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Department of Education

Review of the In Home Care (IHC) program

Final Report 9 August 2023

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Acknowledgement

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We would also like to acknowledge the Secretariat of National Aboriginal and Islander Child Care (SNAICC) and the First Peoples Disability Network Australia (FPDN) as peak bodies that brought First Nations perspectives and the voices of the communities they work with to this review.

We would also like to thank the many individuals that provided input to this review. This included:

- Peak bodies
- In Home Care Support Agencies (IHCSAs)
- In Home Care (IHC) providers
- Families who have previously accessed, currently access, or are on waitlists to access IHC
- Key subject matter experts from the Australian Government Department of Education.

Each of these stakeholders contributed time, effort and insight into this review.

Executive summary

Introduction

The In Home Care (IHC) program is an approved child care service, capped at 3,200 places nationally, providing up to 100 hours of subsidised care for families per fortnight. IHC is targeted at families who are eligible for the Child Care Subsidy (CCS)/Additional Child Care Subsidy (ACCS) but are unable to access other forms of ECEC because they are either geographically isolated, work non-standard or variable hours, or are families with complex and challenging needs. While the IHC program is not included in the National Quality Framework (NQF), there are still requirements placed on IHC providers through the IHC guidelines.

The IHC program is currently subject to both the Australian Competition and Consumer Commission (ACCC) Childcare Inquiry and the Productivity Commission (PC) Inquiry into Early Childhood Education and Care (ECEC). These inquires, and the outcomes from these, present an opportunity for significant reform within the ECEC sector including reform to the IHC program. The Department of Education has commissioned PricewaterhouseCoopers Consulting Australia (PwC) to undertake a review of the IHC program and advise on potential improvements for the program. The focus of this review is timely to consider the future design of IHC to improve access, affordability, quality and equity of the program given the broader ECEC reforms.

Approach to the review

A mixed methods approach was taken to synthesising insights from previous reviews, analysis of demand data, primary data collection (28 interviews and12 survey responses from IHC providers and 357 survey responses from families), a review of policy levers and funding mechanisms in aligned human services (including aged care, disability care, out of home care and general practice), a series of workshops to co-design the future of the program and the development and use of a multi-criteria analysis (MCA) framework to assess the viability of different future design options.

Summary of findings

The purpose of the review is to assess whether the IHC program is meeting the objective of providing access to affordable ECEC for families that are unable to access other forms of ECEC due to being geographically isolated, working non-standard hours, or families with complex and challenging needs. The review has found that the IHC program is partially meeting this objective.

The program supports access to subsidised ECEC which enables families that work non-standard and variable hours to participate in the workforce, provides quality ECEC to children and families in rural and remote areas, and supports equitable access for children and families with complex and challenging needs. The introduction of the family rate cap, and changes and enforcement of eligibility criteria, has better targeted the program to families for whom other forms of ECEC are inaccessible or inappropriate to meet their needs, while the introduction of minimum qualifications for educators has improved quality.

However, the current program continues to experience challenges relating to workforce shortages, affordability, and therefore access, for all three cohorts of families. To date, the IHC program has adopted a single, consistent approach to meeting the needs of families irrespective of circumstances. To better meet the objectives of the program, and therefore improve equity, the IHC program should be tailored to meet the specific needs of each of the three very different cohorts of families. This could be achieved through providing funding aligned to family need, funding professional development so that educators can develop the skills they need to meet the specific needs of families, and through enabling FDC to provide ECEC out-of-hours for families. Families could also benefit by making eligibility processes and requirements simpler, streamline and improved data and IT systems for monitoring, reporting and oversight, and continuing to work with ACECQA to develop an enhanced IHC national framework and supporting IHC Standards.

Specific findings of the review

Finding 1: The IHC program aligns with the Australian Government's vision and objective for ECEC and is a necessary program of last resort for families unable to access other forms of ECEC.

Changes to the IHC program since 2018 include:

- Introduction of the family rate cap, the maximum amount the Australian Government will subsidise per session of care through the CCS, followed by an increase in January 2019.
- Removal of block operational funding for IHC providers
- Introduction of minimum, relevant qualifications (Certificate III) for IHC educators
- Establishment of IHC Support Agencies (IHCSAs) to assess eligibility of families to access IHC and to match families to appropriate IHC providers

These changes have increased affordability for families, improved the quality of educators, and brought greater consistency, and therefore equity, to the assessment of family eligibility to access IHC. This aligns with the Australian Government objectives of improving equity, affordability, quality and accessibility of ECEC for families.

Despite recent improvements to the IHC program there remain challenges associated with delivering services to all families. Families report that out-of-pocket costs are still high for the program, impacting access and affordability, while both families and IHC providers report a shortage of educators.

The current monitoring and reporting system, and the lack of real-time data and systems, makes it difficult to monitor quality and project demand for IHC services. This impacts on the ability to meet the objective to improve access to and quality of IHC. The Department of Education is currently working with the Australian Children's Education and Care Quality Authority (ACECQA) to develop an enhanced IHC national framework and new supporting IHC Standards.

Finding 2: IHC is more costly to deliver than other forms of ECEC due to additional fees associated with travel, board, non-standard hours rates, and educator locator fees. This impacts the financial viability of IHC providers and the affordability of care for families.

Costs for IHC have risen significantly in recent years compared to other forms of ECEC. From 2018-19 to 2021-22 CCS/ACCS payments for the IHC program increased 35.7 per cent. In comparison, CCS/ACCS payments for Family Day Care (FDC) decreased 28.1 per cent over this period. This increase for IHC is attributed to a growing number of families eligible for ACCS and large increases in hourly fees. Whereas the average hourly fee per child (based on an average of 1.8 children per session) for IHC was $14.51 in 2018-19 this rose to $21.55 in 2022-23 representing a 49.5 per cent increase. In comparison, the average hourly fee for FDC rose 15.9 per cent over this period (from $10.17 to $11.79). IHC providers report that the high costs of service delivery, and the removal of block operational funding, has impacted financial viability, with a 40 per cent decrease of registered providers in the market between 2018 and 2022[1].

There are large gap fees for families to use the IHC program. The average family who does not meet ACCS criteria using the program for 4.2 hours per session has an average gap fee of $40.32[2]. For families eligible for ACCS the average gap fee is $9.03.

[1] ORIMA Research and Department of Education administrative data

[2] The ACCC (2023) report identifies an average out of pocket cost of $60.69 per family per day. The ACCC report utilises December 2022 quarterly data, whereas we used IHC data sourced from ORIMA and Department of Education administrative data from July 2022 to May 2023. The ACCC report does not also specify session length. These are the likely reasons for differences in out-of-pocket costs reported.

Out-of-pocket gap fees for families are the greatest barrier to accessing the IHC program, as well as being a primary reason for families exiting the program. This is reflected in feedback from families who report that the cost of IHC was a factor when considering access to services[3].

Finding 3: Utilisation of IHC places has reduced since 2018, however, waitlists have increased. This is most likely due to a shortage of educators and other factors that make IHC less attractive to educators.

Since the redesign of the program in 2018 the number of IHC places utilised has reduced from 59 per cent before 2018 (of 3,000 places nationally) to 37 per cent in 2022 (of 3,200 places nationally). The number of IHC hours accessed across Australia has also decreased (eight per cent from 2019 to 2022). This suggests the introduction of IHCSAs has been effective in appropriately assessing and enforcing eligibility requirements.

Of the IHC places currently utilised 43.8 per cent are families with complex and challenging needs, followed by 35.6 per cent by families that work non-standard or variable hours and 20.6 per cent by geographically isolated families.

While utilisation of places and hours of IHC has decreased between 2018 and 2022 there has been a 43 per cent increase in waitlists during this period. It is likely that the increase in families on the waitlist is due to a shortage of IHC educators[4].

Finding 4: There is a shortage of educators available to provide IHC to geographically isolated families. To access educators these families incur significant, additional costs that are not covered under the CCS.

Demand for IHC for geographically isolated families is trending up with a 162 per cent increase in the number of geographically isolated families accessing the program from July 2018 to December 2022[5]. These families tend to have limited changes to their circumstances and engage with the program for extended periods of time, in the absence of there being other forms of ECEC available to them[6].

Families accessing IHC in regional and remote areas often face higher out-of-pocket fees with the average gap payment for a 4.2-hour session in Very Remote Australia being $49.00 per session and $42.04 per session for Remote Australia in 2022. It is important to note that these out-of-pocket costs to a family exclude the additional costs incurred by families in remote areas relating to transport, board, food and other ancillary costs to access an educator that are not reimbursed as part of the IHC program. This creates affordability challenges for families to utilise the program.

Despite already experiencing a shortage of educators in these regions, the current guidelines prohibit IHC educators from providing care for more than one family. This requirement means that multiple families who live on a remote station are unable to 'share' an educator for their children.

Finding 5: It is difficult to attract educators to provide IHC for families that work non-standard and variable hours due to the lack of set shifts, short notice and irregular hours.

Demand for IHC fluctuates based on the hours which a parent/carer may work. For example, front line staff such as nurses who do not have set shifts may have high demand, or no demand for the IHC program in any given week. This makes it unattractive for an educator as they do not have predictable or secure work hours. Having secure, predictable work is important for educators to have regular income, and for their own wellbeing.

