoria (366) and Queensland (304). The ACT and NT had 33 and 39 service providers respectively. Importantly, providers can operate across different locations and service types – therefore totals will not add.

Not-for-profit providers account for 60% of all sessions, followed by government (32%) and for-profit providers (8%) (Table 3.1)

The distribution of provider types is relatively similar across states and territories, with the exception of Victoria where government providers play a large role (42%) (Chart 3.2).

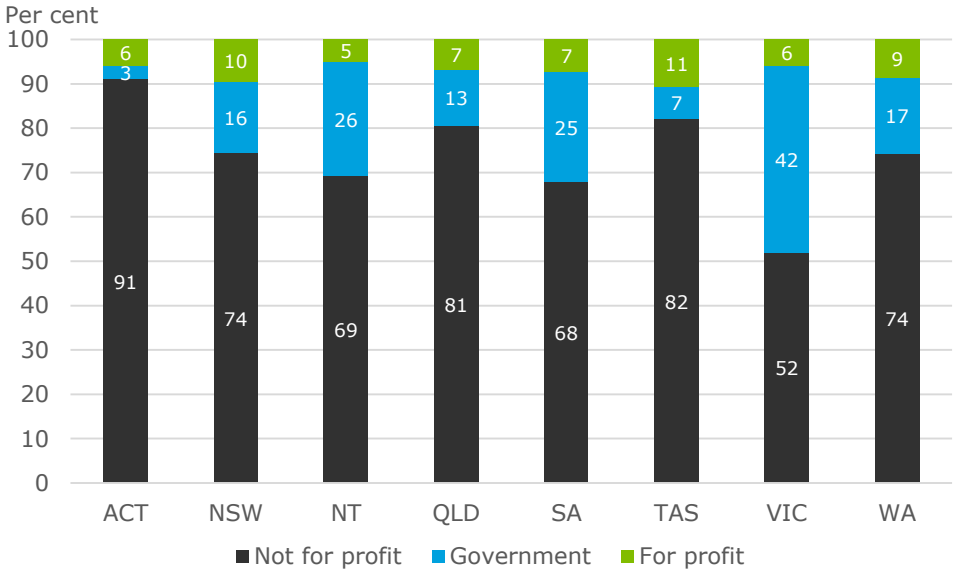
The outlet to provider ratio (Table 3.2) is likely linked to population density and provider type. The NT and SA have the highest outlet to provider ratio, in contrast to the ACT which is a single location.

**Chart 3.1 Number of providers by state or territory, 2018-19**




Source: Deloitte Access Economics analysis of DEX (2019)

**Chart 3.2 Share of provider types by state or territory, 2018-19**




Source: Deloitte Access Economics analysis of DEX (2019)

**Table 3.1 Comparison of sessions delivered and the proportion of total sessions by type of provider, 2018-19**

| Provider type | Proportion of sessions (%) | Average number of sessions delivered | Providers |
|---|---|---|---|
| For-profit | 8 | 24,128 | 97 |
| Government | 32 | 29,012 | 326 |
| Not-for-profit | 60 | 18,578 | 956 |

Source: Deloitte Access Economics analysis of DEX (2019)

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Note: A government provider can be operated by either a local government, state government or a federal funded provider.

9. These linking errors occur because of name and organisation ID discrepancies between datasets.

**Table 3.2 Number of outlets by provider type, 2018-19**

| | ACT | NSW | NT | QLD | SA | TAS | VIC | WA |
|---|---|---|---|---|---|---|---|---|
| Outlets | 61 | 1,193 | 117 | 740 | 402 | 124 | 808 | 256 |
| Avg. outlet to provider ratio | 1.8 | 2.7 | 3.0 | 2.4 | 3.0 | 2.2 | 2.2 | 2.8 |

Source: Deloitte Access Economics analysis of DEX (2019)

Providers may have **multiple outlets**, which are the physical location used to provide services to clients.

# Sessions delivered

Average number of sessions delivered

## Analysis

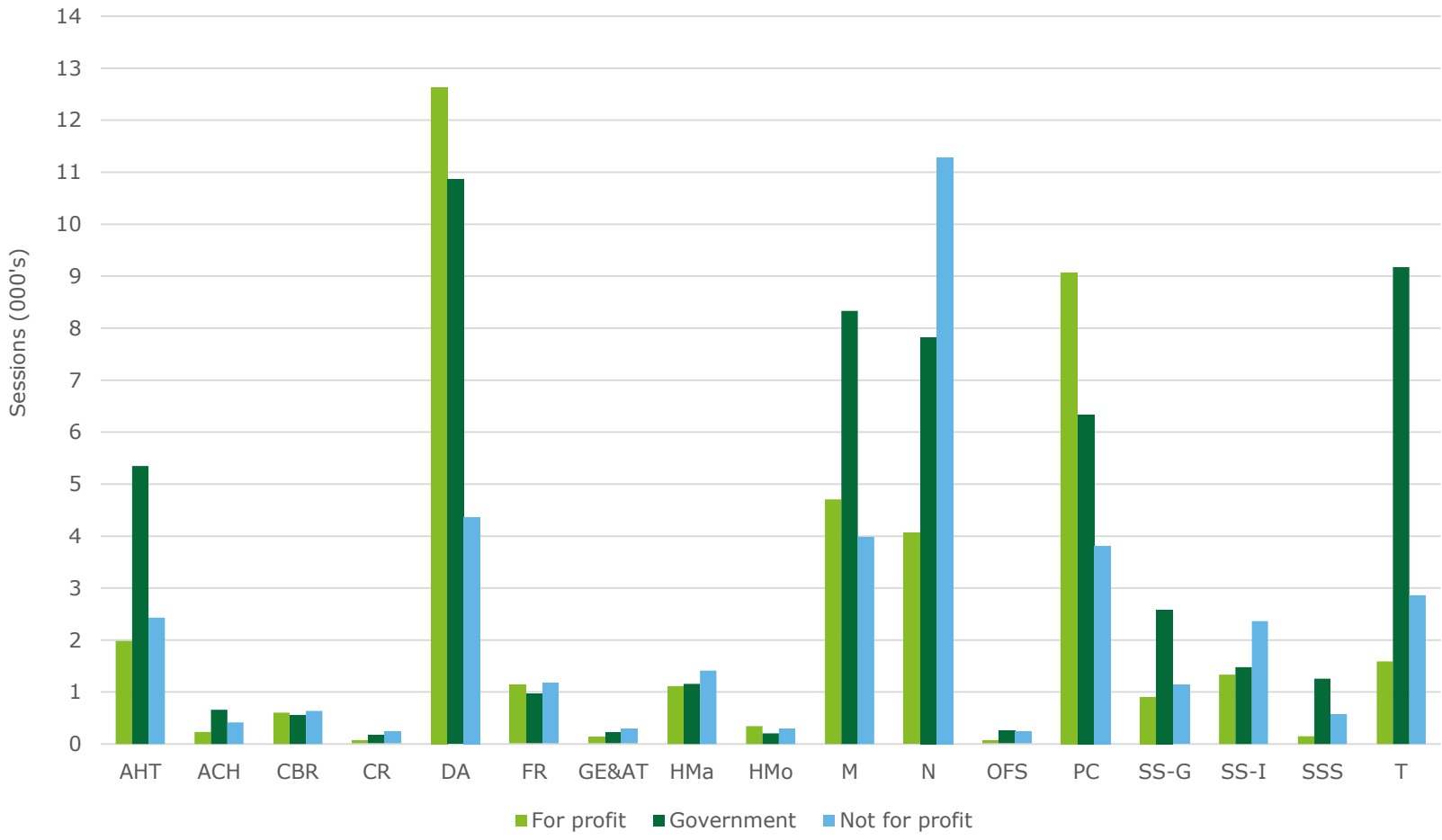
The data suggest each provider type has a niche set of service types where they provide more services than the other provider types (Chart 3.3).

Government service providers deliver noticeably more, up to double, the amount of services compared to the other provider types including: Allied Health And Therapy Services (5,300), Assistance With Care And Housing (600), Meals (8,300), Social Support – Group (2,300), Social Support Group(2,500) and Transport (9,200) services.

Not-for-profit providers delivered the most Nursing (more than 11,000) and almost double the amount of services in Social Support – Individual (2,500).

For-profit providers lead the delivery of Personal Care – approximately twice the amount of sessions (9,000) compared to government providers. They also deliver the most Domestic Assistance service sessions (12,600).

**Chart 3.3 Average number of sessions delivered by provider and service type, 2018-19**




Source: Deloitte Access Economics analysis of DEX (2019)

# Who and what

Client characteristics by level of remoteness, provider location and provider type

## Analysis

The median and inter-quartile range are used to provide an overview of the distribution of clients with various characteristics across states and territories, remoteness levels and different provider types. The length of the box (the inter-quartile range) represents providers between the 25th percentile and 75th percentile, or the middle 50% of providers.

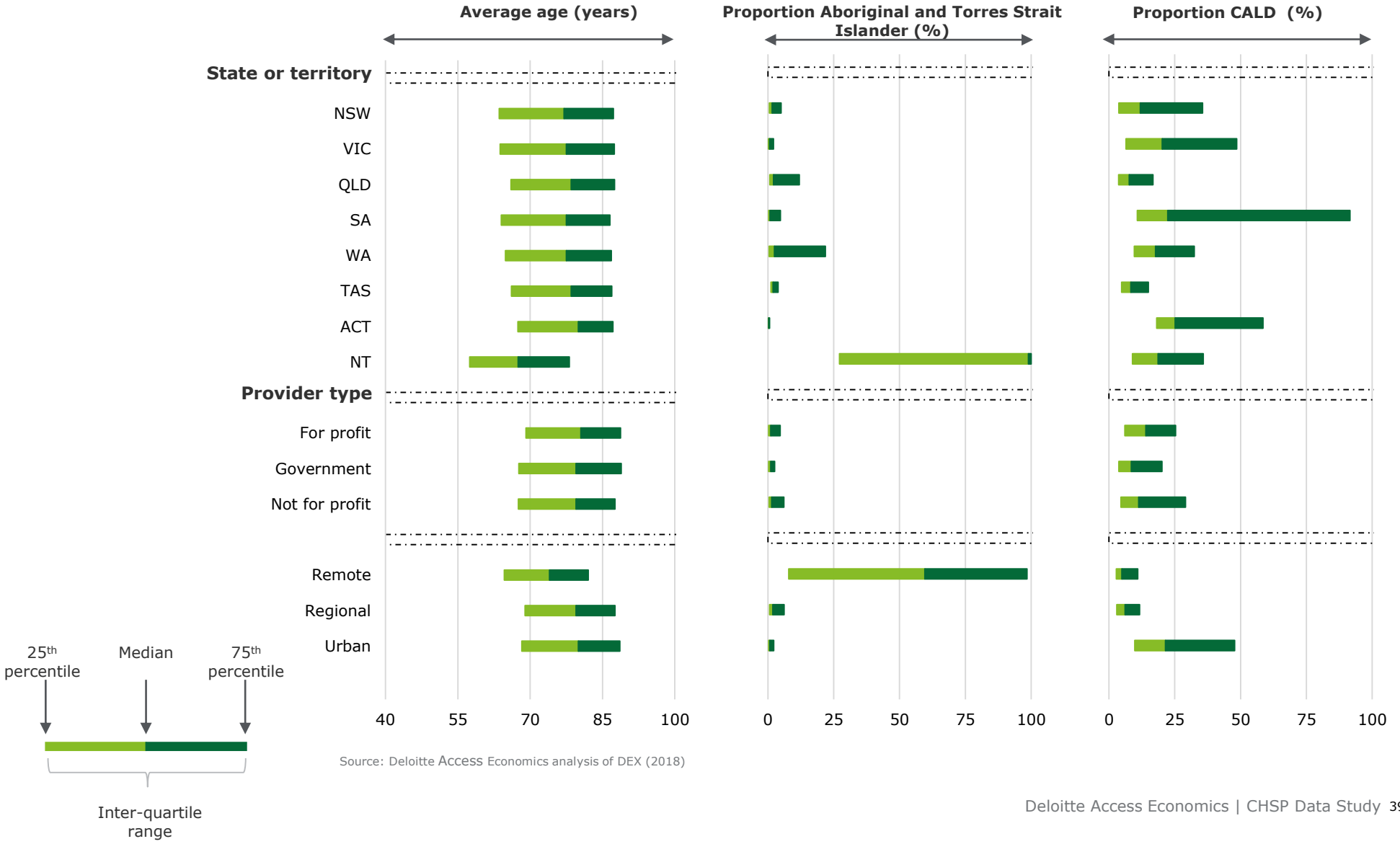
The data have been summarised by weighting each characteristic by client attendances for each provider. This means the distribution will be more representative of clients who receive services more frequently.

The average (median) age of clients was relatively consistent across a number of service provider characteristics in 2018-19. However, providers in remote areas and the NT were more likely to deliver services to younger clients, on average.

Higher proportion of Aboriginal and Torres Strait Islander clients were also correlated with remote areas and the NT reflecting the lower age entry for ASTI clients.

Higher average proportions of CALD clients are observed for services delivered in urban areas. The ACT had the highest median percentage.

**Chart 3.4 Average age, proportion Aboriginal and Torres Strait Islander, proportion CALD across a range of service providers characteristics, 2018-19**




Source: Deloitte Access Economics analysis of DEX (2018)

# Who and what

## Client characteristics by level of remoteness, provider location and provider type

## Analysis

The median and inter-quartile range are used to provide an overview of the distribution of clients with various characteristics across states and territories, remoteness levels and different provider types. The length of the box (the inter-quartile range) represents providers between the 25th percentile and 75th percentile, or the middle 50% of providers.

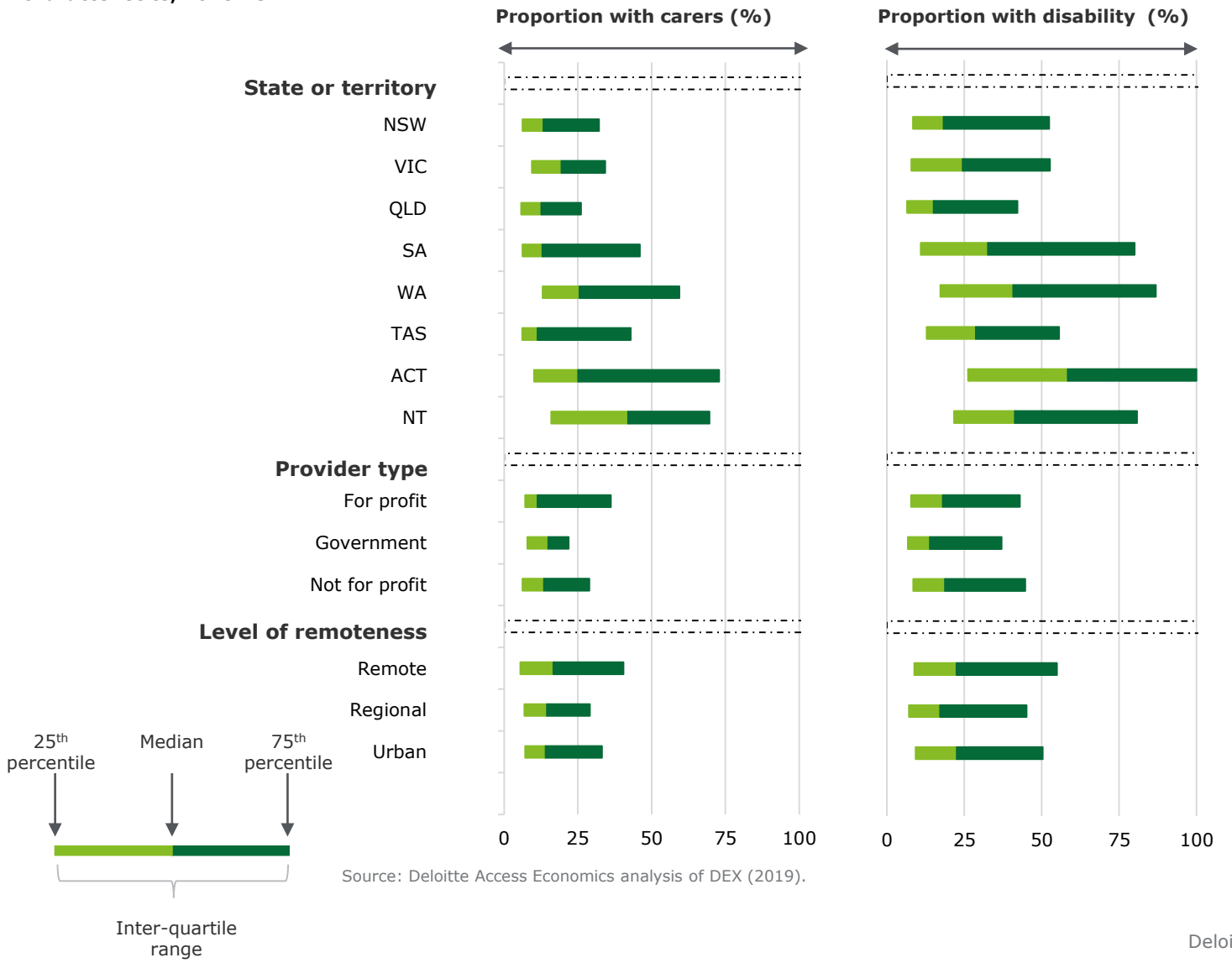
For-profit providers and providers in remote areas are more likely to service clients with a carer.

The proportion of clients with disability is noticeably varied across providers.

The more populous states: NSW, Victoria and Queensland have less variation and a lower median proportion of clients with disability.

Government providers have a lower proportion of clients experiencing homelessness which could be due to the larger number of total clients serviced by government.

**Chart 3.5 Average proportion of clients with carers, proportion with disability and proportion experiencing homelessness for service providers across a range of characteristics, 2018-19**




Source: Deloitte Access Economics analysis of DEX (2019).

# Market analysis

The NT, WA and ACT have the largest share of services with some market challenges

## Analysis

Logical classification of service type SA2 markets produced: 23% thin, 37% balanced and 40% liquid service type SA2 markets in Australia in 2018-19.

The NT, WA and the ACT have the most thin markets (Chart 3.6) while Queensland, NSW and SA have the most liquid markets. A very low number of clients and/or providers in a market was one of the major factors driving whether a market was classified as being thin.

As show in Chart 3.7, Other Food Services and Cottage Respite have the most thin SA2 markets in 2018-19 with shares of 49% and 44% respectively.

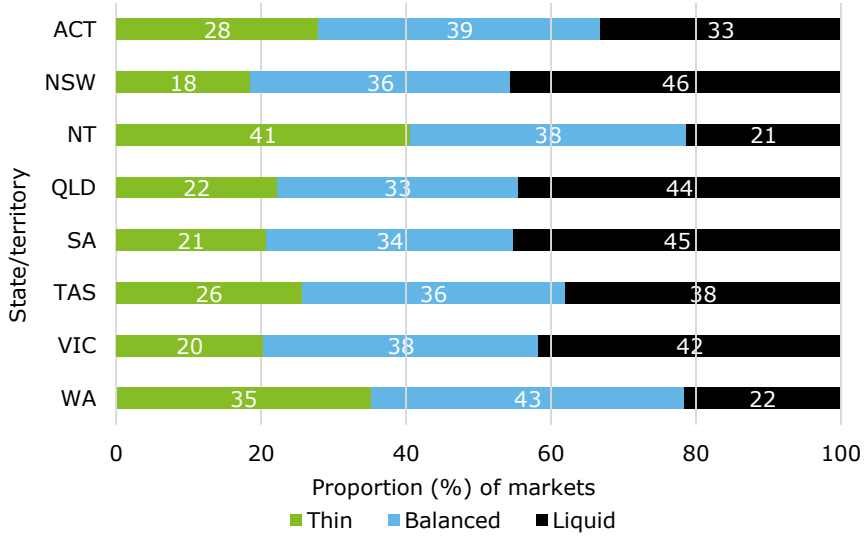
Assistance with Care and Housing, Home Maintenance and Centre-based Respite had the most liquid markets in 2018-19.

Other Food Services, Cottage Respite, Goods, Equipment and Assistive Technology, and Assistance with Care and Housing are the service types with significantly lower shares of balanced markets, at approximately 3-7% of their total market counts.

The logical classification of service type SA2 markets utilised markers of demand and supply side factors (see Appendix C), including:

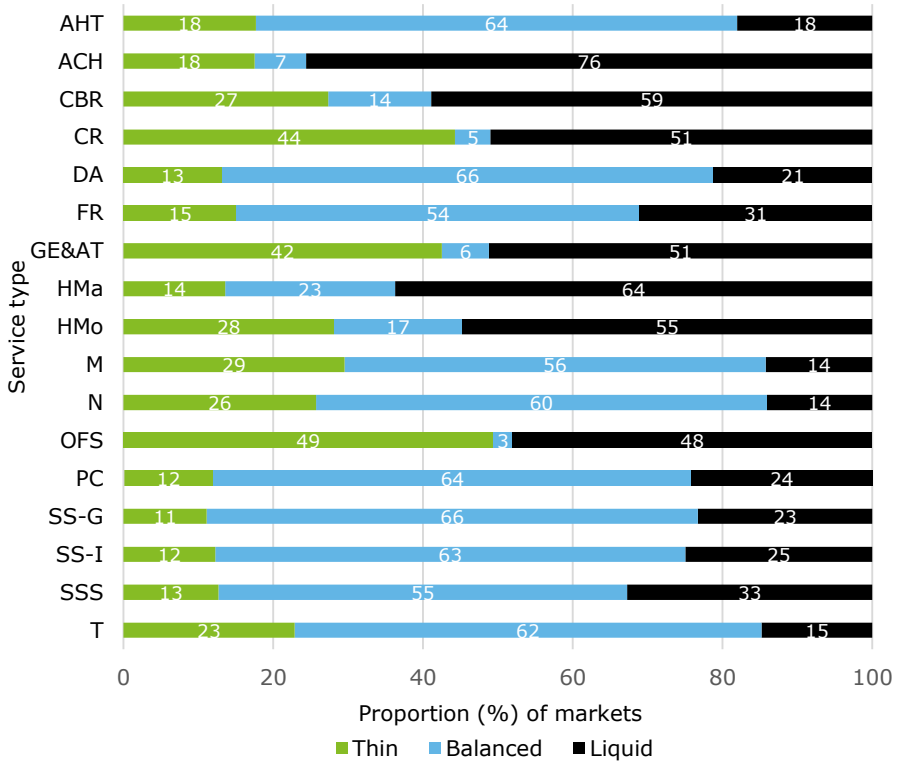
- Count of providers operating in the market
- Count of clients in each market
- Count of recommendations received for clients in that market.
- Ratio of rejections by providers to recommendations.
- Elapsed time between recommendation and the first instance of service delivery

**Chart 3.6 Percentage of thin, balanced and liquid service type SA2 markets in each state and territory in 2018-19**




Source: Deloitte Access Economics analysis of DEX, NSAF and Financial data

**Chart 3.7 Comparison of the percentage (%) of thin, balanced and liquid service type SA2 markets by service types in 2018-19**




Source: Deloitte Access Economics analysis of DEX, NSAF and Financial data

# Market analysis

Relative concentration of service delivery in ACPRs

## Analysis

Figure 3.2 maps the count of services delivered in thin markets in each ACPR where **each client is counted once for each distinct service type they receive**. Figure 3.3 maps the population aged 65 years or older in each ACPR.

While it is intuitive that there are relatively few clients in thin markets in remote Australia as there are few clients overall, it is apparent that there are areas that are classified as being thin while still having a relatively high number of people over the age of 65. For example, this may be the case in regional areas of Victoria or in and around Perth (red boxes).

Importantly, the metrics used to derive thin markets indicate areas of relatively greater need. These locations are not solely in regional and remote areas of Australia, but also in inner regional and metropolitan areas too.

**Figure 3.1 Count of clients receiving services in thin markets by ACPR, 2018-19**

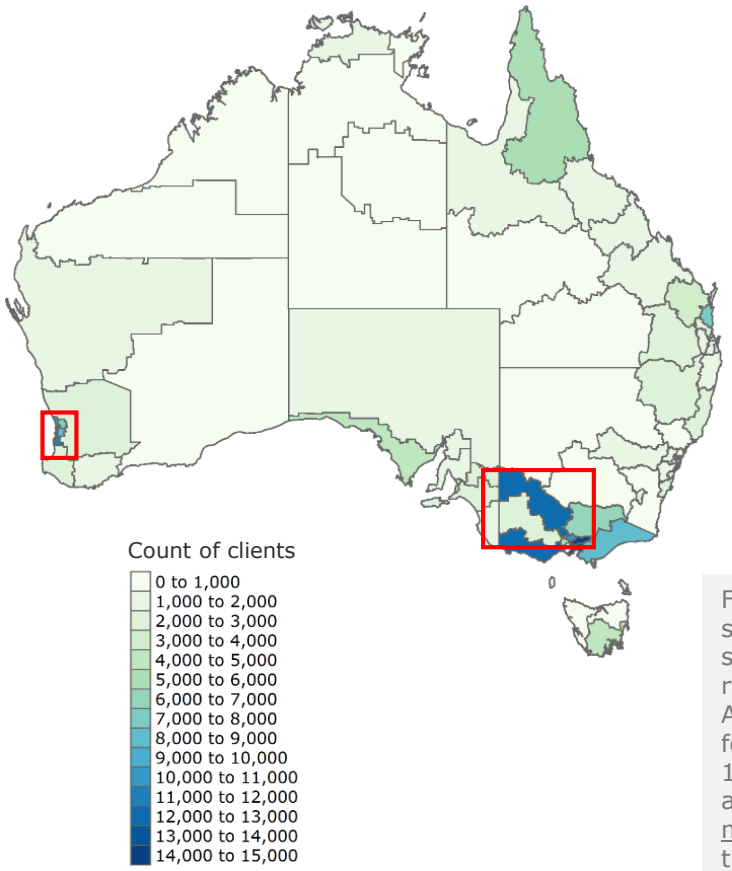
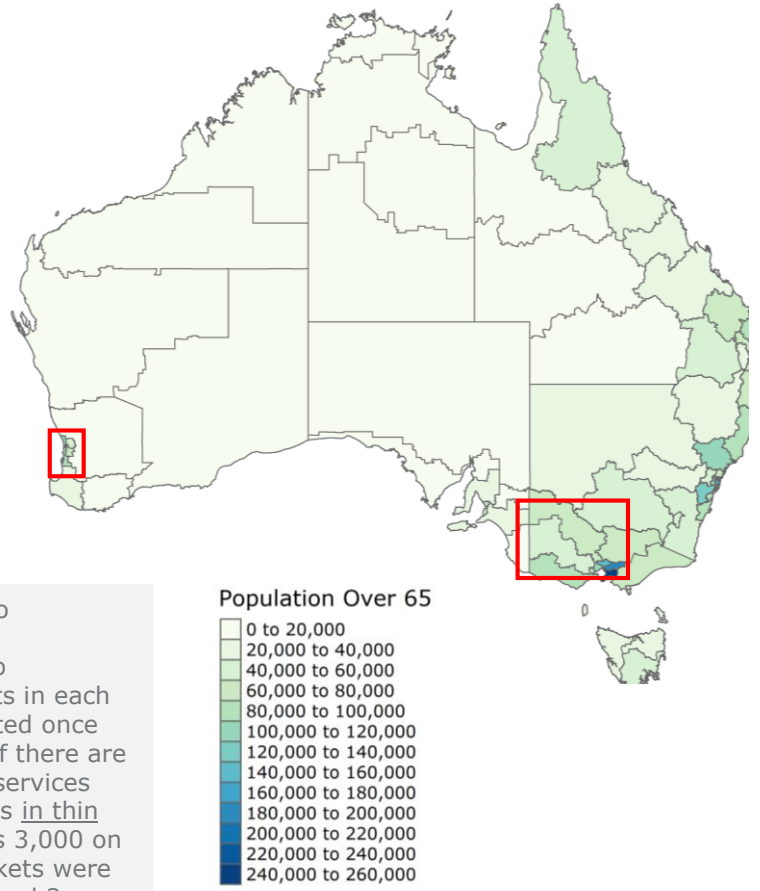



Figure 3.2 maps the concentratio service delivery in thin markets. shows the number of clients who receiving services in thin markets in each ACPR. Each service type is counted once for each client, so for example, if there are 1,000 people receiving Nursing services and 2,000 people receiving Meals in thin markets, this would be shown as 3,000 on the map for the ACPR. Thin markets were derived at the Statistical Area Level 2 geographical classification.

**Figure 3.2 Population over 65 by ACPR, 2018-19**




Source: Deloitte Access Economics analysis of DEX, NSAF and CHSP expenditure data.

# Market analysis

## Expended funding per client across market types

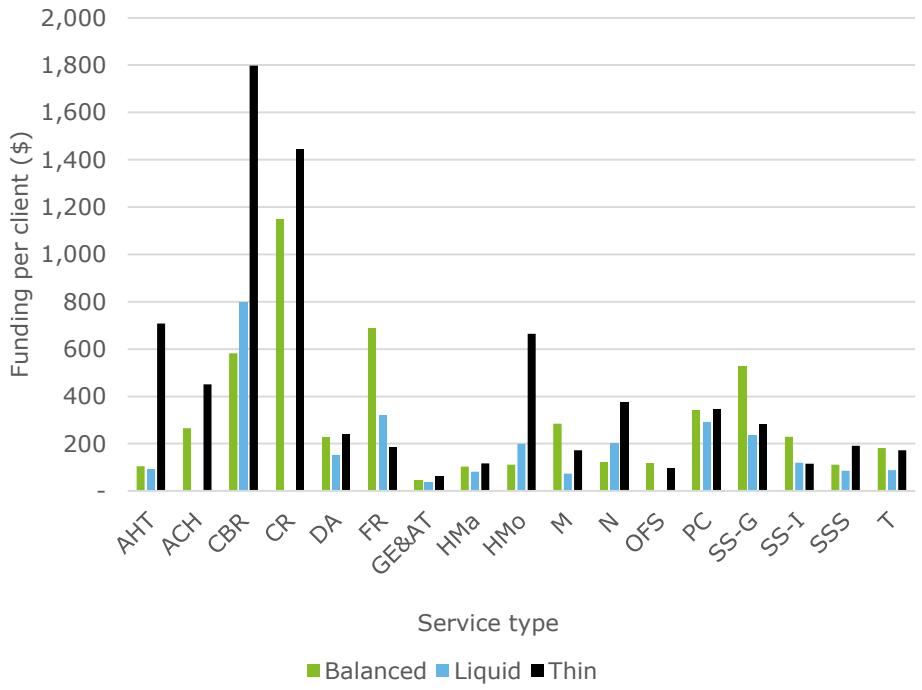
## Analysis

In comparison to balanced markets, thin markets have fewer providers but slightly higher count of clients, which also corresponds to a similar level of average funding. A few service types however display significantly higher average funding per client in thin markets, such as Allied Health and Therapy Services and Centre-based Respite (Chart 3.8). This may be a marker of more complex clients in these markets.