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[3] Of the total survey respondents which includes those that are on the waitlist, accessing and have previously accessed the program, 18 per cent reported that cost was a factor when considering access to IHC. However, not all respondents completed this question. Of those that did respond 52 per cent reported cost as a factor.

[4] IHCSA and IHC provider consultations data

[5] IHC quarterly reports

[6] Peak body consultation

Families that engage IHC during non-standard hours incur additional penalty rates for their IHC educators.[7] Any income from working extra hours by these families may be offset by the increased out-of-pocket costs of engaging educators from IHC providers at times that require penalty rates to be paid. While educators are eligible for these rates, there is still a considerable under-supply of these educators willing to work these non-standard hours.

Finding 6: There is a shortage of educators with the skills required to make the reasonable adjustments to meet the needs of families with complex and challenging needs.

Families with complex and challenging needs are the highest users of the IHC program representing 43.8 per cent of places utilised. This cohort includes families who have family members (including the children) with additional needs or a disability whose ECEC requirements cannot be catered for in another approved ECEC setting, or through other government funded or community-based services. This may also include other complex family situations which may prevent families accessing mainstream ECEC, such as serious illness or other family breakdowns. Between 2018 and 2022 there has also been a 25 per cent growth in waitlists for these families to access IHC.

Where families are unable to access IHC the main impediment to this is reported to be the lack of educators with skills to make reasonable adjustments required meets the specific needs of these children and families. This includes knowing how to recognise and manage behaviours associated with disability and developmental delay, or to provide physical care supports (e.g. administration of medication or PEG feeding) during the time they are providing ECEC to the children.

While some IHC providers have indicated they can recruit educators with specialist skills this is not the norm. Families that can access educators with experience in areas such as behavioural issues or other disability specific adjustments can pay a premium for these educators, further increasing the out-of-pocket costs to families.

Finding 7: The IHC program could be better tailored to meet the needs of the three very different cohorts of families it is designed for.

The current IHC program applies a single, consistent approach to eligibility, funding and service delivery to families whether they are geographically isolated, work non-standard or variable hours, or are families with complex and challenging needs. While this may support equality across families in how the program treats them, to further improve equity, the program could be better tailored to meet the very different and specific needs unique to each of these three cohorts of families.

For all three cohorts of families the key barriers to access the program are workforce shortages and affordability, though the main drivers of these differ for each cohort. While families that are geographically isolated experience a shortage of educators caused by the tyranny of distance, families that work non-standard or variable hours have difficulty attracting educators willing to work irregular hours, and at short notice. Families with complex and challenging needs are unable to access educators with the experience and skills to meet the needs of their children and their family. Where educators can be accessed, families from all three cohorts often pay high out-of-pocket gap fees in the form of premiums, penalty rates and other, additional costs.

To improve access, equity and affordability to IHC future approaches will need to be designed that address the barriers specific to each of the three cohorts of families.

[7] Family survey, verified by ORIMA data

Opportunities for the future of the IHC program

Following a co-design process with the Department, a range of options to improve the IHC were developed, which are listed in Figure 1.

Figure 1: Summary of options

Focus area	Option	Families that would be impacted		
Options to improve demand management	Better support transition of some families from IHC to mainstream ECEC or alternative service systems.	Green	Green	Grey
	[Prioritised] Streamline and simplify administrative processes and responsibilities	Green	Green	Green
Expanding and supporting the provider market	[Prioritised] Expand FDC to provide additional support to IHC eligible families	Grey	Green	Amber
	Alternative delivery models of IHC	Grey	Green	Green
	Broaden/integrate IHC with other services/programs	Green	Grey	Amber
Workforce	Expand eligible qualifications	Amber	Amber	Green
	Support workforce pipeline for after hours and remote educators	Grey	Amber	Green
	Broaden pool of available educators	Grey	Amber	Green
	Upskill workforce to provide care to children with complex care needs	Green	Grey	Grey
Funding and fees	[Prioritised] Providing funding aligned to family needs	Green	Green	Green
	[Prioritised] Fund professional development opportunities for the workforce	Amber	Amber	Amber
	Block funding to support provider financial viability	Green	Green	Green
Quality and Safety	[Prioritised] Improve data and IT systems for monitoring, reporting and oversight	Green	Green	Green
	[Prioritised] Enhance national consistency and quality of the program	Green	Green	Green

Key: [Prioritised] = Prioritised option. **Grey** = no impact to families, **Amber** = moderate impact to families, **Green** = significant impact to families. (person icon) = Families with complex and challenging needs, (clock icon) = Families that work non-standard hours, (windmill icon) = Geographically isolated families.

Following an assessment and prioritisation process, six key opportunities were identified for the Department of Education to explore further:

- **Make access to IHC simpler for eligible families** by consolidating the assessment of family eligibility into a single, national support agency (or equivalent), publishing all IHC provider details online, and reducing the administrative requirements and frequency for families to confirm ongoing eligibility for IHC.

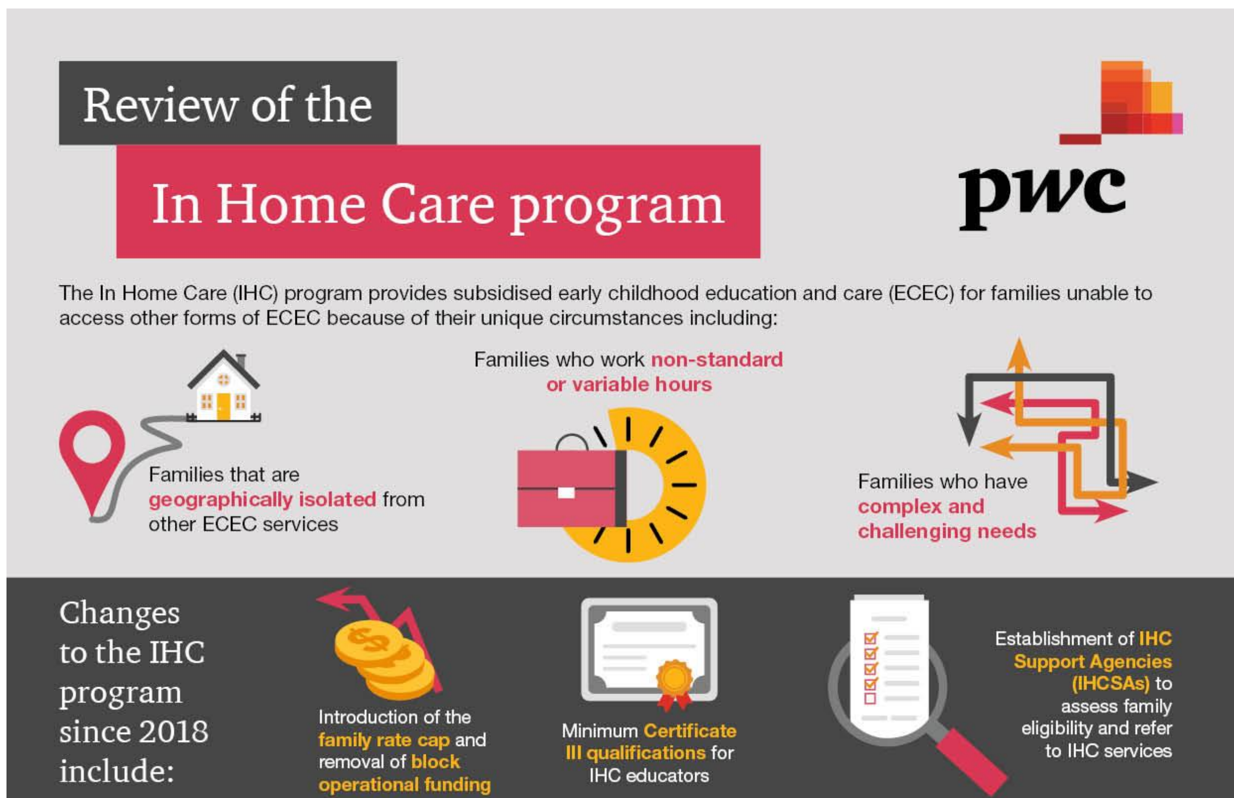
- **Empower and expand FDC offerings** by offering financial incentives for FDC services to provide ECEC for out-of-standard-hours care families and supporting alternative models of FDC to alleviate demand for IHC. These could be tested through an initial pilot program.
- **Provide funding aligned to family needs** that factor in complex and challenge needs, and additional costs associated with delivery of IHC that are not currently covered. While this could be achieved through either amending the existing CCS/ACCS scheme, block funding to IHC providers, or a dedicated, per family driven IHC subsidy scheme, the optimal funding mechanism requires further investigation.
- **Fund professional development** opportunities for the workforce to support quality of IHC for families, and to enhance the value proposition for educators.[8]
- **Develop and implement streamlined and improved data and IT systems** for monitoring, reporting and oversight of the IHC program to strengthen quality and better support national planning and decision making.
- **Enhance national consistency and quality of the program** by continuing to work with the Australian Children's Education and Care Quality Authority (ACECQA) to develop an enhanced IHC national framework and supporting IHC Standards[9].