Liquid markets have more clients, more suppliers, and higher funding, on average, compared to balanced markets which translated into lower average funding per client compared to balanced markets, mainly driven by large differences in Assistance Home and Caring, Flexible Respite, Meals and Domestic Assistance. The exceptions to this trend are Centre-based Respite, Home Modifications and Nursing.

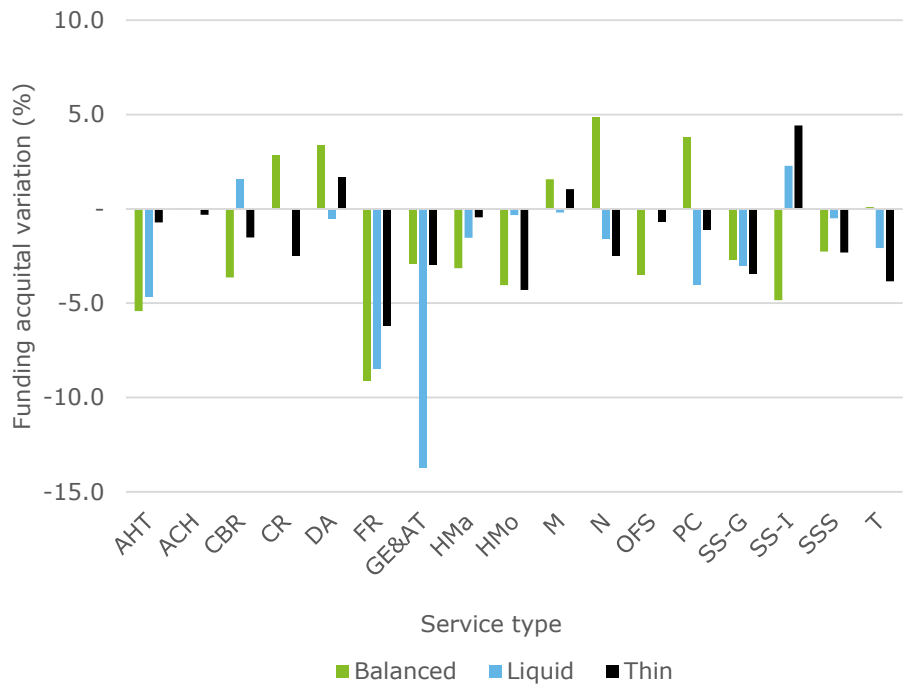
The proportion of funding that is acquitted also varies across markets and service types, as shown in Chart 3.9. Markets where expenditure was lower than planned may be indicative of either overestimating demand, or an inability to align supply with service demand.

**Chart 3.8 Average expended funding ($) per client for each service type in each market type**




Source: Deloitte Access Economics analysis of DEX, NSAF and Financial data

**Chart 3.9 Average variation in funding acquittal (%) for each service type in each market type**




Source: Deloitte Access Economics analysis of DEX, NSAF and Financial data

# Volunteers workforce

Analysis of selected survey questions on volunteer workforce

## Analysis

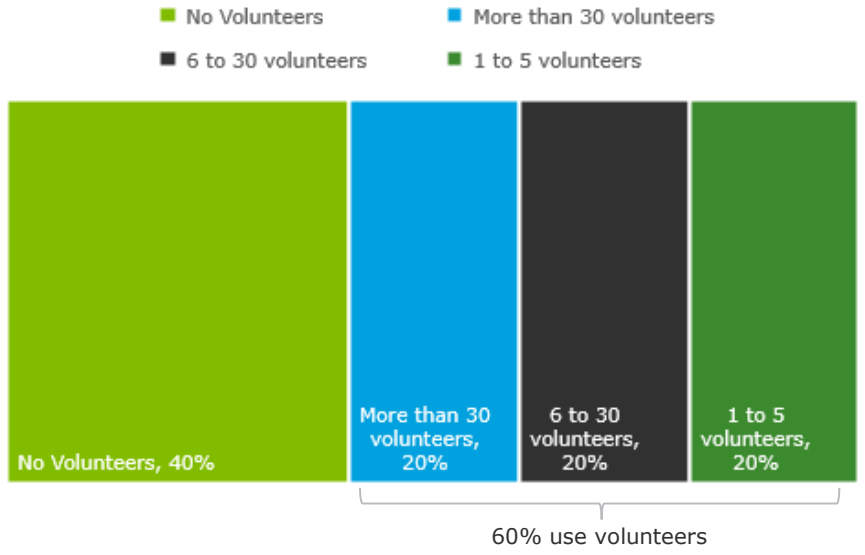
There were 863 valid responses to the CHSP service provider survey, resulting in a response rate of 60% (further details provided in Appendix A and Appendix B). These providers spanned all states and territories, service types and included a range of business sizes. These were uniquely matched to departmental Activity Work Plan data.

60% of survey respondents use volunteers as part of their CHSP workforce (Chart 3.10). One third of service providers with volunteers as part of their workforce use 1 to 5 volunteers, the next third use 6 to 30 and the last third use more than 30 volunteers.

Providing direct client services was the most commonly reported role for volunteers (Chart 3.11).

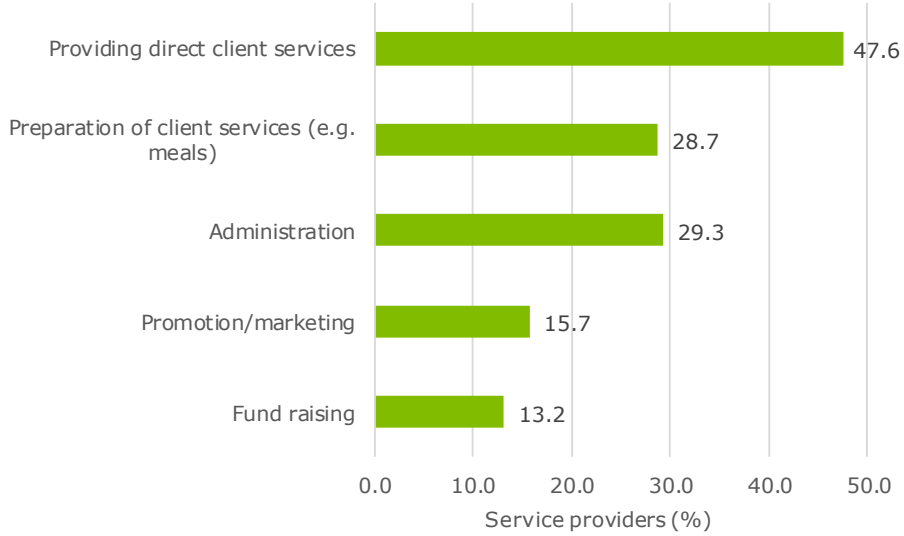
Service providers can be grouped into different sizes based on the number of reported full-time equivalent staff (FTE) (Table 3.3). Large providers are less likely to use volunteers. Nearly 50% of larger providers do not use any volunteers compared to only 30% of small providers.

**Chart 3.10 Does your organisation routinely use volunteers as a part of your CHSP workforce?**




Source: Deloitte Access Economics analysis of service provider survey (2019)

**Chart 3.11 How do volunteer's contribute to service delivery?**




Note: respondents could select multiple options, hence the percentages will not sum to 100%

Source: Deloitte Access Economics analysis of service provider survey (2019)

**Table 3.3 Use of volunteers by provider size (FTE)**

| Size (FTE) | FTE ranges (count) | No Volunteers (%) | 1 to 5 Volunteers (%) | 6 to 30 volunteers (%) | More than 30 volunteers (%) |
|---|---|---|---|---|---|
| Large | 70+ | 49 | 15 | 20 | 16 |
| Medium | 11-70 | 42 | 19 | 18 | 20 |
| Small | 0-10 | 30 | 24 | 22 | 25 |

Source: Deloitte Access Economics analysis of service provider survey (2019)

The National Aged Care Workforce Census and Survey[10] shows that volunteer work complements that of the paid labour force. For example, volunteers often assist with social activity support assistance and a range of other activities including companionship and/or befriending aged care consumers.

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10. Mavromaras et al (2017). 2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016. Report prepared for the Department of Health.

# Flexibility use and client contributions

Analysis of selected survey questions on flexibility use and client contribution

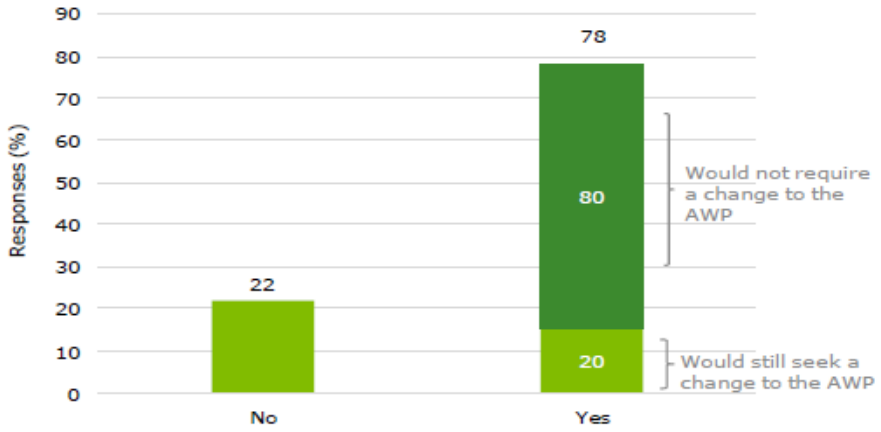
## Analysis

Nearly 80% of survey respondents indicated that they would be better supported by increasing the flexibly provision from 20% to 50%, chart 3.12. Of those that responded "Yes", 80% responded they expected the 50% flexibility provision to be sufficient to manage changing demand across their services without requiring a change to their Activity Work Plan (AWP).

The majority of respondents (81%) require client contributions for all or some of their CHSP services (Chart 3.13). The most common reasons for setting client contributions included, (Chart 3.14):

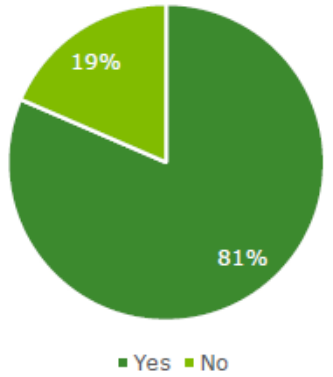
- To recoup cost
- To encourage clients to value services
- Due to historical policies of the state/territory that provider operated in which required client contributions.

**Chart 3.12 Flexibility provision and survey participants perspective on change**



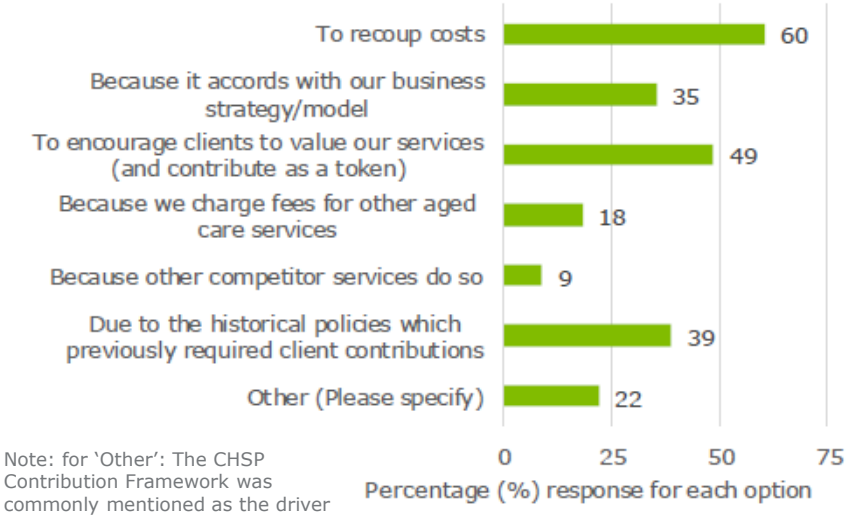

Source: Deloitte Access Economics analysis of service provider survey (2019)

**Chart 3.13 Proportion of CHSP providers who set client contributions**



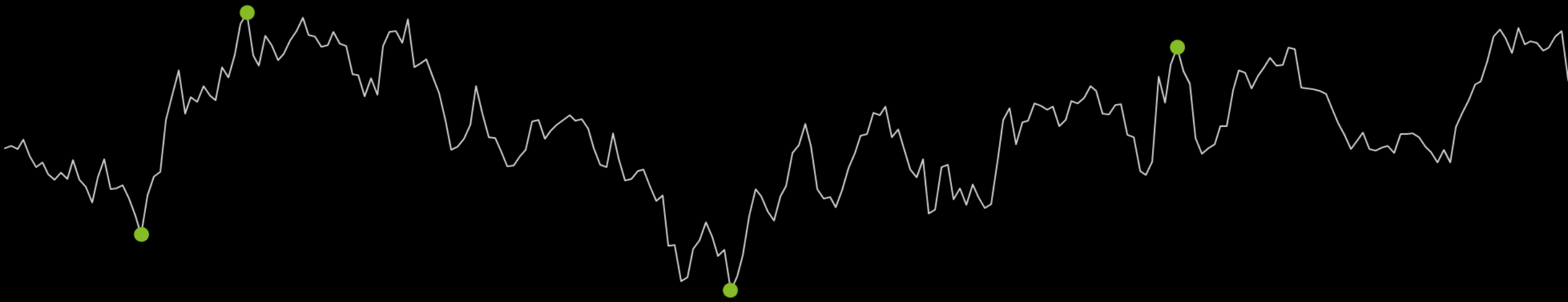

Source: Deloitte Access Economics analysis of service provider survey (2019)

**Chart 3.14 Reasons for setting client contributions**




Note: for 'Other': The CHSP Contribution Framework was commonly mentioned as the driver for setting client contributions

Source: Deloitte Access Economics analysis of service provider survey (2019)



# 4 Funding, expenditure and unit prices.

How does funding, expenditure and unit prices vary?

# Funding

## Funding by service type and state and territory

## Analysis

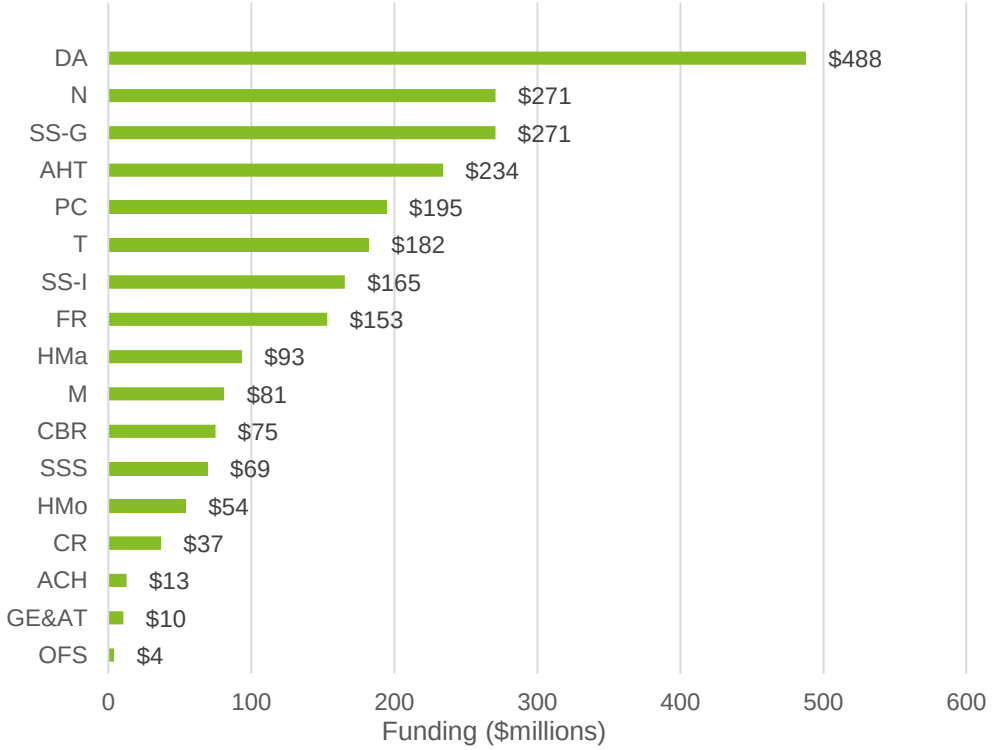
In 2018-19, **$2.39bn** in funding was allocated to providers across Australia under CHSP funding streams.[11]

More than half of funding was for the combination of Domestic Assistance ($488m), Nursing ($271m), Social Support – Group ($271m) and for Allied Health and Therapy Services ($234m). Funding was substantially lower for Other Food Services ($4m), Goods, Equipment and Assistive Technology ($10m) and Assistance with Care and Housing ($13m).

By state and territory, 29% of funding was allocated to NSW, 25% to Victoria and 22% to Queensland. SA, Tasmania, ACT and NT, received less than 10%, while WA received 10% (Chart 4.2).

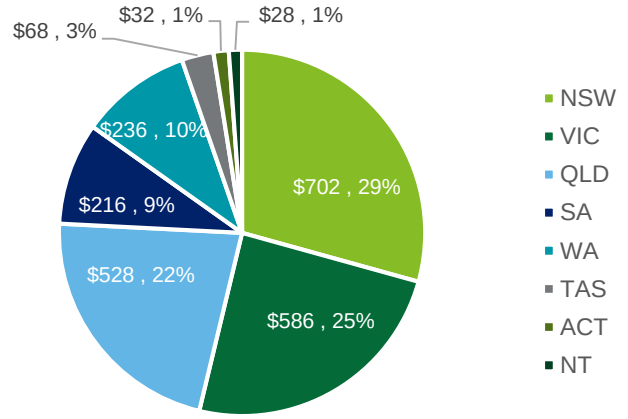
Funding allocations are largely in line with the share of clients across states and territories (Chart 4.3). However, Victoria for example receives less funding than its share of clients (25% vs 28%) while NSW receives slightly more (29% vs 25%).

**Chart 4.1 Total funding by service type ($m), 2018-19**



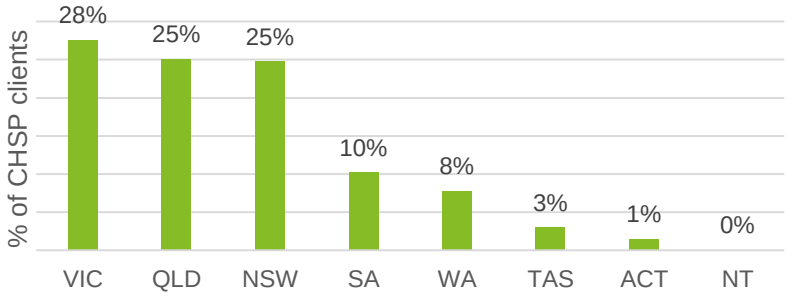

Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19.

**Chart 4.2 Total funding by state and territory ($m, %), 2018-19**




Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19.

**Chart 4.3 Client distribution by state and territory, 2018-19**




Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19.

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11. Public reporting by the Aged Care Financing Authority (ACFA) quoted total CHSP funding at approximately $2.6 billion. The reason for the difference is due to the construction of the database used as the source for the analysis in this section. To construct funding and expenditure at an ACPR level, two separate AWP workbooks were merged and then joined to the DEX data. One of the AWP workbooks ('20190603 – AWP Report') had a fewer number of providers than in the AWP tracking workbook or the DEX data – for example providers whose financial reporting for the year was not yet available. In the resultant join, those providers not present in the AWP tracking workbook were excluded.

# Funding by state and territory

Funding and output distribution by service types and location

## Analysis

The funding distribution differs slightly from the volume of output delivered by states and territories.

For example, 1.4 million units of Meals were delivered in Victoria in 2018-19 (nearly 23% of total Meals units), but received approximately $13.6m in funding (nearly 17% of total funding for Meals). NSW and Queensland delivered 2.6 million and 1.3 million units of Meals Services (43% and 22%) and received respectively $33m and $14m (41% and 17% of total funding for this service type).

Victoria delivered nearly 1.1m hours of Nursing (49% of total Nursing hours), more than 3 times compared to NSW, which delivered more than 352 million hours (16% of total Nursing hours). NSW had funding of $58m (22% of total funding for Nursing) while Victoria's funding amounted to approximately double that - $120.0m (44% of total funding).

**Table 4.1 Output delivered by service type and state and territory ('000s), 2018-19**

| | AHT | ACH | CBR | CR | DA | FR | GE&AT | HMa | HMo | M | N | OFS | PC | SS-G | SS-I | SSS | T |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NSW** | 295 | 22 | 409 | 227 | 1,999 | 706 | 12 | 399 | 14,272 | 2,604 | 352 | 19 | 841 | 2,040 | 984 | 74 | 1,899 |
| **VIC** | 698 | 27 | 279 | 166 | 2,096 | 396 | 5 | 159 | 2,740 | 1,396 | 1,062 | 7 | 757 | 2,322 | 267 | 186 | 247 |
| **QLD** | 459 | 15 | 303 | 142 | 2,378 | 367 | 8 | 378 | 7,911 | 1,345 | 397 | 9 | 584 | 1,593 | 748 | 72 | 1,077 |
| **SA** | 176 | 16 | 87 | 45 | 664 | 78 | 32 | 123 | 2,492 | 207 | 216 | 4 | 131 | 512 | 324 | 33 | 360 |
| **WA** | 101 | 6 | 164 | 189 | 852 | 110 | 3 | 198 | 1,359 | 287 | 28 | 6 | 251 | 900 | 257 | 4 | 589 |
| **TAS** | 28 | 3 | 19 | 17 | 268 | 67 | 1 | 31 | 277 | 88 | 76 | 0 | 127 | 131 | 89 | 17 | 208 |
| **ACT** | 17 | 2 | 35 | 8 | 103 | 29 | 4 | 18 | 571 | 70 | 25 | 0 | 36 | 100 | 47 | 5 | 106 |
| **NT** | 6 | 0 | 6 | 5 | 8 | 2 | 0 | 0 | 0 | 3 | 0 | 0 | 2 | 1 | 6 | 1 | 5 |
| **AUS** | 1,780 | 91 | 1,302 | 798 | 8,369 | 1,755 | 66 | 1,306 | 29,621 | 6,000 | 2,157 | 45 | 2,728 | 7,599 | 2,721 | 391 | 4,491 |

Note: WA data not representative as WA transitioned to the CHSP in 2018. Principle unit of output are used – hours, quantity and dollars.
Source: Deloitte Access Economics analysis of DEX (2019)

**Table 4.2 Funding by service type and state and territory ($ millions), 2018-19**

| | AHT | ACH | CBR | CR | DA | FR | GE&AT | HMa | HMo | M | N | OFS | PC | SS-G | SS-I | SSS | T | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NSW** | 36.1 | 4.9 | 24.2 | 9.6 | 135.3 | 57.7 | 0.6 | 22.9 | 28.0 | 33.0 | 58.8 | 1.2 | 63.9 | 74.1 | 59.6 | 10.3 | 81.7 | 701.7 |
| **VIC** | 95.8 | 3.3 | 14.6 | 7.8 | 104.8 | 34.1 | 0.0 | 10.7 | 3.5 | 13.6 | 120.0 | 0.3 | 50.6 | 70.7 | 10.1 | 38.5 | 7.0 | 585.7 |
| **QLD** | 57.4 | 1.0 | 12.8 | 7.1 | 130.1 | 27.7 | 1.7 | 27.7 | 12.9 | 14.1 | 47.4 | 0.5 | 33.8 | 54.3 | 41.7 | 12.3 | 45.4 | 527.9 |
| **SA** | 24.7 | 1.4 | 6.6 | 3.1 | 40.4 | 10.7 | 4.0 | 9.4 | 3.6 | 8.6 | 28.5 | 0.2 | 12.6 | 22.2 | 21.5 | 4.4 | 14.3 | 216.3 |
| **WA** | 11.5 | 1.0 | 8.2 | 7.1 | 51.8 | 13.7 | 2.2 | 17.6 | 4.1 | 3.6 | 5.6 | 1.8 | 22.2 | 40.0 | 22.9 | 0.8 | 21.5 | 235.6 |
| **TAS** | 5.3 | 0.5 | 1.9 | 1.0 | 15.0 | 4.7 | 0.7 | 2.3 | 0.9 | 2.3 | 8.2 | 0.0 | 7.9 | 5.0 | 4.6 | 1.3 | 6.0 | 67.5 |
| **ACT** | 1.6 | 0.3 | 2.0 | 0.3 | 6.3 | 2.8 | 0.6 | 1.6 | 0.9 | 0.6 | 2.0 | 0.0 | 2.8 | 2.6 | 3.3 | 0.7 | 3.8 | 32.3 |
| **NT** | 1.6 | 0.4 | 4.5 | 0.7 | 3.9 | 1.5 | 0.6 | 1.2 | 0.2 | 5.2 | 0.2 | 0.0 | 0.9 | 1.6 | 1.6 | 1.1 | 2.5 | 27.8 |
| **AUS** | 233.9 | 12.7 | 74.8 | 36.8 | 487.7 | 152.9 | 10.4 | 93.4 | 54.2 | 81.0 | 270.7 | 3.9 | 194.6 | 270.7 | 165.4 | 69.4 | 182.3 | 2394.8 |

Note: WA data not representative as WA transitioned to the CHSP in 2018
Source: Deloitte Access Economics analysis of DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19

# Funding by client

Average funding per client by service types and location

## Analysis

Average funding per client ranged from $1,137 in SA to $2,411 in the NT in 2018-19. Average funding in WA is higher than average at $2,118 per client (Chart 4.4).

Average funding per client ranged from $589 for Home Maintenance services to $10,379 for Cottage Respite nationally (Table 4.3).

By service type, for example, the average funding per client for Allied Health and Therapy Services was $956 on average but was $761 in NSW and $1,478 in WA.

There are also some notable outliers – even at a state and territory level – such as for Home Modifications in Tasmania where the average funding per client was in excess of $24,000 in 2018-19. Similarly, average funding per client for meals in the NT was also substantially higher compared to other states and territories. This may be driven by availability of other programs and also data quality issues (e.g. a lower than average client count increasing the average funding per client).

**Chart 4.4 Average funding per client by state and territory ($), 2018-19**

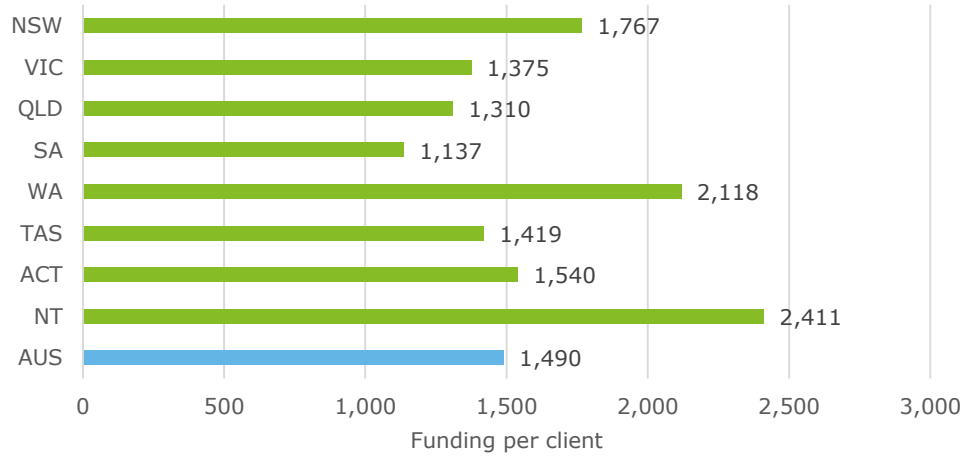



**Table 4.3 Average funding per client by service type and state and territory ($), 2018-19**

| | AHT | ACH | CBR | CR | DA | FR | GE&AT | HMa | HMo | M | N | OFS | PC | SS-G | SS-I | SSS | T |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NSW** | 761 | 3,053 | 6,520 | 10,947 | 2,058 | 4,535 | 1,568 | 926 | 2,088 | 974 | 1,764 | 500 | 5,548 | 2,760 | 1,667 | 829 | 1,159 |
| **VIC** | 931 | 1,251 | 5,071 | 12,038 | 1,153 | 3,110 | 83 | 293 | 325 | 716 | 2,794 | 316 | 1,929 | 2,481 | 739 | 1,595 | 587 |
| **QLD** | 1,163 | 2,260 | 4,957 | 7,111 | 1,435 | 3,199 | 439 | 511 | 785 | 689 | 1,719 | 835 | 1,987 | 3,182 | 1,228 | 1,157 | 938 |
| **SA** | 866 | 1,662 | 4,852 | 12,874 | 1,238 | 4,492 | 556 | 464 | 623 | 554 | 3,601 | 727 | 2,429 | 1,465 | 1,087 | 432 | 840 |
| **WA** | 1,478 | 2,360 | 6,040 | 11,989 | 1,552 | 6,020 | 1,323 | 1,044 | 2,408 | 1,032 | 2,825 | 5,918 | 3,953 | 4,728 | 2,720 | 391 | 1,445 |
| **TAS** | 1,257 | 3,668 | 4,121 | 13,287 | 1,371 | 5,096 | 1,247 | 549 | 24,349 | 583 | 1,742 | 575 | 2,564 | 2,547 | 1,235 | 1,078 | 793 |
| **ACT** | 445 | 3,927 | 9,567 | 5,460 | 1,839 | 2,399 | 1,523 | 1,121 | 3,333 | 896 | 1,190 | 0 | 3,893 | 1,908 | 1,502 | 905 | 1,313 |
| **NT** | 1,456 | 2,431 | 13,966 | 13,902 | 2,017 | 5,569 | 788 | 2,899 | 705 | 4,102 | 3,399 | 414 | 1,592 | 2,577 | 1,174 | 1,525 | 1,692 |
| **AUS** | 956 | 2,028 | 5,807 | 10,379 | 1,480 | 3,884 | 689 | 589 | 1,109 | 824 | 2,252 | 880 | 2,784 | 2,705 | 1,391 | 1,117 | 1,043 |

Note: WA data not representative as WA transitioned to the CHSP in 2018
Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19

# Funding by session

Average funding per session by service types and location

## Analysis

Average funding per session ranged from $61 per session for the NT and Tasmania to $78 for WA in 2018-19. Average funding per session varied from $17 per session for Meals to $748 per session for Cottage Respite nationally (Table 4.4).