Each of these opportunities present different risks and implementation timelines. Implemented together, these could lead to significant improvements to equity, accessibility, affordability and quality of IHC for the three cohorts of families who access IHC as the only form of ECEC they are able to access.

[8] A Professional Development Subsidy is available via ECEC services to help qualified staff to complete training that adds to their skills as of 1 July 2023. However, this is initially only available to services and staff in regional, remote and very remote locations, and First Nations services and educators.

[9] The Department of Education have recently commenced a project to progress and formalise these arrangements. This is expected to occur throughout FY24.

Review of the IHC program – infographic summary



Findings of the review

Finding 1

The IHC program aligns with the Australian Government's vision and objective for ECEC.

- The IHC program has increased affordability for some families, improved quality, and brought greater consistency to the assessment of family eligibility.
- Families report that costs remain high while both families and IHC providers report a shortage of educators.
- The lack of real-time data and systems makes it difficult to monitor quality and project demand for IHC services.

Finding 2

IHC is more costly to deliver than other forms of ECEC.

36% increase in Child Care Subsidy (CCS)/ Additional Child Care Subsidy (ACCS) payments for IHC **from FY19 to FY23** (compared to 28% for Family Day Care (FDC)

49% increase in IHC hourly fee per child[1] ($14.51 to $21.55) from FY19 to FY23 (compared to 16% from $10.17 to $11.79 for FDC).

The **average gap fee** for families ineligible for ACCS is **$40.32 for a 4.2-hour session** compared to $9.03 for ACCS eligible families.

Finding 3

Utilisation of IHC has reduced since 2018, however, waitlists have increased.

37% of IHC places were utilised in 2022 compared to 59% pre-2018, partly due to changes and enforcement of eligibility requirements

43% increase in waitlist in part due to a shortage of educators.

Places utilised are families with complex and challenging needs	44%	Families that work non-standard or variable hours	36%	Geographically isolated families	21%

[1] Based on an average of 1.8 children per session of IHC

Finding 4

Geographically isolated families incur significant, additional costs that are not subsidised.

This excludes additional costs relating to transport, board, food and other ancillary costs to access an educator that are not reimbursed.

Finding 5

Few educators have the skills required to meet the needs of families with complex and challenging needs.

25%

increase in the waitlist for these families to access IHC from 2018 to 2022.

- Families report a lack of educators with skills to make reasonable adjustments required meet specific needs of these children.
- There is a premium to access educators with experience in behavioural issues or disability-specific adjustments.

Finding 6

The unpredictable and irregular hours associated with providing IHC for families that work non-standard and variable hours make it difficult to attract educators.

- IHC during non-standard hours incurs penalty rates to access educators.
- There is a considerable under-supply of educators willing to work non-standard hours.

Finding 7

The IHC program could be better tailored to meet the needs of the three very different cohorts of families.

- While workforce shortages and affordability impact all families the drivers of differ for each cohort.
- The future state will need to be designed in a way that meets the very different and specific needs unique to each of these three cohorts of families.

Future state opportunities

1. Make access to IHC simpler for families by having a single, national support agency to assess eligibility and reduce requirements to confirm eligibility for IHC.
2. Incentivise FDC services to provide ECEC for non-standard hours care families.
3. Provide funding based on family needs that factor in reasonable adjustments and additional costs that are not currently subsidised.
4. Fund professional development opportunities for the workforce to support quality and enhance the value proposition for educators.
5. Improve data and IT systems for monitoring, reporting and oversight of the IHC program to strengthen quality, planning and decision making.
6. Continue to work with ACECQA to develop an enhanced IHC national framework and supporting IHC Standards.

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Background

Early Childhood Education and Care reforms

In Australia, the Early Childhood Education and Care (ECEC) system includes both informal or non-regulated care, often provided by relatives, friends and non-regulated childminding services (such as creches), and formal or regulated care. Formal ECEC includes:

- Outside school hours care (OSHC) for primary school aged children
- Centred-based Day Care (CBDC), which can be provided on a regular or occasional basis
- Family Day Care (FDC), which is provided in the family home of approved educators; and
- In Home Care (IHC), which is education and care provided in the family home for families unable to access CBDC, FDC and OSHC because of their unique circumstances.

Over the past decade there has been significant reform to the ECEC system in Australia in recognition of the benefits of quality ECEC to the health, wellbeing, learning and development trajectories of children. Access to high quality ECEC leads to improved cognitive and emotional development, greater academic achievement, and a range of benefits later in life for children such as greater employability and productivity, better health outcomes, reduced interaction with the criminal justice system and reduced reliance on social services. Access to ECEC is also a key enabler of workforce participation for parents and carers.

To drive quality across the ECEC sector, the National Quality Framework (NQF) was introduced in 2012 including the National Law, National Regulations, and the National Quality Standards. The Australian Children's Education and Care Quality Authority (ACECQA) was established as the independent national authority to assist government in administering the NQF.

In 2018 the Child Care Subsidy (CCS) and the Additional Child Care Subsidy (ACCS) were introduced replacing the previous Child Care Benefit (CCB), Child Care Rebate (CCR), and Special Child Care Benefit (SCCB) payments system. These payments support families to access ECEC. The new CCS/ACCS system has made ECEC more affordable for families[10], and offers subsidies based on a more graduated 'activity test'[11] for parents and caregivers.

The draft *National Vision for ECEC* will provide the direction for longer term reform at national, state and territory level. It will guide government and sector discussion and decision-making about the ECEC system. It will also help all parts of the system to work together to achieve the shared vision.

An Early Years Strategy is also in development which is intended to help create a more integrated, holistic approach to the early years and better support the education, wellbeing and development of Australia's children[12]. It will seek to support improved coordination between Commonwealth programs, funding and frameworks impacting early childhood development.

Concurrent to this review the Productivity Commission and the Australian Competition and Consumer Commission (ACCC) are conducting inquiries into ECEC. The scope of the Productivity Commission inquiry is to consider cost and availability barriers that affect access to ECEC services and options to improve affordability and access to ECEC services, developmental outcomes for Australian children, outcomes for disadvantaged children and economic growth through workforce participation[13]. The ACCC is examining the workforce costs and availability, administrative costs, regulatory compliance costs within the ECEC system[14].

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[10] Child Care Package Evaluation 2021

[11] An activity test is used to determine the amount of subsidised care available under the CCS. Depending on the combined hours of work, training, study, voluntary work or other recognised activity undertaken, a family can receive up to 100 hours of subsidy per fortnight per child. Department of Education, Skills and Employment, 2023, *Child Care Provider Handbook*, https://www.dese.gov.au/child-care-package/child-care-provider-handbook/appendix-child-care-subsidy/determining-child-care-subsidy

[12] Commonwealth Department of Social Services - Early Years Strategy

[13] Productivity Commission – Early Childhood Education and Care

[14] Australian Competition & Consumer Commission – Childcare inquiry 2023 Project overview

The In Home Care (IHC) program

The IHC program, which commenced in July 2018, is intended to make ECEC more affordable and accessible for parents and carers. IHC places are capped at 3,200 places nationally and are available to families who are eligible for the CCS but who are unable to access other forms of ECEC because of their unique circumstances including:

- Families that are geographically isolated from other ECEC services
- Families who work non-standard or variable hours, and
- Families who have complex and challenging needs.

Since 2014 the IHC program and its predecessors have been the focus, or in scope, of several reviews (Figure 2).

Figure 2: Previous reviews of the IHC program and its predecessors

Consistent findings of these reviews are that there remain four key challenges for the program:

1. Data: the need for continuous improvement and access to timely and accurate data.
2. Workforce: the need to address challenges in recruiting and retaining IHC educators.
3. Affordability: the need to understand the impact on demand and service viability.
4. Administration: need for improved consistency and to understand the administrative impact the current structure has on families, services, and support agencies.

In 2023, the Australian Department of Education commissioned PricewaterhouseCoopers Consulting Australia (PwC) to review the IHC program and design a 'future state' of the program.

Context of the review

Despite positive changes to the ECEC system, including to the IHC program, access and affordability continue to be key challenges. This is driven by workforce shortages, variable service quality, and issues with financial viability of IHC providers. The ECEC system continues to be the subject of current reviews and reforms. This includes:

- Development of Shaping Our Future: The National Children's Education and Care Workforce Strategy, 2022–2031
- Enactment of the Family Assistance Legislation Amendment (Cheaper Child Care) Bill 2022 due to be implemented on 1 July 2023
- Development of an Early Years Strategy (currently underway)
- Development of a draft *National Vision for ECEC* (due to be finalised by the end of 2023)
- *Inclusion Support Program (ISP) review* (due to be completed by mid-2023) into the performance of the program in building the capability of mainstream ECEC services to develop and adopt inclusive practices that support the needs of children with additional needs e.g. with disability, challenging behaviours, or serious medical conditions
- Australian Competition and Consumer Commission (ACCC) Childcare Inquiry 2023 focused on the market for the supply of childcare services, including IHC

- *Productivity Commission inquiry into Australia's early childhood education and care system, 2023-24,* tasked with making recommendations to support affordable, accessible, equitable and high-quality ECEC that reduces barriers to workforce participation and supports children's learning and development.

The focus of this review is to build from the 2020 In Home Care evaluation, identify the current state of the program, and to consider the future design of the program to improve access, affordability, quality and equity of the program.