By service type, for example, the average funding per session of Allied Health and Therapy Services was $97 on average but was $73 per session in SA and $149 per session in the NT.

There are also some notable outliers – even at a state and territory level – such as for Home Modifications in Tasmania where the average funding per session was in excess of $23,000 in 2018-19. Average funding per session for Cottage Respite was also substantially higher in the NT compared to other states and territories. As with variation in the funding per client, this may be driven by availability of other programs and also data quality issues (e.g. a lower than average number of sessions increasing the average funding per session).

**Chart 4.5 Average funding per session by state and territory ($), 2018-19**

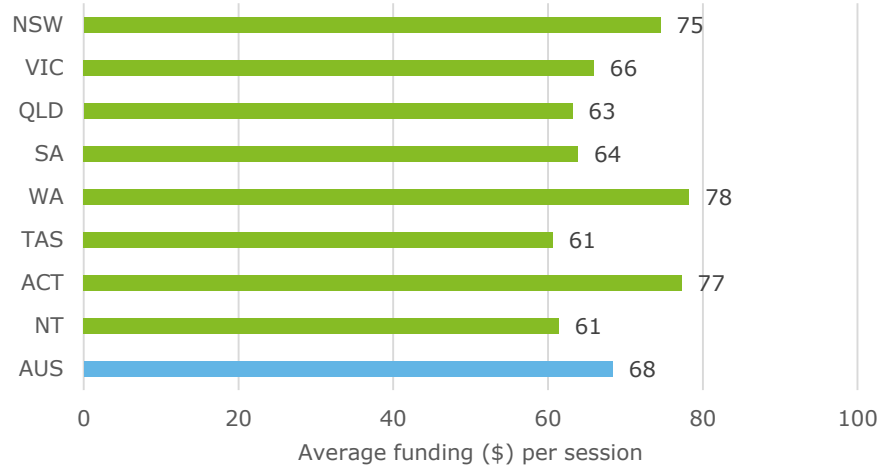



**Table 4.4 Average funding per session by service type state and territory ($), 2018-19**

| | AHT | ACH | CBR | CR | DA | FR | GE&AT | HMa | HMo | M | N | OFS | PC | SS-G | SS-I | SSS | T |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NSW** | 101 | 176 | 197 | 1,110 | 87 | 131 | 537 | 116 | 1,423 | 25 | 82 | 59 | 68 | 93 | 61 | 164 | 44 |
| **VIC** | 98 | 121 | 199 | 923 | 60 | 150 | 18 | 95 | 229 | 12 | 59 | 29 | 44 | 98 | 54 | 190 | 31 |
| **QLD** | 108 | 140 | 168 | 410 | 64 | 148 | 238 | 78 | 307 | 12 | 89 | 65 | 42 | 114 | 55 | 182 | 37 |
| **SA** | 73 | 152 | 174 | 526 | 63 | 229 | 120 | 99 | 492 | 25 | 89 | 36 | 49 | 67 | 43 | 97 | 40 |
| **WA** | 94 | 114 | 154 | 1,051 | 74 | 170 | 976 | 127 | 2,008 | 13 | 94 | 146 | 50 | 157 | 72 | 104 | 40 |
| **TAS** | 105 | 118 | 126 | 905 | 74 | 173 | 967 | 112 | 23,708 | 10 | 239 | 31 | 58 | 112 | 26 | 56 | 38 |
| **ACT** | 77 | 184 | 362 | 519 | 90 | 135 | 1,316 | 184 | 2,244 | 21 | 56 | 0 | 80 | 105 | 43 | 164 | 46 |
| **NT** | 149 | 191 | 267 | 2,209 | 76 | 315 | 631 | 351 | 570 | 29 | 58 | 26 | 23 | 101 | 28 | 378 | 38 |
| **Aus** | 97 | 145 | 187 | 748 | 70 | 148 | 222 | 100 | 619 | 17 | 73 | 71 | 51 | 101 | 54 | 167 | 41 |

Note: WA data not representative as WA transitioned to the CHSP in 2018
Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19

# Funding by unit of output

Average funding by unit of output by service types and location

## Analysis

Planned funding per actual unit of output delivered ranged from $22 in NSW to $43 in Victoria in 2018-19.

By service type, average funding per unit of output varied from $11 per Meals unit delivered to $161 per hour of Assistance with Specialised Support Services.

As Home Modifications is measured in dollars, the average funding per unit of output (dollars) is around $0.9 to $3.2 in the case of Tasmania – where low volumes would be driving the higher ratio.

Average funding per hour of Personal Care, as an example, ranged from $44 per hour in the NT to $83 per hour in WA, compared to the national average of $67 per hour.

**Chart 4.6 Average funding per unit of output by state and territory ($), 2018-19**

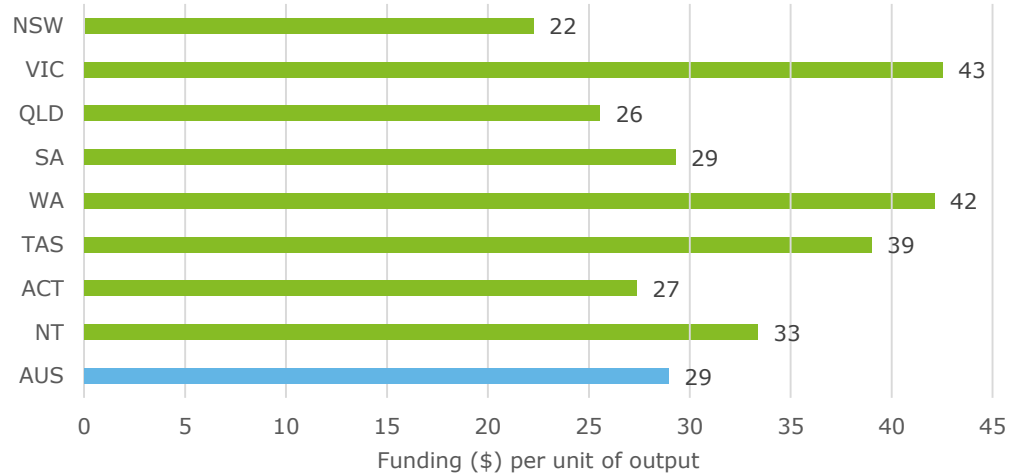



**Table 4.5 Average funding per unit of output by service type and state and territory ($), 2018-19**

| | AHT | ACH | CBR | CR | DA | FR | GE&AT | HMa | HMo | M | N | OFS | PC | SS-G | SS-I | SSS | T |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NSW** | 104 | 121 | 53 | 38 | 62 | 75 | 49 | 52 | 1.6 | 12 | 139 | 64 | 71 | 32 | 53 | 128 | 42 |
| **VIC** | 105 | 98 | 46 | 43 | 48 | 72 | 0 | 64 | 1.3 | 9 | 111 | 37 | 64 | 28 | 36 | 184 | 21 |
| **QLD** | 115 | 73 | 38 | 38 | 49 | 68 | 41 | 62 | 1.4 | 10 | 116 | 48 | 56 | 30 | 48 | 178 | 34 |
| **SA** | 119 | 87 | 59 | 60 | 49 | 105 | 111 | 64 | 1.2 | 8 | 117 | 40 | 82 | 35 | 58 | 114 | 32 |
| **WA** | 110 | 152 | 47 | 31 | 58 | 107 | 820 | 88 | 3.0 | 12 | 188 | 176 | 83 | 41 | 78 | 117 | 35 |
| **TAS** | 148 | 124 | 34 | 58 | 52 | 63 | 964 | 71 | 3.2 | 9 | 105 | 21 | 60 | 36 | 49 | 76 | 26 |
| **ACT** | 96 | 145 | 57 | 38 | 61 | 97 | 127 | 89 | 1.6 | 9 | 78 | 0 | 78 | 26 | 70 | 145 | 36 |
| **NT** | 132 | 110 | 59 | 55 | 76 | 43 | 451 | 195 | 0.9 | 23 | 242 | 35 | 44 | 66 | 45 | 293 | 28 |
| **AUS** | 110 | 107 | 48 | 39 | 53 | 76 | 60 | 64 | 1.5 | 11 | 118 | 77 | 67 | 32 | 53 | 161 | 35 |

Note: WA data not representative as WA transitioned to the CHSP in 2018
Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19

# Variation in aggregate funding and expenditure

Most service types showed a surplus of funding relative to the expended amount in 2018-19

## Analysis

In 2018-19, $2.39 billion in grant funding was allocated to providers across Australia under CHSP funding streams.[12] Service providers used $2.29 billion in grant funding, leading to a funding surplus of approximately $103.4m. Table 4.6 provides a breakdown of the funding, expenditure and overall client contributions (additional to grant funding) by service type.

There was a surplus of funding relative to the expended amount for the majority of service types. The service types where this surplus was largest were; Flexible Respite ($23.3m), Allied Health and Therapy Services ($16.8m) and Social Support - Group ($14.9m). Conversely, service types with the largest deficit were; Domestic Assistance (-$8.1m), Meals (-0.5m) and Assistance with Care and Housing ( approximately -0.2m).

Clients also paid an additional $216.4m to providers in 2018-19.[12] The service types with the largest client contributions compared to total funding were Meals (31.9% of total funding) and Home Modifications (15.9%) while the service types with the smallest client contributions were Assistance with Care and Housing (no client contributions) and Nursing (1.9% of total funding).

**Table 4.6 Funding and expenditure by service type ($ million), 2018-19**

| Service type | Grant funding ($ million) | Client contributions ($ million) | Total funds available ($ million) | Expended grant funding ($ million) | Net grant funding ($ million) | Net funding (%) |
|---|---|---|---|---|---|---|
| Allied Health and Therapy Services | 233.9 | 7.2 | 241.2 | 241.1 | 16.8 | 7% |
| Assistance with Care and Housing | 12.7 | 0.0 | 12.7 | 12.7 | -0.2^ | -2% |
| Centre-based Respite | 74.8 | 3.3 | 78.2 | 78.1 | 6.6 | 9% |
| Cottage Respite | 36.8 | 2.5 | 39.3 | 39.3 | 3.4 | 9% |
| Domestic Assistance | 487.7 | 63.1 | 551.3 | 550.8 | -8.1^ | -2% |
| Flexible Respite | 152.9 | 11.0 | 164.1 | 163.9 | 23.3 | 15% |
| Goods, Equipment and Assistive Technology | 10.4 | 0.6 | 11.1 | 11 | 2.3 | 22% |
| Home Maintenance | 93.4 | 13.3 | 106.9 | 106.7 | 1.8 | 2% |
| Home Modifications | 54.2 | 10.3 | 64.6 | 64.5 | 7.7 | 14% |
| Meals | 81.0 | 38.0 | 119.9 | 119 | -0.5^ | -1% |
| Nursing | 270.7 | 5.4 | 276 | 276.1 | 4.2 | 2% |
| Other Food Services | 3.9 | 0.2 | 4.1 | 4.1 | 0.9 | 22% |
| Personal Care | 194.6 | 18.8 | 213.7 | 213.4 | 8.3 | 4% |
| Social Support - Group | 270.6 | 14.4 | 285.2 | 285 | 14.9 | 5% |
| Social Support - Individual | 165.4 | 12.3 | 177.9 | 177.7 | 5.9 | 4% |
| Specialised Support Services | 69.4 | 1.7 | 71.1 | 241.1 | 7.4 | 11% |
| Transport | 182.3 | 14.4 | 197.2 | 12.7 | 8.9 | 5% |
| **Total** | **2,394.8** | **216.4** | **2,611.2** | **2,291.4** | **103.4** | **4%** |

Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19. ^ Expended grant funding may exceed grant funding as it can include previously unspent grant funding from 2017-18.

**12. The Aged Care Financing Authority reported that total CHSP funding in 2018-19 was $2.6 billion. Similarly, service provision data show that $251.9 million in contributions was collected from clients during 2018-19 (page 55). The data reported here were based on providers with both financial reports and also service provision data in 2018-19. Providers have been linked together to provide a comparable dataset for funding and output acquittal analysis, which means that analysis was conducted on 1,379 of the 1,455 funded providers.**

# Variation in delivered output relative to planned output

Delivered output relative to planned output

## Analysis

In 2018-19 there was a total of 71.3m units of output delivered by CHSP providers, compared to a total of 112.1m units of 'planned output'. As a result, total service delivery was approximately 41m units (36%) below plan. Table 4.7 provides a breakdown of delivered and planned output by service type.

There was an output deficit (where delivered output was less than planned output) for the majority of service types. The service types where this deficit was largest in raw terms were; Home Modifications ($14.4m), Social Support - Group (7.4m hours) and Meals (5.9m units).

In percentage terms, the service types where there was a largest output deficit were: Goods, Equipment and Assistive Technology (97%), Other Food Services (64%) and Centre-based respite (57%).

Of the 17 service types, 15 had an output deficit of greater than 20%, suggesting that there has been a consistent under-delivery of output relative to planned output. Service types with the smallest output deficit were: Domestic Assistance (-14%), Nursing (-17%) and Personal Care (-21%).

**Table 4.7 Service delivery outputs by service types, 2018-19**

| Service type | Unit | Planned output (millions) | Delivered output (millions) | Output variation (millions) | Output variation (%) |
|---|---|---|---|---|---|
| Allied Health and Therapy Services | Hours | 2.6 | 1.8 | -0.8 | -30% |
| Assistance with Care and Housing | Hours | 0.2 | 0.1 | -0.1 | -56% |
| Centre-based Respite | Hours | 3.1 | 1.3 | -1.8 | -57% |
| Cottage Respite | Hours | 1.3 | 0.8 | -0.5 | -36% |
| Domestic Assistance | Hours | 9.8 | 8.4 | -1.4 | -14% |
| Flexible Respite | Hours | 3 | 1.8 | -1.2 | -41% |
| Goods, Equipment and Assistive Technology | Quantity | 2 | 0.1 | -2 | -97% |
| Home Maintenance | Hours | 1.8 | 1.3 | -0.5 | -26% |
| Home Modifications | Dollars | 44.1 | 29.7 | -14.4 | -33% |
| Meals | Quantity | 11.9 | 6.0 | -5.9 | -49% |
| Nursing | Hours | 2.6 | 2.2 | -0.5 | -17% |
| Other Food Services | Hours | 0.1 | 0.1 | -0.1 | -64% |
| Personal Care | Hours | 3.5 | 2.7 | -0.7 | -21% |
| Social Support - Group | Hours | 15 | 7.6 | -7.4 | -49% |
| Social Support - Individual | Hours | 4.2 | 2.7 | -1.5 | -35% |
| Specialised Support Services | Hours | 0.6 | 0.4 | -0.2 | -32% |
| Transport | Quantity | 6.8 | 4.5 | -2.3 | -34% |
| **Total** | **-** | **112.3** | **71.3** | **-41.0** | **-37%** |

Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19

# Unit prices

Funded, expended and actual unit prices by service type

## Analysis

Table 4.8 summarises the estimated average unit prices across service providers for each service type in 2018-19.

The actual unit price is higher than the funded unit price across all service types, indicating that the price of service delivery was typically greater than planned. However, the expended unit price is generally comparable with the actual unit price, indicating that client contributions are a relatively low proportion of the price of overall service delivery.

For services measured in hours, the funded unit price varies from $19 for Social Support – Group to $51 per hour for Specialist Support Services, while the actual unit prices ranged from $32 to $76 per hour for these services.