Approach to the review

Scope of the review

The purpose of the review was to determine the extent to which the IHC program is meeting its policy intent and objectives of achieving the best possible outcomes for children and families accessing ECEC.

The review was focused on:

- How the current IHC Program align with the Australian Government's strategic policy to reform the ECEC
- The demand for the IHC program
- The current IHC model as an appropriate mechanism to meet the needs of families
- The cost-effectiveness of the program
- What the future program could look like to achieve the intended outcomes

Key components of the review methodology

The methodology for the review comprised four key stages:

1. Design and planning of the review
    a. Co-design with the Department of Education a Program Logic for the IHC program (see Appendix A).
    b. Develop a review framework (see Appendix B) and methodology to guide the review.
2. Analysis of existing documentation, data and literature
    a. Desktop review of IHC program documentation and synthesis of key insights, findings, and recommendations from previous reviews.
    b. Review of relevant government policies and strategies.
    c. Analysis of IHC utilisation data from July 2018 through to December 2022 obtained from IHCSAs
    d. Analysis of IHC cost data from July 2018 through to May 2023 provided from ORIMA.
    e. Rapid, targeted scan of other government programs tailored to meet the unique needs of individuals and families that are geographically isolated, work non-standard or variable hours, or have complex and challenging needs (Appendix D).
3. Collection of data about the views and perspectives from organisations and families
    a. Consultation with peak bodies (nine interviews).
    b. Consultation with IHC providers (five group consultations, nine individual interviews) and IHC support agencies (five consultations).
    c. Online survey of IHC providers (34 surveys distributed, 12 responses received) with a 36 per cent response rate.
    d. Online survey of families waitlisted, accessing or who previously accessed IHC services (4,123 surveys distributed, 357 responses) with a response rate of 9 per cent).
4. Co-designed future-state options for the IHC program
    a. Co-design with the Department of Education a Multi-Criteria Analysis (MCA) framework to assess potential options. Criteria included: equity, affordability, accessibility, quality, sustainability, legislative and regulatory changes required, operational changes required, fiscal changes, timelines for implementation and any interdependencies. See Appendix C for the MCA framework.
    b. Co-design workshop to develop potential options for change.
    c. Assessment of the impact and alignment of each option against the principles of the National Vision for ECEC. Implementation risks criteria assess the challenges and barriers to implementing each option.
    d. Co-design workshop to prioritise options for the future program.

Parameters of the review

While this review followed best-practice methodologies for program review and design, the following limitations should be considered:

- Point in time analysis: This review was conducted over a short timeframe (four months) which constrained the options for the methodology and the amount of data that could be collected. The report does not reflect data on longer term impacts which would require a review over several phases.
- Underestimates of cost data: Analysis of cost data suggests that some IHC providers may be waiving the gap fee for families who have applied for the ACCS. This means that the average gap fee for families reported in this review is likely to be an underestimate of the gap fees families are paying. Changes in effect from 1 July 2023 requiring all gaps fees be paid by families using electronic funds transfer mean there will be greater visibility in future when IHC providers waive gap fees.
- Data limitations: Cost and utilisation data sourced from ORIMA is not disaggregated by family cohort. Therefore, estimates of utilisation and access by family cohort has relied upon In Home Care Support Agency (IHCSA) quarterly reports. It is important to note these reports are point-in-time and do not capture the hours of IHC provided per child, rather they capture the number of families/children accessing the program.
- Data cleansing: Data sourced from ORIMA underwent data cleansing based on guidance from the ORIMA team. This has led to the exclusion from our analysis of entries where data was either incomplete or there were errors. While this methodology is consistent with analysis conducted by ORIMA it is unclear what impact this may have on the accuracy of findings.
- Hidden demand: The existing data report tools only provide a point in time snapshot of waitlists. Current available data also does not capture families who are eligible for the program but who never engage and are therefore not counted on the waitlist. This may be for a range of reasons including those that are deterred by out-of-pocket cost estimates, or by the shortage of educators and time on waitlist.
- Additional fees: Data analysed from ORIMA includes administration costs associated with the program that are charged to families by IHC providers. However, additional fees, such as registration fees, educator finding fees and other ancillary costs are not collected within the ORIMA dataset. This means the costs to some families are greater than the data indicates.
- No in-depth consultation with families: While families provided input into the review through surveys, due to administrative issues, families were not consulted through qualitative primary data collection methods such as interviews. Consultation would have further enhanced an understanding of their experience of the program.

Findings

This section synthesises the findings from the review against each of the key questions and lines of inquiry (the co-designed review framework is in Appendix B).

Alignment of the IHC program with ECEC strategic policy and reform

Key findings

- The IHC program aligns with the Australian Government objectives of improving equity, affordability, quality and accessibility of ECEC for families.
- Changes to the IHC program since 2018 have increased subsidies for families, improved the quality of educators, and brought greater consistency to the assessment of family eligibility to access IHC.
- The removal of operational block funding for IHC providers, and the introduction of minimum qualifications for educators, has impacted the financial viability of IHC providers and contributed to workforce shortages.
- While IHC enables service to families unable to access other forms of ECEC the current program design is not tailored to meet the needs of the three very different cohorts of families it is targeted towards.

Alignment of the IHC program with broader ECEC policy

The draft *National Vision for ECEC* is underpinned by four key principles: equity, affordability, quality, and accessibility. The IHC program aligns with these principles given it is intended to provide appropriate services for families who cannot access any other form of ECEC. Enabling families that are geographically isolated, work non-standard or variable hours, or have complex and challenging needs to receive IHC improves both accessibility and equity for these families and their children.

Under the CCS/ACCS system ECEC providers, including IHC providers, receive payments based on the hours of IHC provided, with the amount of subsidy families are eligible to receive based on the 'activity test'. This aligns with the ECEC principles of affordability and equity.

Requiring IHC educators to hold minimum, relevant qualifications[15] aligns with the ECEC principle of quality as it ensures that educators have a certain skill level in ECEC when providing services to families and children.

Impact of IHC program changes on families and IHC providers

To support the objective of providing a high quality, flexible ECEC option to families unable to access other approved ECEC options, the IHC program underwent redesign in 2018. Key changes included:

- Introduction of the family rate cap, the maximum amount the Australian Government will subsidise per session of care through the CCS, followed by an increase in January 2019.
- Removal of block operational funding for IHC providers
- Introduction of minimum, relevant qualifications (Certificate III) for IHC educators
- Establishment of IHCSAs to assess eligibility of families to access IHC and to match families to appropriate IHC providers

The increase to the family hourly rate cap in 2019 (from $25.48 to $32, indexed annually) has enabled IHC providers to be better remunerated for their services, while improving affordability for families[16]. However, the current rate cap is often too low to cover additional costs associated with penalty rates for non-standard hours, and additional costs to access IHC in rural/remote areas.

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[15] As of 2018 all educators must be undertaking, at minimum, studies associated with achieving a Certificate III in ECEC. Other recognised qualifications include a Diploma or Bachelor degree in ECEC and primary school teaching qualifications registered with state-based Teacher Regulatory Authorities.

[16] IHC provider consultations

“Certain agencies charge high fees … this whole process is too overwhelming” – IHC Family

Changes associated with the introduction of CCS in 2018 included the removal of block operational funding for IHC providers. While this was intended to transition funding to a more equitable per child/family funding model several providers reported that this change has impacted their financial viability and meant that costs have also led to fee increases for families.

The introduction of Certificate III as a minimum qualification has helped improve quality of IHC service delivery. However, IHC providers have reported reduced workforce capacity, particularly in geographically isolated areas, further constraining access and affordability for some families. IHC providers and IHCSAs report that workforce capacity has also been impacted by the transition of educators to other care industries where wages are higher (such as the NDIS), movement to other ECEC services, and reduced demand for IHC educators during COVID-19[17].

Sector Comparison Box 1: Subsidies for disability services in regional and remote areas.

Much like the IHC program, other sectors face challenges of pricing and delivery to rural and remote areas of Australia. The costs for delivery of disability services in regional, remote and very remote areas of Australia are higher than for metropolitan areas. To ensure people are able to access and afford the disability services they need the National Disability Insurance Scheme (NDIS) has set higher subsidy price limits for remote (40 per cent increase) and very remote (50 per cent increase) supports[18].

To improve access to IHC higher subsidies could be applied for geographically isolated families to help address the higher costs associated with service delivery in these regions.

The establishment of IHCSAs has brought greater consistency and independence to the way families are assessed for eligibility to IHC, and therefore improved equity and access. However, some IHC providers report that some inconsistencies remain across different IHCSAs[19]. Needing to liaise with both IHCSAs and IHC providers has also led to confusion and additional burden for some families[20].

“Being able to create an inclusive program makes me proud to be involved” – IHCSA staff member

It should also be noted that the Department of Education is working with ACECQA on the IHC Quality and Safety Project. This project is intended to improve consistency, quality and safety of IHC through an enhanced IHC national framework. The framework is currently being developed and a pilot will be implemented commencing in 2024.

Effectiveness of the IHC program in delivering ECEC to families unable to access mainstream services

While IHC is a necessary program of last resort for families unable to access other forms of ECEC, the current program design is not tailored to meet the needs of the three very different cohorts of families who need it. Some families also have difficulty accessing the program, contributing to low utilisation[21]. More broadly, families report that costs are still high for the program, impacting access and affordability[22].

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[17] IHCSA and IHC provider consultations

[18] NDIS 2021-22 Annual Pricing Review – Final Report

[19] IHC provider consultations

[20] Family surveys

[21] Family surveys

[22] Ibid.

For families in remote and regional areas there is a workforce shortage making it difficult to access educators. This means that families may have to pay additional costs to attract educators, such as room/board costs and travel costs[23]. Similarly, families that work non-standard and variable hours find it difficult to access educators willing to accommodate their education and care needs. Attracting educators to provide IHC to these families also tends to incur additional costs or loadings.

For families with complex and challenging needs, educators may be needed that have additional skills to make reasonable adjustments for disability or other complex needs whilst they are providing ECEC to these children. For example, this might include educators knowing how to recognise and manage behaviours associated with disability and developmental delay, or to provide physical care supports (e.g. administration of medication, PEG feeding, etc.) during the time they are providing ECEC to the children. While these families may be unable to access educators with the requisite skills to provide IHC to their children, they may also be ineligible for NDIS funding, meaning they are unable to access ECEC and supports appropriate for their needs. While there is anecdotal evidence of some families being transitioned from IHC to ISP in mainstream ECEC services, it is unclear how frequently this occurs[24].

Sector Comparison Box 2: Medicare Benefits Schedule funding for out-of-standard hours health care.

As part of the Medicare Benefits Schedule (MBS) there are specific MBS subsidies to cater for out-of-standard hours costs associated with service delivery. Since the introduction of urgent after-hours MBS items there has been a substantial increase in the number of urgent after-hours care services delivered. Providing subsidies that cover the additional costs associated with non-standard hours IHC may improve access and affordability for families that work non-standard and variable hours. However, care must be taken to ensure only families in need of non-standard hours IHC who are unable to access other forms of ECEC are able to receive these subsidies.

[23] Ibid.

[24] IHCSA consultations

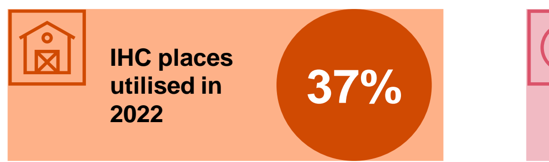
Demand for the IHC program

Key findings

- The number of IHC places utilised has reduced since the redesign of the program in 2018 suggesting the introduction of IHCSAs has been effective in appropriately assessing and enforcing eligibility requirements.
- The greatest proportion of families accessing IHC are those with complex and challenging needs (43.8 per cent of total families).
- Geographically isolated families have seen the largest access growth, with a 162 per cent increase in access to the program.
- The waitlist to access IHC has increased by 43 per cent since 2018, which is thought to be primarily due to a shortage of educators and factors which make IHC less attractive to educators such as short shifts, irregular hours, etc.

Utilisation of IHC places

Since the redesign of the program in 2018, demand for IHC has decreased from 41 per cent of places utilised (3,200 places nationally) in 2019 to 37 per cent in 2022[25]. This compares to 59 per cent of places utilised prior to 2018 under the former IHC program (3,000 places nationally)[26].



Of the IHC places currently utilised 43.8 per cent are utilised by families with complex and challenging needs, followed by 35.6 per cent by families that work non-standard or variable hours and 20.6 per cent by geographically isolated families[27].

The proportion of IHC distributed places that are utilised is greatest in Queensland (48 per cent of distributed places) and Victoria (47 per cent of distributed places). In comparison, the proportion of IHC distributed places that are utilised is lowest in ACT (14 per cent), NT (19 per cent), and TAS (19 per cent)[28].

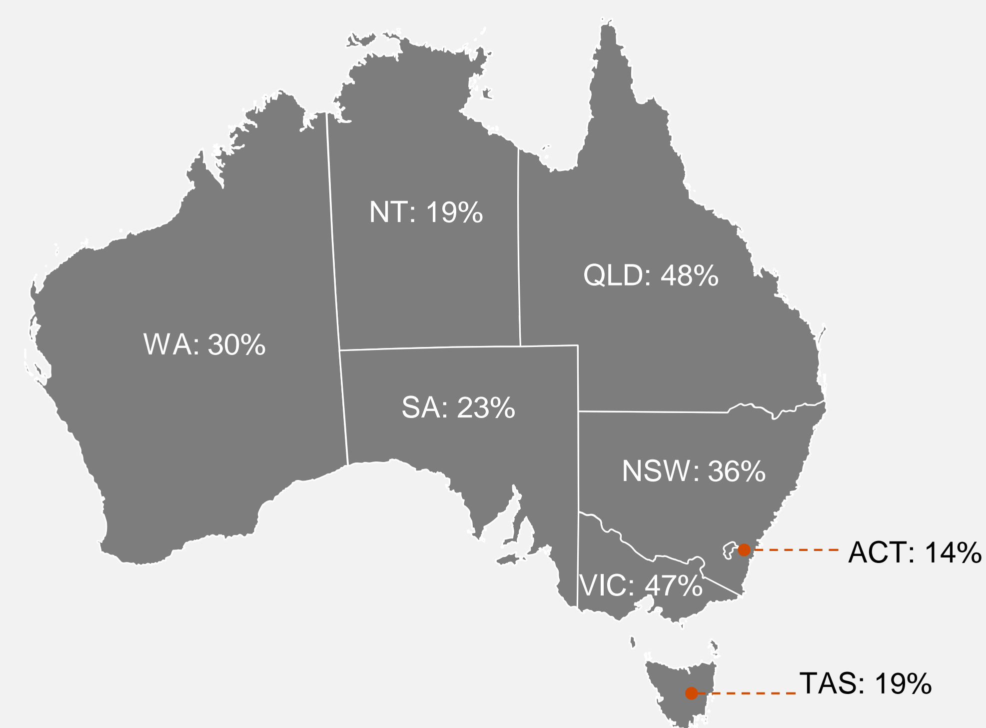
25 ORIMA Data Research – total accessed hours of IHC

26 Nanny Pilot Program Evaluation (2017).

27 IHC quarterly data

28 Ibid.

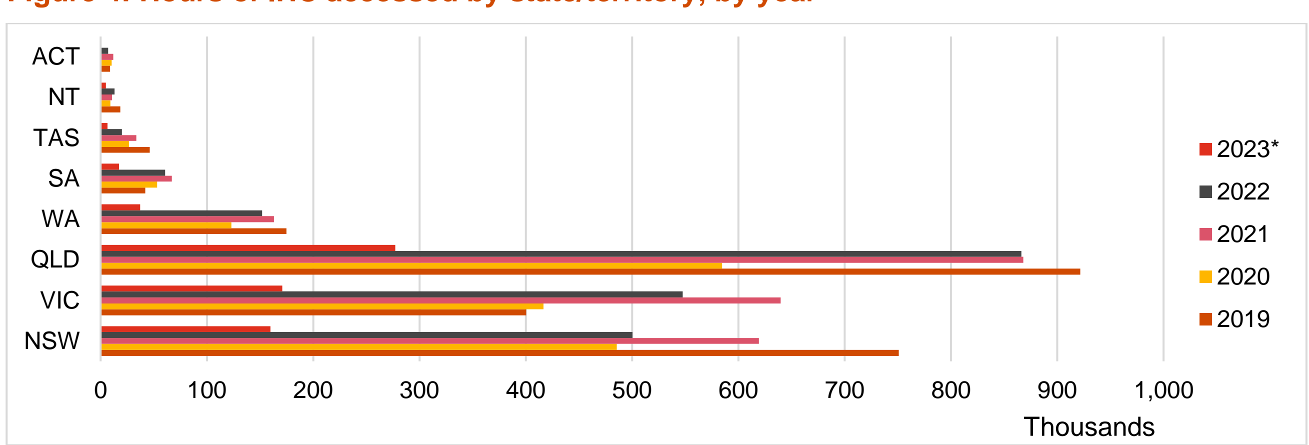
Figure 3: Proportion of IHC distributed places utilised, by state/territory[29]



Hours of IHC accessed

The number of IHC hours accessed across Australia decreased by eight per cent from 2019 to 2022 (Figure 4). Victoria and South Australia were the only states/territories that saw an increase in IHC hours utilised. The sharpest decline in hours accessed was in Tasmania. It is worth noting that in Tasmania the IHCSA is also the Inclusion Agency, which they report has enabled them to successfully transition families from IHC to other forms of ECEC. For example, one family applied for IHC for their child with Down's Syndrome. The IHCSA worked with them to access supports through the ISP program which resulted in the child being placed in CBDC.