The funded unit price for service measured in quantity ranged from $8 per unit of Meals to $310 per unit of Goods, Equipment and Assistive Technology.

The variation between actual unit price and funded unit price varies between 38% for Allied Health and Therapy Services to 139% for Meals.

**Table 4.8 Service delivery outputs by service types, 2018-19**

| Service type | Output | Unit price ($/output) | | | |
|---|---|---|---|---|---|
| | | *Funded unit price* | *Expended unit price* | *Actual unit price* | *Variation* |
| Allied Health and Therapy Services | Hours | 93 | 123 | 128 | 38% |
| Assistance with Care and Housing | Hours | 61 | 128 | 128 | 111% |
| Centre-based Respite | Hours | 30 | 49 | 52 | 71% |
| Cottage Respite | Hours | 32 | 40 | 42 | 30% |
| Domestic Assistance | Hours | 47 | 58 | 66 | 41% |
| Flexible Respite | Hours | 50 | 71 | 78 | 56% |
| Goods, Equipment and Assistive Technology | Quantity | 310 | 377 | 415 | 34% |
| Home Maintenance | Hours | 53 | 71 | 81 | 53% |
| Home Modifications | Dollars | 1 | 2 | 2 | 65% |
| Meals | Quantity | 8 | 12 | 18 | 139% |
| Nursing | Hours | 98 | 126 | 131 | 34% |
| Other Food Services | Hours | 47 | 63 | 69 | 48% |
| Personal Care | Hours | 51 | 68 | 76 | 48% |
| Social Support - Group | Hours | 19 | 31 | 32 | 74% |
| Social Support - Individual | Hours | 41 | 58 | 62 | 50% |
| Specialised Support Services | Hours | 51 | 68 | 76 | 48% |
| Transport | Quantity | 24 | 36 | 39 | 66% |

Note: *Variation* between actual unit price and funded unit price as a proportion of funded unit price.

Both output and unit price for Home Modifications are measured in terms of dollars. A provider may use more than one dollar of funding for every dollar of output that they provide to a client.

Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19

Three versions of unit price were developed:

1. **Funded Unit Price** – the government funding for the service divided by the volume of output planned over the forthcoming year. The funded unit price should be thought of as an indicator of the expected price of delivery per unit of output.
2. **Expended Unit Price** - the expenditure claimed by providers for the services delivered by the volume of output delivered. The expended unit price differs from the actual unit price in that it does not include client contributions.
3. **Actual Unit Price** - the expenditure claimed by providers and the client contribution for the services, divided by the volume of output delivered. The actual unit price should be thought of as the truest indicator for the real price of delivery per unit of output.

# Client contributions

Client contributions per session and client by service type

## Analysis

Table 4.9 presents various measures of client contributions paid to providers by service type over 2018-19. As noted on page 47, data were analysed for 1,379 of 1,458 funded providers, representing those providers who could have their service provision and expenditure data linked. For these providers, clients paid $216.4m towards the cost of their care in 2018-19. The service types with the largest raw contributions were; Domestic Assistance ($63.1m), Meals ($38.0m) and Personal Care ($18.8m).

When considering contributions as a proportion of funding, there is one obvious outlier. Client contributions for Meals represented 47% of the funding allocated under CHSP, by far the largest amongst service types. This was followed by Home Modifications (19%) and Home Maintenance (14%).

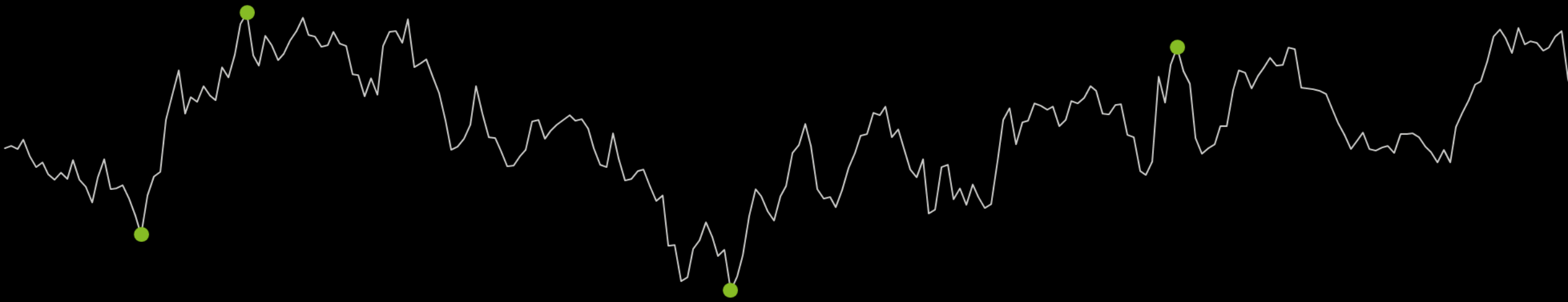
There is significant variation around the national average contributions per client and across service types. Cottage Respite ($884), Meals ($468) and Flexible Respite ($314) had the highest average contributions. Allied Health and Therapy Services ($32), Specialised Support Services ($33) and Other Food Services ($46) had the lowest average contribution per client.

**Table 4.9 Client contributions by service types, 2018-19**

| | Client contributions ($ millions) | Client contributions as share of grant funding (%) | Client contribution per client ($) | Client contribution per session ($) |
|---|---|---|---|---|
| Allied Health and Therapy Services | 7.2 | 3.1 | 32 | 4 |
| Assistance with Care and Housing | 0.0 | - | - | - |
| Centre-based Respite | 3.3 | 4.4 | 325 | 14 |
| Cottage Respite | 2.5 | 6.7 | 884 | 67 |
| Domestic Assistance | 63.1 | 12.9 | 203 | 10 |
| Flexible Respite | 11.0 | 7.2 | 314 | 12 |
| Goods, Equipment and Assistive Technology | 0.6 | 6.2 | 69 | 19 |
| Home Maintenance | 13.3 | 14.2 | 89 | 17 |
| Home Modifications | 10.3 | 19.0 | 246 | 140 |
| Meals | 38.0 | 46.9 | 468 | 11 |
| Nursing | 5.4 | 2.0 | 49 | 2 |
| Other Food Services | 0.2 | 4.8 | 46 | 5 |
| Personal Care | 18.8 | 9.7 | 287 | 5 |
| Social Support - Group | 14.4 | 5.3 | 162 | 8 |
| Social Support - Individual | 12.3 | 7.4 | 117 | 5 |
| Specialised Support Services | 1.7 | 2.4 | 33 | 5 |
| Transport | 14.4 | 7.9 | 90 | 4 |
| **All service types** | **216.4** | **9.0** | **148** | **7** |

Note: Client contribution per client is the average contribution per unique client, including those who did not pay any fees.
Client contribution per session is the average contribution per session, including sessions where a fee was not paid.

Source: Deloitte Access Economics analysis (2019), DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19



# 5. Demand and supply.

# Growth in client numbers versus expenditure per client

Several services display strong relationships with historical state and territory based program delivery

## Analysis

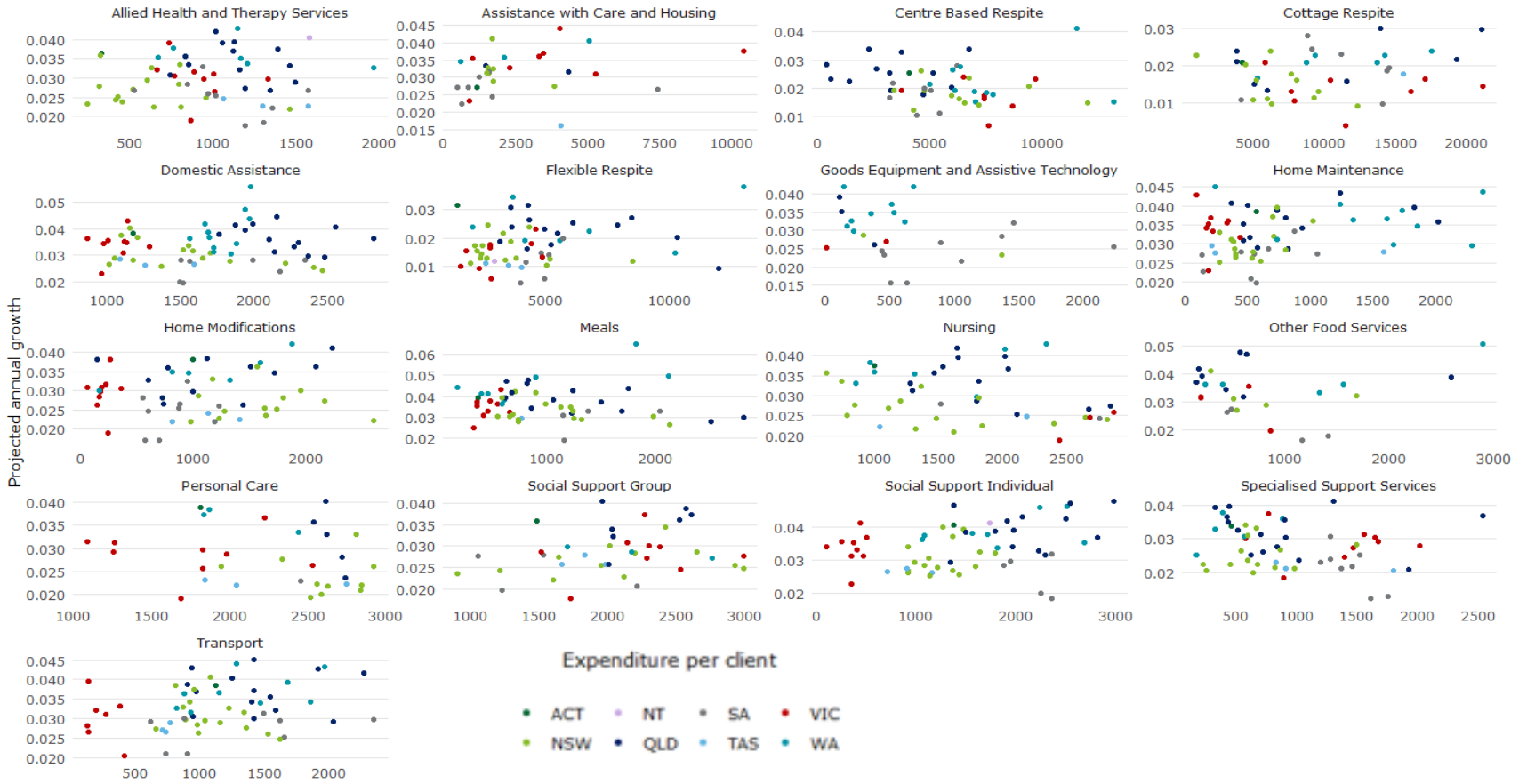
Chart 5.1 shows the relationship between projected average annual client growth between 2019 and 2029 and expenditure per client in 2019, by state and territory. Each point in the chart represents one ACPR.

These charts can also be compared with output acquittal and funding acquittal, and expended unit price versus output acquittal which are shown on page 60 to 62, which also display data by ACPR (although of course providers may not be in the same relative position).

The data indicate that there are a number of areas that are likely to cost relatively more in coming years – for example, ACPRs in Queensland have both high growth and high expenditure per client compared to ACPRs in NSW for a number of services (e.g. Domestic Assistance, Nursing, Transport, etc). Similarly, while some ACPRs in Victoria expect strong growth in Transport clients, expenditure per client has historically been quite low so they are unlikely to drive costs substantially.

A similar story exists for Domestic Assistance, which is expected to see stronger growth in costs in Queensland and in WA compared to other states and territories.

**Chart 5.1 Expenditure per client ($) and projected average annual growth in clients (%) by ACPR and state/territory**




Source: Deloitte Access Economics analysis based on DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19. Outliers have been removed from the chart to improve clarity. Visual cut-offs were used to remove some observations.

**ACPRs towards the top of the chart are expected to have higher average annual growth over the next decade compared to those at the bottom, while those ACPRs to the right have higher expenditure per client compared to those on the left.**

# Reduction in services

Which service types and/or ACPRs did providers desire to cease delivering services or reduce their number of funded outputs from 1 July 2020?

## Analysis

A survey was developed to ask CHSP providers whether they would like to reduce their service delivery. Respondents were asked to respond to the following question at a point in time in 2018-19:

*"Are there any service types and/or ACPRs where you would like to cease delivering services or reduce your number of funded outputs from 1 July 2020? You have selected [yes]. Please select the relevant service type and ACPR combinations."*

Overall, 7% of respondents (n=863) indicated that they would like to reduce components of their service delivery from 1 July 2020.*

Table 5.1 shows the share of service pathways by service type and state or territory where service providers would consider reducing service delivery. For example, providers in Victoria reported that they would consider reducing services across 31.3% of Meals and Other Food Services service pathways. These were generally the most common responses across states and territories.

**Table 5.1 Percentage (%) of service pathways (n=8,053) where providers want to reduce their service delivery**

| Service Type | NSW/ACT | VIC | QLD | SA | WA | TAS | NT | Service average |
|---|---|---|---|---|---|---|---|---|
| Allied Health and Therapy Services | 2.2 | 0 | 3.7 | 1.5 | 1.4 | 5.6 | 5.6 | 2.2 |
| Assistance with Care and Housing | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Centre-based Respite | 7.5 | 3.7 | 2.5 | 22.2 | 6 | | 0 | 7.7 |
| Cottage Respite | 11.6 | 0 | 5.3 | 0 | 0 | | | 6.1 |
| Domestic Assistance | 0.3 | 1.9 | 0.7 | 6.3 | 2.8 | 3.8 | 3.8 | 1.9 |
| Flexible Respite | 1.7 | 8.5 | 2.9 | 16.3 | 6.5 | 4.3 | 0 | 5.5 |
| Goods, Equipment and Assistive Technology | 1.4 | 0 | 0 | 0 | 0 | 0 | 0 | 0.4 |
| Home Maintenance | 4.3 | 5.3 | 0.7 | 7.1 | 1.6 | 5.6 | 0 | 3.6 |
| Home Modifications | 0 | 8.9 | 0 | 1.8 | 0 | 0 | 0 | 1.9 |
| Meals | 19.1 | 31.3 | 7.7 | 14 | 18.4 | 14.3 | 0 | 16.8 |
| Nursing | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Food Services | 4.2 | 31.3 | 11.1 | 8.3 | 22.5 | | | 16.8 |
| Personal Care | 0.4 | 4 | 2.5 | 5.7 | 2.8 | 0 | 0 | 2.4 |
| Social Support - Group | 3.4 | 1.8 | 3.6 | 2.6 | 12.5 | 5.6 | 0 | 4 |
| Social Support - Individual | 1.1 | 3.5 | 3.9 | 9.8 | 6 | 0 | 4 | 4 |
| Specialised Support Services | 1.4 | 7.3 | 0 | 0 | 0 | 0 | 9.5 | 2.3 |
| Transport | 3.4 | 4 | 4.4 | 16.7 | 10 | 10 | 4.3 | 7.2 |
| **State or territory average** | 2.4 | 4.8 | 2.4 | 7.6 | 5.5 | 3.9 | 2.9 | 4 |

Note: Each cell shows the proportion of responses within that cell that have reported underspend (cells with less than 5 were removed).

Source: Deloitte Access Economics analysis of service provider survey (2019)

*** Service providers were asked to respond between 13 August 2019 and 13 September 2019. It is unclear whether these survey results would provide a clear indication of areas where providers would prefer to reduce their service agreements in 2020, noting the ongoing COVID-19 pandemic.**

# Unmet demand

Which service types and/or ACPRs had unmet demand (where demand exceeds the services providers could supply) in which surplus funds could have been expended?