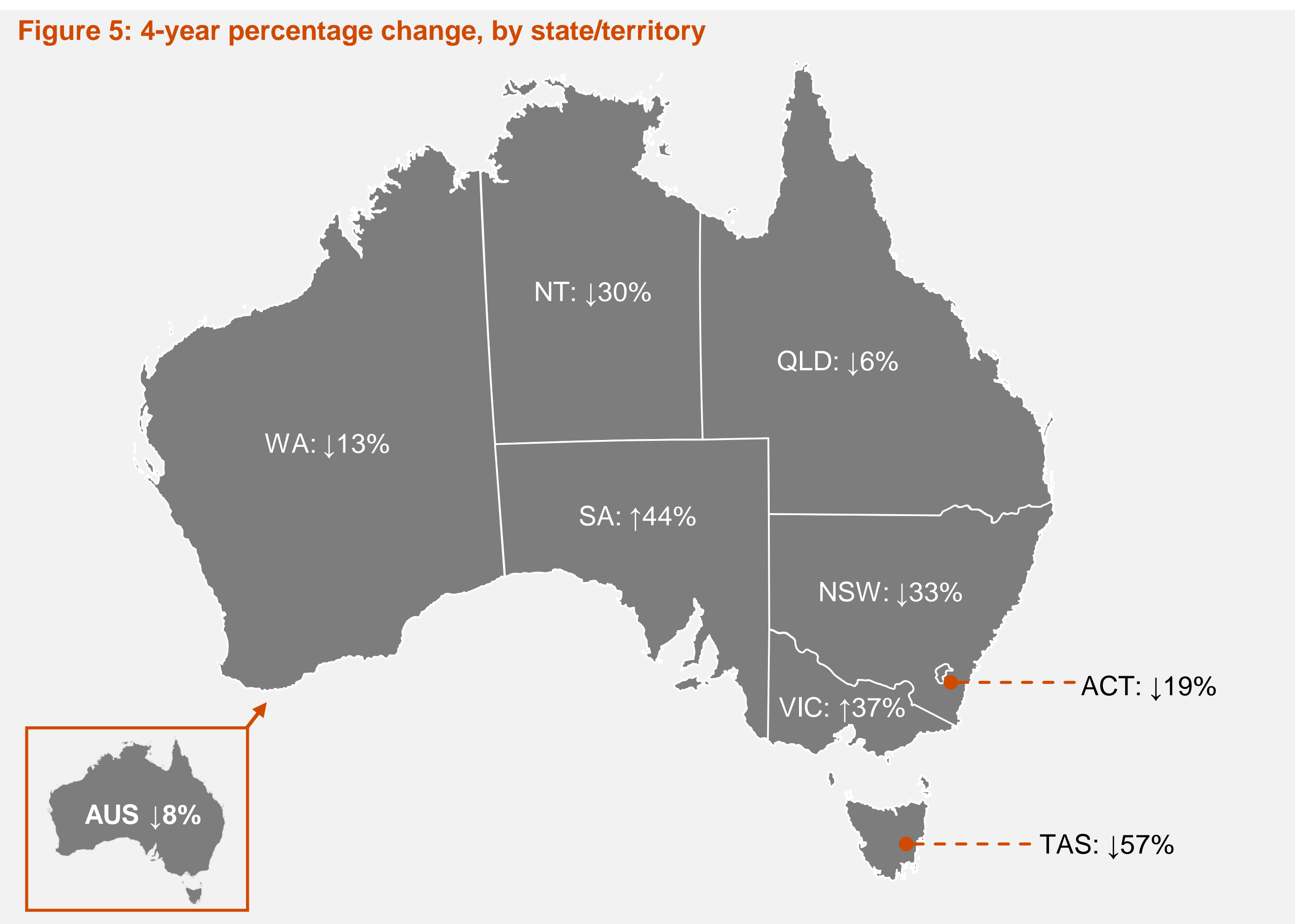
Figure 4: Hours of IHC accessed by state/territory, by year



Source: ORIMA Research, rounded to nearest full percentage place
* 2023 up to 23 May 2023, within periods between July to October there is traditionally an uptick in services provided, as such we have omitted 2023 from analysis, but included to show the current uptake of the program.

29 IHC Quarterly data, December 2022.

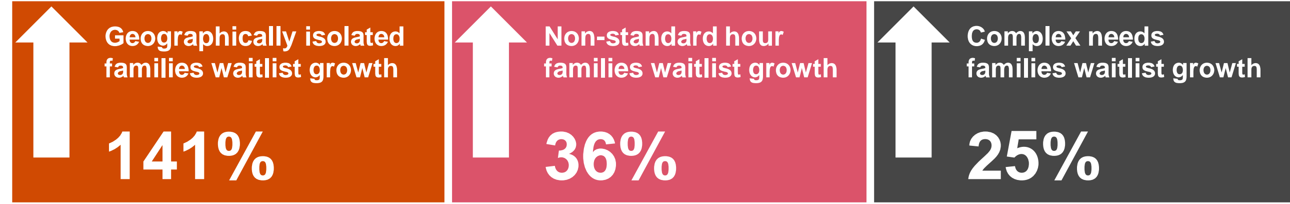
Figure 5: 4-year percentage change, by state/territory



Source: ORIMA Research, May 2023

Waitlist to access IHC

There has been a 43 per cent increase in waitlists to access IHC between December 2018 and December 2022. It is thought that this increase is primarily due to a shortage of IHC educators[30].



Appropriateness of the IHC program to meeting the needs of families

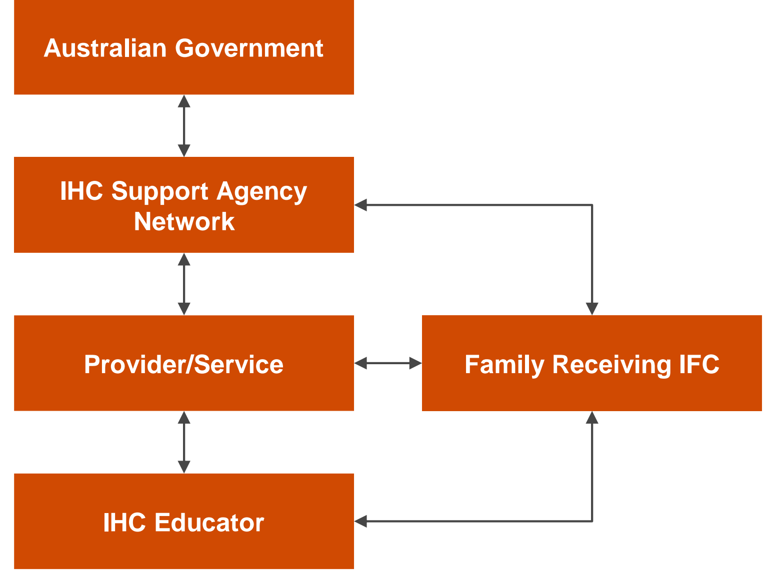
Key findings

- The IHC program is not currently included in the National Quality Framework (NQF).
- The current monitoring and reporting system associated with compliance and quality, in addition to the lack of real-time data and systems, makes it difficult to monitor quality, safety and project demand for IHC services.
- While the current IHC program treats all families equally, a more appropriate model may be to recognise the very different needs of the three cohorts and tailor the IHC program to the specific needs of each of the three cohorts.
- Further improvements to the IHC program would support more families to participate in the workforce.

Structure of the IHC program

Under the current IHC structure families accessing IHC services interact with IHCSAs to be assessed for eligibility before being referred to an IHC service (Figure 6). If a family is eligible to access IHC they then engage with an IHC service, before receiving services from an IHC educator.

Figure 6: Current structure of the IHC program



Source: Modified from the AIFS Final IHC Evaluation Report (2020)

[30] IHC provider consultation, IHC provider surveys and Family surveys

While the current IHC program is not included in the NQF, there are still requirements placed on IHC providers through the IHC guidelines. IHC providers are required to report incidents relating to safety within 24 hours to the Department of Education. In Tasmania and South Australia there is also state-based regulation which must be adhered to.

"Regulation offers a great layer of protection for children, educators and families. There needs to be legislative standards and consistency across the board" – IHCSA

The other form of monitoring and reporting that occurs is the submission of quarterly reports on demand, utilisation and waitlists by IHCSAs to the Department of Education. This reporting system is point-in-time, only, meaning there is a lack of real-time data to accurately monitor and project demand.

"We need better data sharing options and processes. The current system only provides a point-in-time and does not capture why families are exiting the program" – IHCSA

Prior to 2018 families would engage directly with an IHC provider. However, a conflict of interest was perceived to exist with IHC providers responsible for determining eligibility for IHC as well as providing families with services[31]. The introduction of IHCSAs to the program is intended to separate the functions of eligibility assessment and service provision. Where an organisation serves as an IHCSA and an IHC provider, the conflict of interest is now managed with these functions being delivered by different parts of a business and through effective contract management. However, families report that the introduction of IHCSAs has created additional burden for families to access IHC with "a lot of paperwork for a few weeks of care"[32]. The administrative process has, in the words of one service provider, "added more hurdles than needed to access care"[33].

Does the IHC program support all cohorts of IHC families to access suitable ECEC?

One of the key issues with the current IHC program and its structure is that all families are treated the same despite the three cohorts of families that IHC is targeted towards each having very different needs and challenges. For example, providing IHC for a child with disability requires an educator with a specific set of capabilities and skills to adapt the ECEC to the child's disability needs. Families working non-standard hours may require an educator (and associated funding and incentives) that is available after hours, variable hours, on short notice, and/or for short shifts.

In the current program an educator can only provide IHC to a single family. However, for families that are geographically isolated there may be several families within a community, on a workstation, a farm, etc, that require ECEC but live far from an established town or regional centre. Allowing an educator to provide IHC to multiple families in geographically isolated areas would enable batter access for these families.

Rather than a 'one size fits all' approach IHC would be better structured if it were tailored to meet the specific and nuanced needs of the various family cohorts.

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[31] IHC provider consultations

[32] Family surveys

[33] IHC provider consultation

“Childcare is already difficult to access in our remote communities… the one size fits all approach doesn’t work for our remote families” – IHC provider

Impact of IHC on workforce participation

The IHC program has enabled geographically isolated families, such as farm-working families, to focus on work while their children receive IHC. One family (a mother, father and three children) that work on remote stations responded to the survey saying they have been accessing IHC since 2020 while working on remote stations in the NT, Western Australia, and Queensland[34].

“Without IHC for our children, we would have struggled to maintain work roles… having the flexibility of IHC being available in all states is a great thing” – Family working across various stations in Australia.

However, many families in rural/remote areas find it challenging to access an educator, limiting their ability to increase, or return to, participation in work. This becomes increasingly more difficult when a family in a rural or remote area has complex or challenging needs. As an example, one respondent to the family survey reported being unable to participate in the workforce due to the lack of educators available to the family in their area. This situation meant that the family had to reduce working commitments to care for their child’s needs[35].

“We were unable to find a carer capable to meet my son’s needs… I found the system didn’t help our situation so we had to reduce hours of work to solve the problem.” – Family eligible for IHC but unable to access an educator.

While the IHC program supports families that work non-standard hours it remains difficult to find an IHC educator with the flexibility to provide ‘ad-hoc’ IHC on short notice. This means that parents that work ‘on-call’ or that do shift work often need to turn down work requests as they cannot access ECEC. For example, one nurse reported that they frequently turn down offers of shift work to care for their children. When they can access IHC they reported that it was very expensive[36]. One family reported paying more than $4,000 in a week for non-standard hours care (which is verified by analysis of cost data)[37].

For families where a child has complex or challenging needs IHC enables parents to return to work while their child receives ECEC. This is illustrated by a family in WA with a child diagnosed with a Kartagener Syndrome[38]. Access to IHC enabled the mother to work part-time while her child was able to remain home to recover from an acute medical condition and receive IHC. The child was able to fully recuperate and is now attending school[39].

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[34] Submission by IHCSA

[35] Family survey

[36] Ibid.

[37] ORIMA Research

[38] Kartagener syndrome is a rare genetic disorder that causes chronic and recurrent respiratory infections and illnesses.

[39] Submission by IHCSA

“We are so grateful for IHC… this program meant my daughters education hasn’t been delayed”– Family with complex medical needs

Where families with complex and challenging needs are unable to access IHC, the main impediment is the lack of educators with skills required to deliver IHC that meets the specific needs of these children. While some IHC providers have indicated they can recruit educators with specialist skills this is not the norm[40]. Several families responding to the survey reported that they “have given up” on accessing services and just “rely on friends, family” or in some instances, must exit the workforce. These impacts were supported by feedback from IHC providers and peak bodies.

Cost-effectiveness of the IHC program

Our review did not complete a traditional cost-effectiveness study due to the limited data available for the program. In place of this, we assessed the spend on the IHC program, the cost to families, and the financial viability of IHC services over time.

Key findings

- Compared to Family Day Care (FDC), IHC incurs significantly less CCS funding, but a greater amount of ACCS, in terms of both amount and proportion of funding.
- The stability of funding over time is to be expected given the capped nature of the program.
- The funding structure associated with the program and the costs associated with delivery of the program has compromised the financial viability of providers.
- Families are faced with significant out-of-pocket costs, with some family cohorts facing much larger out-of-pocket costs than others to access the program. A comparison between out-of-pocket fees for FDC and IHC show a 47 per cent increase in out-of-pocket fees for IHC families.

CCS/ACCS expenditure on IHC

While the cost to deliver the IHC program includes internal government administration costs, and funding for IHCSAs, the largest expenditure is in the form of CCS/ACCS payments for IHC.

From 2018-19 to 2021-22 CCS/ACCS costs increased each year except for 2019-20 (due to COVID-19)[41]. Over this period expenditure on CCS/ACCS increased 35.7 per cent (

[40] IHC provider consultation

[41] ORIMA Research of Departmental administration data

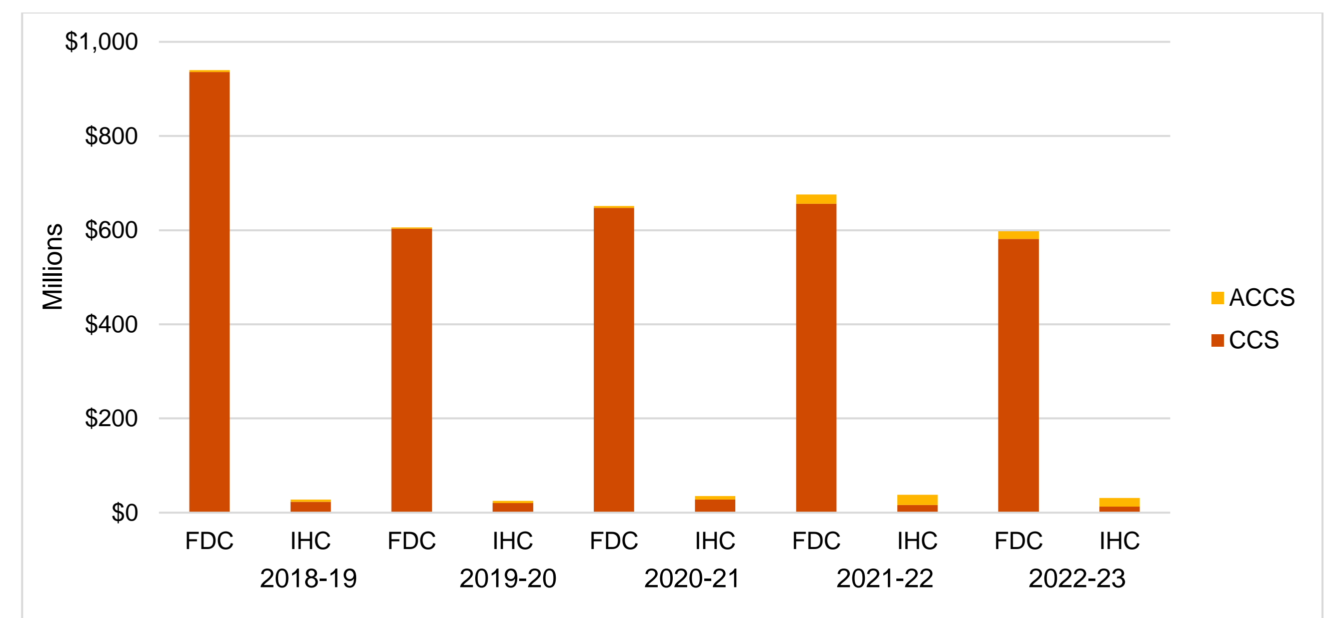
Figure 7). In comparison CCS/ACCS payments for FDC have decreased each year by a total of 28.1 per cent. This is driven by an increase in the number of families eligible for ACCS and large increases in hourly fees. While 17.5 per cent of IHC families were eligible for ACCS in 2018-19, this rose to 58.4 per cent of families in 2022-23[42]. Whereas the average hourly fee per child (based on an average of 1.8 children per session) for IHC was $14.51 in 2018-19 this increased to $21.55 in 2022-23 representing a 49.5 per cent increase[43]. In comparison, the average hourly fee for FDC rose 15.9 per cent over this same period (from $10.17 to $11.79)[44]. This indicates that while there are a small number of families accessing IHC nationally these families tend to experience high levels of disadvantage. To meet the complex and challenging needs of these families, and the barriers to access, the cost of IHC is also increasing.

[42] As at 21 May 2023

[43] DoE administrative data

[44] Ibid.

Figure 7: CCS/ACCS expenditure on IHC and FDC, by year



Source: ORIMA Data Research
* 2022-23 Financial year statistics cover the period from 4/07/2022 to 21/05/2023
Note: due to data methodology used to analyse data may be different to publicly available information.

Financial viability of IHC providers

Prior to 2018 IHC providers received specific funding, for each enrolment, to cover the costs of administrative overheads, and learning and development activities[45]. To help cover the costs of service delivery IHC providers were also able to access grants through the Community Support Programme (CSP). Since the introduction of the CCS/ACCS in 2018 IHC providers no longer have access to these funding source. Instead, IHC providers now have access to Community Child Care Fund (CCCF) grants. However, due to reported ineligibility and challenges with the application process only half of IHC services have received CCCF grant funding, and only a few have received grants for special circumstances or business support. A common theme from consultation with IHC providers was that additional funding to support operational funding, which could be based on the number of families enrolled, would improve financial viability[46].

While IHC providers retain responsibility for professional development the lack of dedicated funding means that there is little on offer for educators. While IHCSAs are intended to support communities of practice for educators they do not have direct engagement with educators meaning they must rely on IHC providers as conduits. However, IHCSAs report that IHC providers are often unwilling to connect educators with IHCSAs, particularly where an IHCSA is also a provider of ECEC services (whether IHC or other forms of ECEC), out of concern that their workforce could be recruited elsewhere[47]. This impacts the ability to attract and retain educators.