## Analysis

The survey also asked CHSP providers about unmet demand at a point in time in 2018-19. Respondents were asked:

"*Which service types and/or ACPRs did you have unmet demand (where demand exceeds the services you can supply) in which surplus funds could have been expended? Please select the relevant service type and ACPR combinations.*"

Overall, 18% of respondents (n=863) indicated that they had unmet demand for one or more of their services where they could have used additional funding.*

Table 5.2 shows the share of service pathways by service type and state and territory where demand is reported to exceed supply. For example, providers in Victoria reported that 16.7% of Allied Health and Therapy service pathways had unmet demand. Other key findings include:

- 13% of all service pathways (n=8,053) were reported to have unmet demand on average.
- Unmet demand across services was more common in SA (18.9%) and Tasmania.
- Domestic Assistance was the most commonly reported service with some level of unmet demand (20.7%). It is also the most commonly delivered service type.

**Table 5.2 Percentage (%) of service pathways (n=8,053) where reported demand exceeds supply**

| Service Type | NSW/ACT | VIC | QLD | SA | WA | TAS | NT | Service average |
|---|---|---|---|---|---|---|---|---|
| Allied Health and Therapy Services | 11 | 16.7 | 16 | 17.6 | 15.5 | 0 | 5.6 | 14 |
| Assistance with Care and Housing | 18.4 | 0 | 0 | 22.2 | 0 | 0 | | 10.6 |
| Centre-based Respite | 10 | 0 | 7.5 | 0 | 14 | | 33.3 | 8.9 |
| Cottage Respite | 23.3 | 0 | 15.8 | 0 | 8 | | | 14.8 |
| Domestic Assistance | 20.1 | 19.3 | 21.5 | 25.7 | 17.8 | 26.9 | 7.7 | 20.7 |
| Flexible Respite | 6.4 | 5.4 | 7.6 | 9.8 | 9.8 | 26.1 | 10.5 | 8 |
| Goods, Equipment and Assistive Technology | 5.6 | 0 | 0 | 24.4 | 33.3 | 0 | 0 | 11.6 |
| Home Maintenance | 14.7 | 9.2 | 16.9 | 24.5 | 25 | 11.1 | 8.3 | 17.3 |
| Home Modifications | 20 | 6.7 | 6 | 8.9 | 15.2 | 0 | 0 | 10.8 |
| Meals | 4.4 | 6.3 | 29.2 | 17.5 | 2.6 | 42.9 | 11.1 | 13.7 |
| Nursing | 6.7 | 11 | 6.7 | 1.8 | 20.4 | 7.1 | 0 | 7.9 |
| Other Food Services | 0 | 6.3 | 0 | 33.3 | 0 | | | 4.7 |
| Personal Care | 13.3 | 8.6 | 12.1 | 15.1 | 19.4 | 18.2 | 12.5 | 13.2 |
| Social Support - Group | 10.5 | 9.7 | 9 | 23.7 | 15 | 22.2 | 5.9 | 12.7 |
| Social Support - Individual | 8.7 | 7.7 | 13.6 | 25.6 | 11 | 26.1 | 0 | 12.7 |
| Specialised Support Services | 8.3 | 10.9 | 13.4 | 12 | 0 | 33.3 | 4.8 | 9.9 |
| Transport | 10.2 | 8.9 | 13.9 | 26.3 | 6.3 | 10 | 13 | 13.4 |
| **State or territory average** | 11.1 | 9.8 | 13 | 18.9 | 13.9 | 16.7 | 8.6 | 13 |

Note: Each cell shows the proportion of responses within that cell that have reported underspend (cells with less than 5 were removed and are blank).

Source: Deloitte Access Economics analysis of service provider survey (2019)

*** Service providers were asked to respond between 13 August 2019 and 13 September 2019. It is unclear whether these survey results would provide a clear indication of unmet demand in 2020, noting the ongoing COVID-19 pandemic.**

# Output acquittal versus funding acquittal

Most service types showed a surplus of funding relative to the expended amount in 2018-19

## Analysis

Chart 5.2 shows the variation in net funding acquittal and net output acquittal, by state and territory. Each point in the chart represents one ACPR.

ACPRs in the top left of the quadrant may face a high cost of service delivery while providers in the lower left quadrant may have excess supply. The data indicate that there are several areas where these factors may exist. For example, several ACPRs in WA and Victoria tended to have low output acquittal but also relatively low funding acquittal for Meals services, and these data appear to support the survey findings noting providers wanted to reduce the amount of services they provide (page 58).

There are a handful of services that strongly indicate unmet demand, and these findings support the survey analysis (page 59) – for example, multiple regions in SA may have used flexibility provisions to supply Other Food Services (net funding and output acquittal both exceed 0%). Similarly unmet demand for Domestic Assistance was commonly reported across all jurisdictions, which may be demonstrated by the tight cluster of points.

**Chart 5.2 Net funding acquittal (%) and net output acquittal (%) by ACPR and state/territory**


Source: Deloitte Access Economics analysis based on DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19. Outliers have been removed from the chart to improve clarity. Visual cut-offs were used to remove some observations.

**ACPRs where both funding acquittals and output acquittals in line with targets would be denoted on the chart at the coordinate 0,0 – no variation from allocated funding or planned outputs. Comparing output and funding acquittal, each ACPR is expected to be in the bottom left quadrant where they would deliver at or slightly below allocated funding and planned output.**

# Expended unit price versus output acquittal

Supply and demand may be strongly influenced by historical state and territory-based program delivery

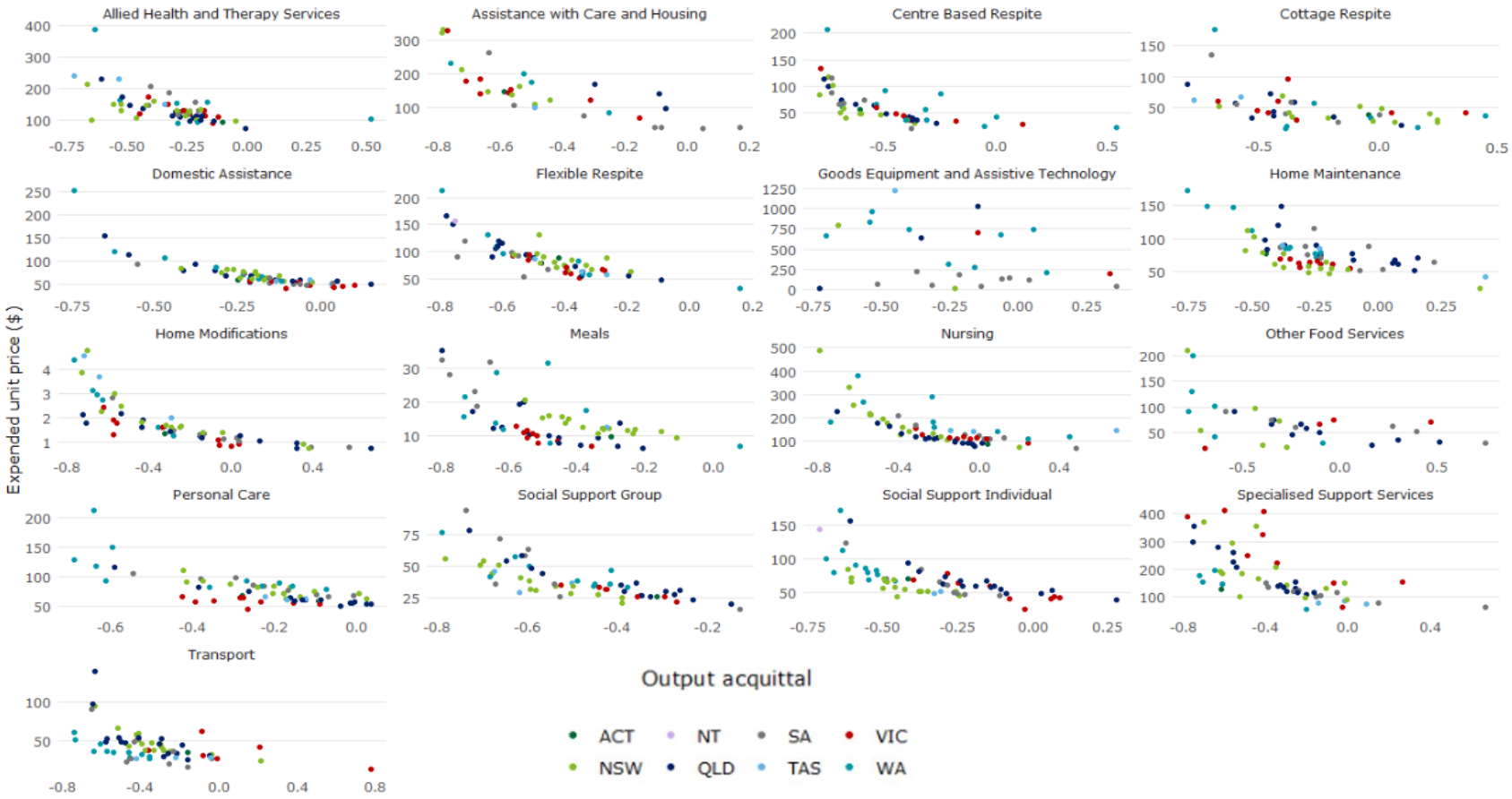
## Analysis

Chart 5.3 compares the expended unit price and net output acquittal by state and territory. Each point in the chart represents one ACPR.

Across all service types, the data indicate that services are more likely to be under-delivered at higher unit prices, as anticipated. Small output acquittal variations are often achieved when unit prices are at their lowest, which is again intuitive as increased delivery for any given level of funding indicates a lower unit price. Nursing in ACPRs in Queensland and Victoria demonstrate this trend.

Meals in NSW tend to be delivered at a higher unit price for any level of output acquittal compared to in Victoria. In contrast, Social Support Individual is delivered as a lower unit price in NSW compared to QLD for a given level of output acquittal. These trends may demonstrate the historical influence of the state and territory-based programs on the CHSP, which still strongly impact on supply and demand.

**Chart 5.3 Expenditure unit price ($) and output acquittal (%) by ACPR and state/territory**




Source: Deloitte Access Economics analysis based on DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19. Outliers have been removed from the chart to improve clarity. Visual cut-offs were used to remove some observations.

**ACPRs towards the top of the chart are expected to have higher expended unit price compared to those at the bottom, while those ACPRs to the right have higher output acquittal proportions compared to those on the left.**

# Expended unit price versus output acquittal

Demand for services (greater number of clients) appears to be correlated with net output acquittal as anticipated

## Analysis

Chart 5.4 further explores the relationship between expended unit price and variations in services delivered, based on the demand in a region (ACPRs were grouped into quintiles based the number of clients for each service type). Each point in the chart represents one ACPR.

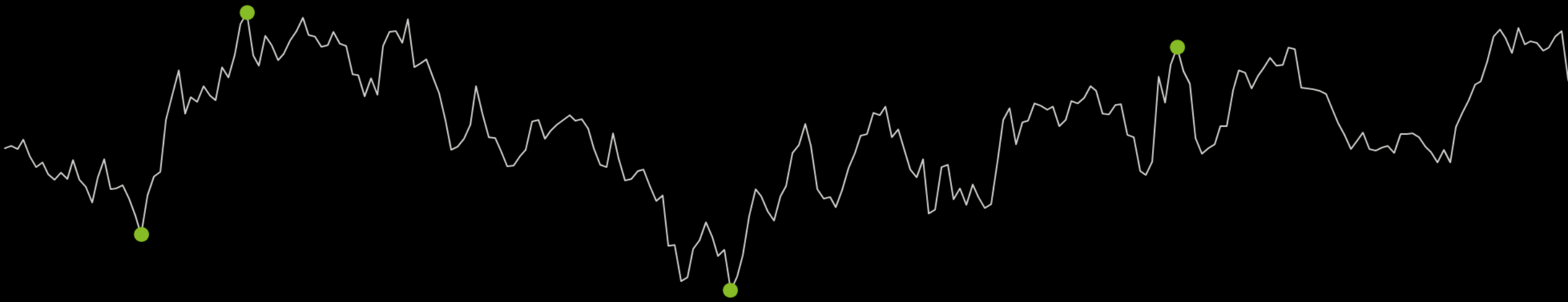
Similar to Chart 5.3, higher expended unit price tend to suggest services will be more likely under-delivered compared to what was planned.

The data indicate that ACPRs with a greater number of clients tend to have lower expended unit price, and were more likely to have a small negative output acquittal. This can be observed clearly in service types such as Domestic Assistance and Personal Care. In contrast service types with relative few clients, such as Cottage Respite, Assistance with Care and Housing and Other Food Services appear to have highly variable unit prices and output acquittal suggesting the unpredictable nature of demand for these services may have a relatively large impact on funding and price outcomes.

**Chart 5.4 Expenditure unit price ($) and output acquittal (%) by average number of clients**


Source: Deloitte Access Economics analysis based on DEX (2019), Department of Health 'Activity Work Plan Tracking' spreadsheet 2018-19 and 'Activity Work Plan Report' 2018-19. Outliers have been removed from the chart to improve clarity. Visual cut-offs were used to remove some observations.

**ACPRs towards the top of the chart are expected to have higher expended unit price compared to those at the bottom, while those ACPRs to the right have higher output acquittal proportions compared to those on the left.**



# Summary.

# Summary

## The CHSP is a national aged care program with complex variation across clients, service providers, funding and service delivery

The CHSP provided services to 841,000 people in 2018-19, the majority (65%) of whom were women. On a per capita basis, clients with special needs are generally underrepresented in the CHSP, to the extent data permit analysis for these special needs groups, which comprise: people identifying as Aboriginal and Torres Strait Islander or from CALD backgrounds; those in rural and remote areas; veterans or their spouses; and clients with a disability.

The most common service types used by CHSP clients are Domestic Assistance, Allied Health and Therapy, and Transport. Allied Health and Therapy is more common in major cities, while Transport is more common in remote areas. Both Allied Health and Therapy, and Transport, tend to be supplied by government providers. Personal Care services are typically provided by for-profit providers, and not-for-profit providers typically do not provide Domestic Assistance.

Service usage varies between the states and territories. For example, while services in Victoria had a strong clinical focus (Nursing and Allied Health and Therapy Services), Transport made up a larger portion of services used by NSW clients. The share of clients using Domestic Assistance exceeded the national average of 20.5% in Queensland, Tasmania, Victoria and WA.

Nearly 20% of service providers indicated that they had unmet demand for one or more of their services in the service provider survey, and less than 10% would consider reducing components of their service delivery in 2020.

A number of service types tend to be used in combination with others. For example, of those who used Allied Health and Therapy Services, 33% also used Domestic Assistance. Similarly, for the clients who used Social Support – Group, 43% also use Transport. Similar combinations for Flexible Respite and Personal care, Home Maintenance and Domestic Assistance and Goods, Equipment and Assistive Technology and Specialised Support Services were also observed.

Functional limitations and several primary health conditions are associated with a noticeably higher value of services used in 2018-19. The average total value of services was higher for all special needs groups, in particular for Aboriginal and Torres Strait Islander and LGBTI clients.

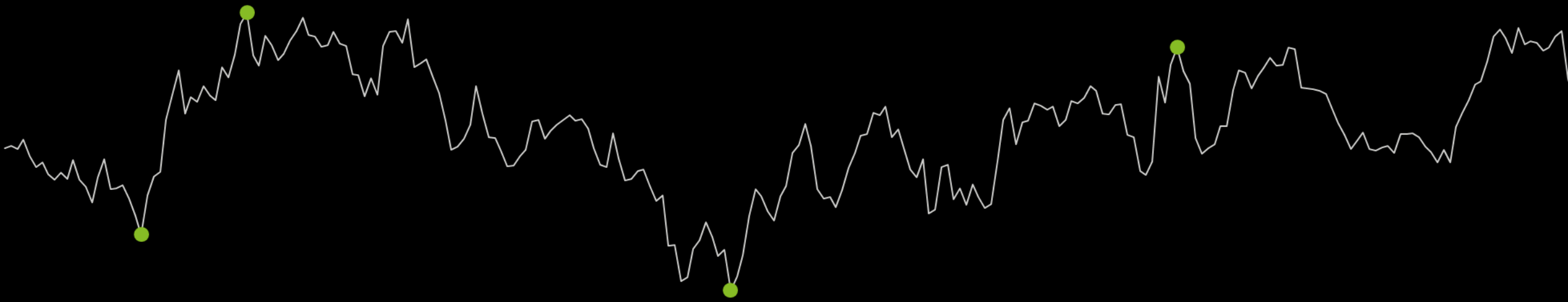
Approximately 5% of CHSP clients also access the HCP concurrently. The CHSP-HCP clients are older compared to CHSP only clients and were more likely to be from at least one of the special need client groups: Aboriginal and Torres Strait Islander, CALD or clients with a disability.

The average funding per client for CHSP services was $1,490 in 2018-19, where funding per session varied from $17 for Meals to $748 for Cottage Respite. While most service providers require client contributions for one or all of their services delivered, these contributions represented a relatively low proportion of the overall price of service delivery. On average the annual client contribution was $252 per client in 2018-19.

While most service types had a surplus of planned funding relative to the expended amount – with an overall surplus of 4% recorded in 2018-19, most service providers also reported an output deficit, on average 37%, where delivered output was less than planned output.

Furthermore, the available data showed a wide variation in unit prices charged by providers and actual unit price of services delivered was higher than the funded unit price across all service types. Further work is required to understand the cost of service delivery in the CHSP, including how it varies across states and territories and small areas.

There is significant heterogeneity in supply-side cost drivers, which made it difficult to understand how prices are determined by providers based on the data that are available. It was also not possible to incorporate a measure of quality into the analysis. Factors such as services needed, as opposed to services used or supplied could not be considered comprehensively with the data available.



# Appendix.

# Appendix A

## Description of data sources

**Department of Social Services (DSS) Data Exchange (DEX)**
Data relating to service provision in the CHSP were extracted from the DSS DEX, including session level information on clients, providers (and their outlets) and the quantity of service output and type. The data are generated through reporting submissions by funded providers to DEX each financial year. There are approximately 90 million session-level observations available across the three financial years 2016-17 to 2018-19 and there are approximately 200 variables available for analysis.

**National Screening and Assessment Form (NSAF) data**
Assessments to access CHSP services by the Regional Assessment Service (RAS) are captured in the NSAF data. This includes:

- All service recommendations for all CHSP services between 2016-17 and 2018-19 and information on possible reasons for that recommendation (e.g. a fall, or loss of a partner)
- Information on clients who have received Comprehensive Assessments (for the HCP Program) in cases where they have also been recommended CHSP services
- Referrals to service providers and whether those referrals were rejected.

The NSAF data were linked to DEX using a statistical linkage key methodology used by the Department in previous work. There is a low matching rate (approximately 50%) between the NSAF data and DEX, which reflects that not all clients have received recent assessments.

**Financial data**
Financial acquittal data for service providers in 2018-19 were extracted from the Department's 'Activity Work Plan Tracking' spreadsheet (AWP). This spreadsheet contained data related to the expenditure, funding received, overspend (or underspend) and financial balance carried forward for service providers. All analysis related to the funding, expenditure or price of CHSP services stems from this dataset. Data relating to the levels of planned output for service providers in 2018-19 was extracted from the Department's 'Activity Work Plan Report' spreadsheet. Although there were 1,607 unique service providers recorded in the DEX data, only 1,458 providers were funded to deliver services, and providers were also excluded from the analysis if their financial reports could not be matched to their service delivery data in 2018-19.

**HCP data**
A list of all the HCP Program clients in care at 31 March 2019 was used. The possible overlap between the CHSP and the HCP Program is therefore only available for those clients with a home care package at that point in time. These data were also used to explore patterns of clients exiting the CHSP.

**CHSP service provider survey**
The survey was circulated to service providers by the Funding Arrangements Managers and was open from 13 August to 13 September 2019. The survey was designed to collect information surrounding current and planned service delivery, including:

- Use and perception of the flexible funding arrangements
- Areas of service delivery where supply and demand may not align
- Differences in operational models such as arrangements for client contributions, and the use of volunteers.

Over 1,000 partial responses were received, these were cleaned to remove incomplete responses, duplicates and responses that were not able to be matched to administrative AWP data. This produced a final set of 863 validated responses used for analysis.

# Appendix B

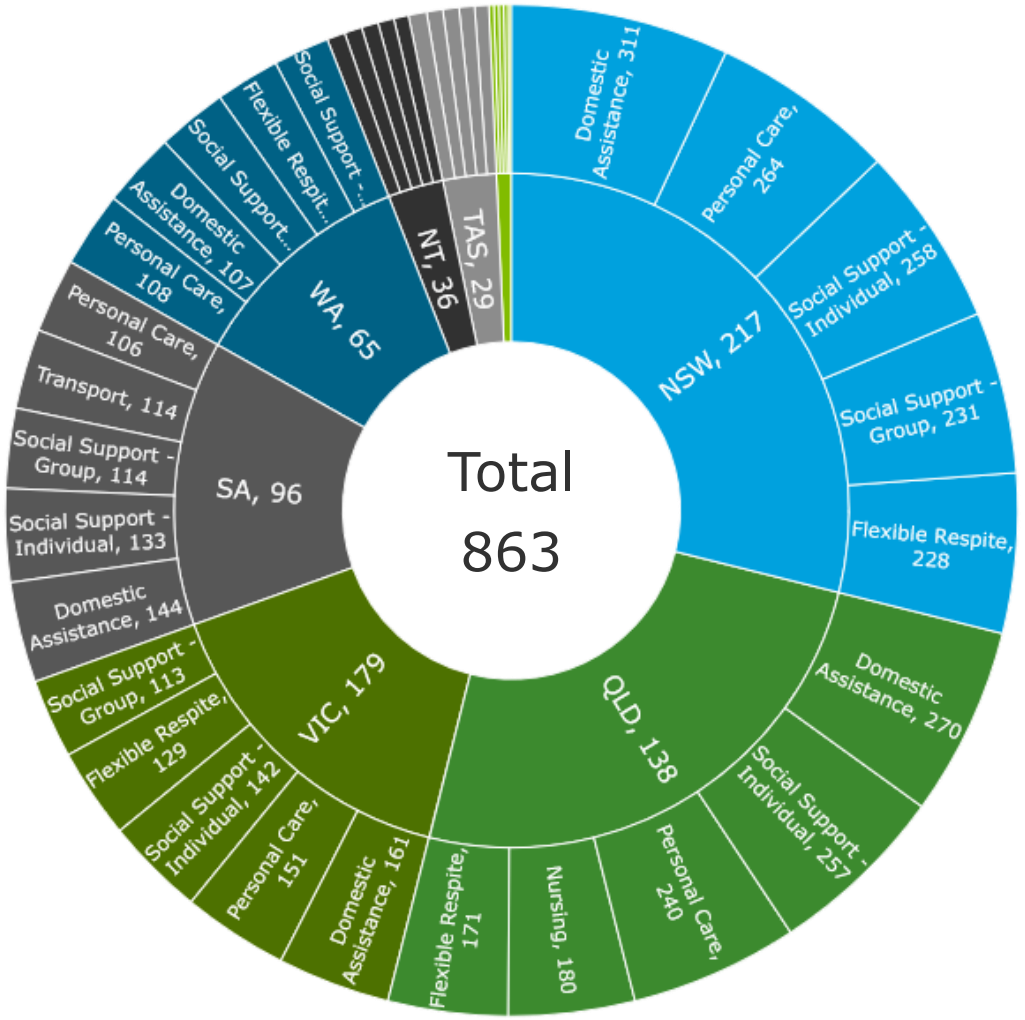
## Representativeness of the respondents in the CHSP provider survey

Services providers may operate multiple services across different locations.

The unique combinations of provider, service type and ACPR are visualised in chart B.1 and described as follows (as per legend):

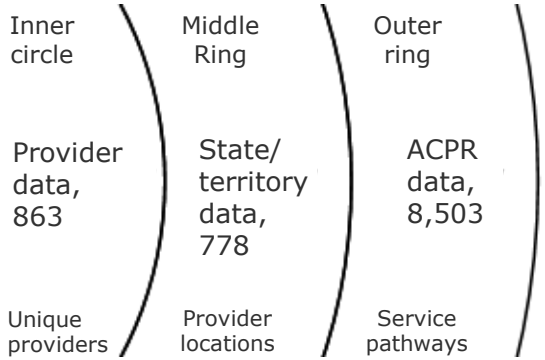
- There were 863 complete responses, which was used as the based for interpreting non-geographic questions (inner circle).
- The same provider operating in two states or territories would be counted twice (778, middle ring), as with each service type in each ACPR (8,503, outer ring).
- The outer ring shows the top 5 most common services per state. While more service providers indicated that they operate in Victoria, Queensland has more unique provider, service type and ACPR combinations.

**Chart B.1 Survey response by unique provider, service type and location combinations**




Source: Deloitte Access Economics analysis of service provider survey (2019)

**Legend:**




The heat maps on pages 58 and 59 present the percentage of responses per provider, service type, ACPR combination for the 778 state/territory responses. ACT has been rolled into NSW due to a low response count.

This represents service pathways i.e. 5 providers providing one service in one ACPR will be a count of 5. One provider providing 5 services in one ACPR will also be a count of 5.

# Appendix C

Methodology of market analysis

## Analysis

For the purpose of this analysis, a "market" represents the supply of an individual CHSP service type in a discrete geographical region. Figure C.1 illustrates how the various geographic levels were used to consider markets with and without service types.

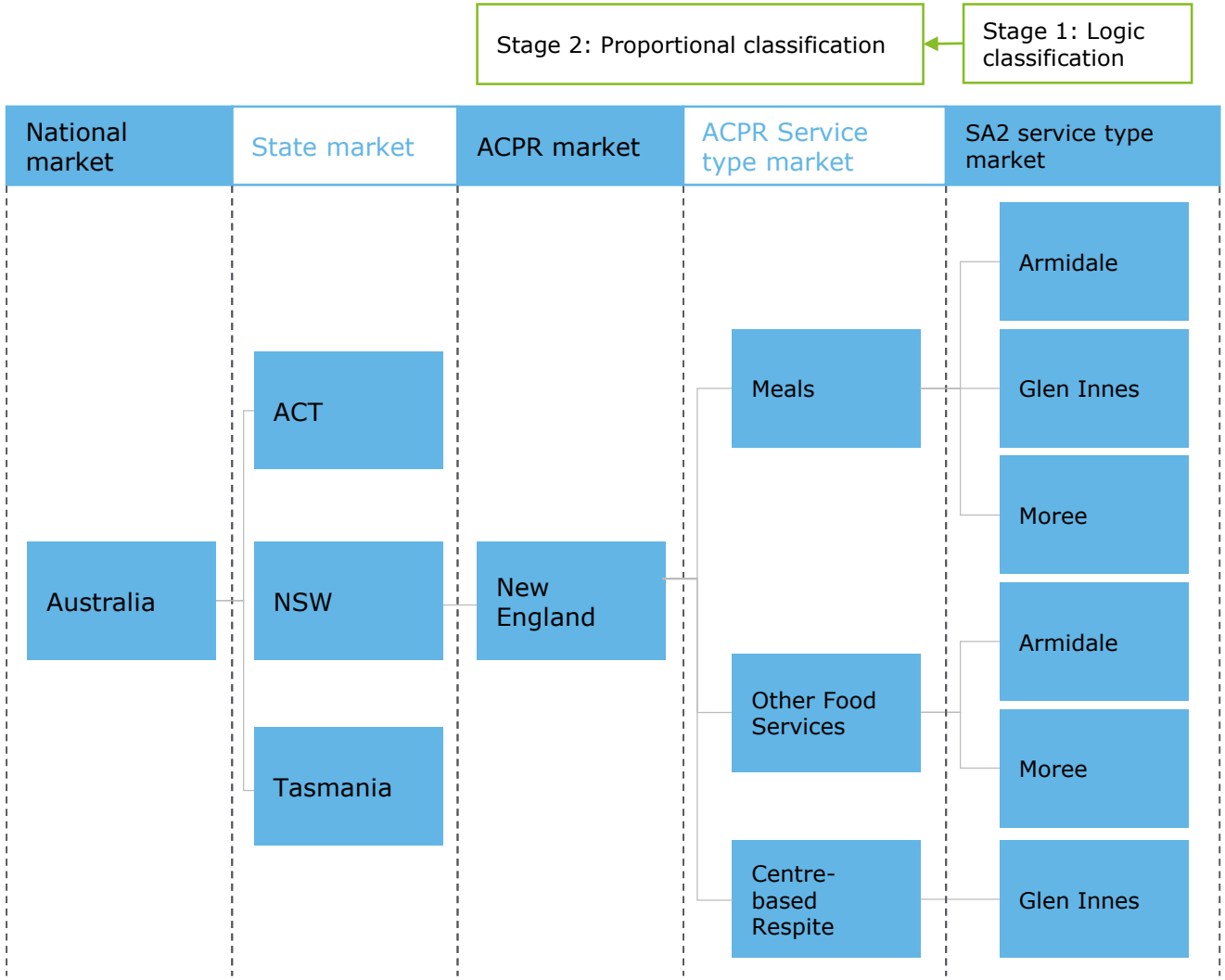
Classification of a market inherently requires a comparison with other markets – a thin market is, by definition, a market that experiences supply or demand challenges when compared to other markets. Similarly, a liquid market is by definition one that may have supply in excess of demand, but demand is still greater than comparable markets.

Classification of markets into thin, liquid and balanced types was undertaken in a two-stage process.

In the first stage, each market was analysed at the service type SA2 level and logically classified based on a set of characteristics covering client access and providers. These are discussed on the next slide and were iterated over to create a sensible balance of market types.

In the second stage, each ACPR service type market and ACPR market was classified using the majority proportion of SA2 service type markets within each ACPR.

**Figure C.1 Market types and classification methodology illustration**




Example 1: in Figure C.1, if the SA2 service type markets for Meals (Armidale, Glen Innes and Moree) were all logically classified as a thin market – then the ACPR-Service type (New England – Meals) would also be classified as a thin market as 100% of the SA2s are thin markets.

Example 2: Similar to Example 1, all SA2 service type markets for meals are logically classified as thin. All SA2 service type markets for Other Food Services are found to be liquid and Centre-based Respite is balanced.

The ACPR market type is then classified based on the most common market type at the SA2 level within the ACPR. In this example it would be thin, the SA2 service type markets are: 50% thin (3), 33% liquid (2), 17% balanced (1).

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