[45] IHC provider consultations

[46] Ibid.

[47] IHCSA consultations

Sector Comparison Box 3: Needs based funding for children in out of home care (OOHC) in Queensland.

To meet the needs of children in OOHC approved carers (foster carers and relative/kinship carers) receive a fortnightly caring allowance as a base payment. To cover the costs of additional care needs the Queensland Government provides a Complex Support Needs Allowance and a High Support Needs Allowance.

In response to a 2015 Inquiry into OOHC in Queensland that found that greater financial support was needed, these subsidies were increased. This led to an increase in foster care families from around 5,000 in 2015 to 6,017 in September 2022.[48]

Providing funding for IHC based on family needs could help with affordable access to educators.

The high costs of IHC service delivery and the reduced funding available impacts the financial viability of IHC providers. More than 40 per cent of IHC providers have exited the market between July 2018 and May 2023[49], contributing to service gaps. As part of this review several peak bodies and IHC providers expressed concern for the financial viability of providers. IHC providers that deliver other forms of ECEC reported cross-subsidising IHC from other programs to remain viable.

"The increasing costs and reduced funding available has made our business reconsider delivery of this program" – IHC Provider

Cost of IHC to families

The out-of-pocket cost for IHC is significant for families (

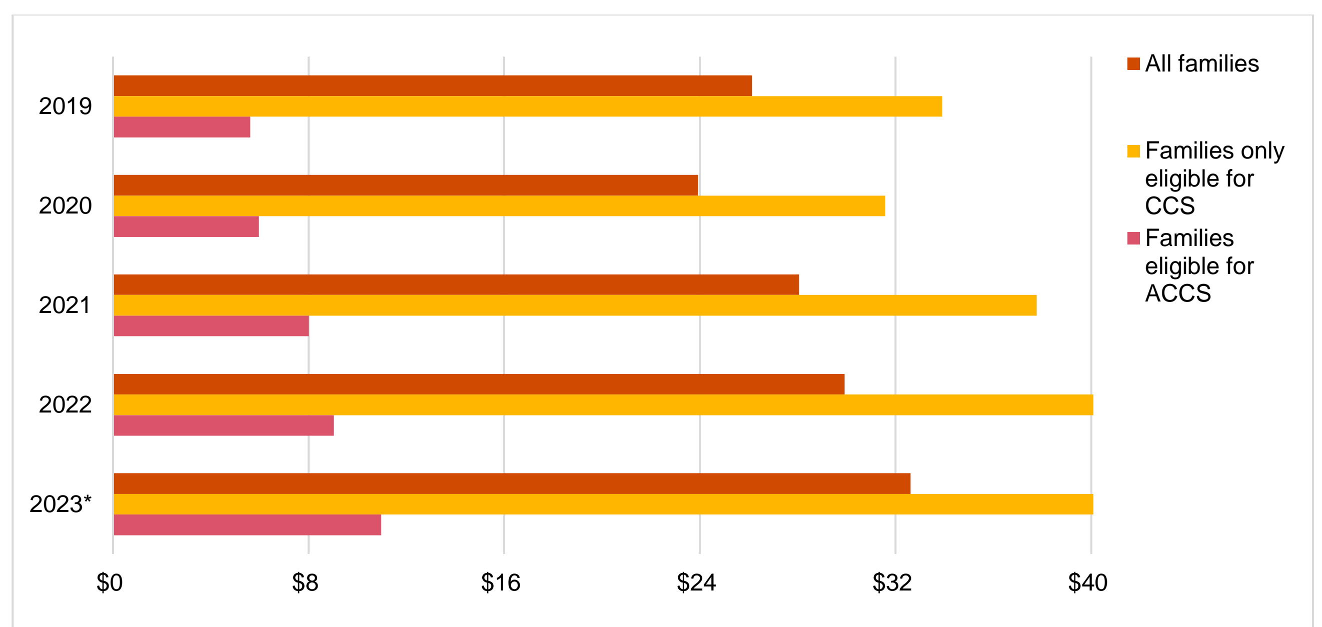
[48] Queensland Department of Child Safety, Seniors and Disability Services

[49] ORIMA Research and DoE administrative data

Figure 8: IHC Average Gap Fee per Session). In 2022, the average fee payable (including administration fees) for a 4.2-hour session of IHC per family was $166.78 with an out-of-pocket gap fee of $29.91. For families only eligible for CCS, the average out-of-pocket gap fee is higher, at $40.32 per session. For families eligible for the ACCS the out-of-pocket gap fee is only $9.03 per session. While families eligible for ACCS have the lowest out-of-pocket gap fees it is worth noting that under the previous CCB/CCR and SCCB scheme there would have been no out-of-pocket costs to access IHC as the full fees were subsidised. Under the CCS/ACCS system these families are now required to pay an out-of-pocket gap fee. Between 2018 and 2023 the average number of children in a family utilising IHC was two.

"The increasing costs and reduced funding available has made our business reconsider delivery of this program" IHC Provider

Figure 8: IHC Average Gap Fee per Session



Source: ORIMA Research
* 2023 up to 23 May 2023.
All families: Average out-of-pocket gap fee – all families.
CCS only: Average out-of-pocket gap fee – families only eligible for CCS.
ACCS: Average out-of-pocket gap fee – families eligible for ACCS

As part of this review IHCSAs highlighted that out-of-pocket gap fees for families were the greatest barrier to them accessing the IHC program, as well as being one of the main reasons for families exiting the program. This is reflected in feedback from families with 18 per cent of survey respondents reporting that the cost of IHC to families was a factor when considering access to services[50].

Families accessing IHC in remote areas often face higher out-of-pocket fees, with the average gap payment for a 4.2-hour session of IHC in Very Remote Australia being $49.00 per session and $42.04 per session for Remote Australia in 2022 (Figure 9: IHC Average Gap Fee by geographical area). Families receiving the same service in Major Cities have an average gap fee of $26.31 in comparison. It is also important to note that there are additional costs for families in remote areas relating to transport, board, food and other ancillary costs to access an educator that are not reimbursed as part of the IHC program[51].

"The increasing costs of travel for our coordinators to visit families [is a particular challenge to providing care]. In many regional locations we go above the reimbursement cap for accommodation. As these prices continue to increase, we have to balance whether the cost of family levies increase or our budget in resourcing and advertising decreases." – IHC Provider

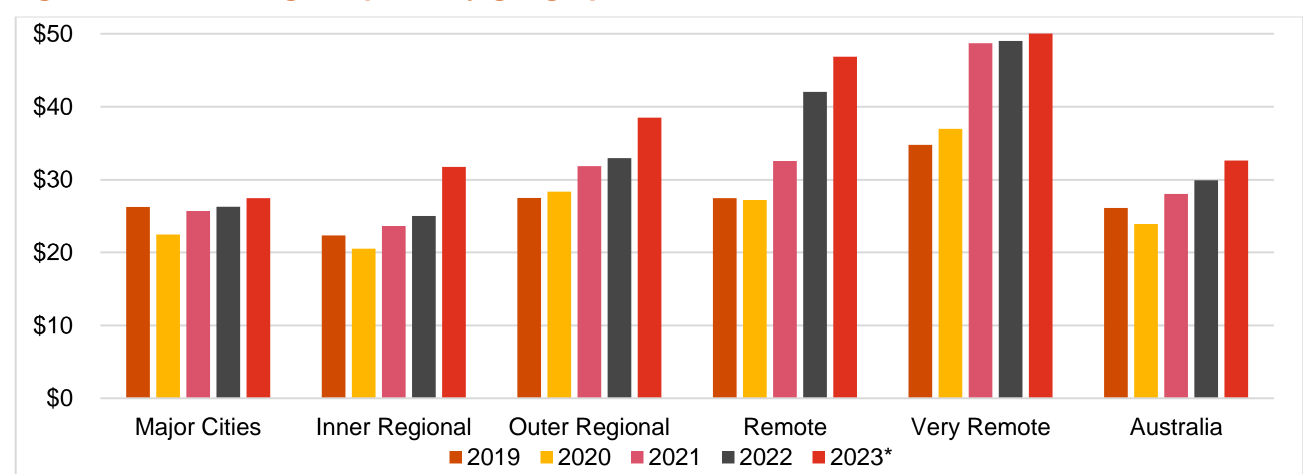
[50] Family surveys

[51] Family surveys

All 22 families that responded to the review survey who were geographically isolated reported that they experienced high costs of IHC, with some reporting out-of-pocket costs of more than $800 per week including additional costs[52]. While there is a mechanism for reimbursement of some travel costs, not all providers are aware of, or accessing, these funds[53].

“We pay for [the educators] food while they are working in our house, we pay for electricity and provide free rent. These are all recruitment and retention strategies. I feel that moving forward we are going to have to lay out more costs to keep our educator.” – Geographically isolated family accessing IHC

Figure 9: IHC Average Gap Fee by geographical area



Source: ORIMA Research
* 2023 up to 23 May 2023.

Compared to the out-of-pocket costs for FDC, families accessing IHC pay significantly higher gap fees for several reasons, including for sourcing appropriate educators, loadings for attraction of educators to remote areas and penalty rates. The below table compares how the average family which can access FDC are nearly $40 better off per day in out-of-pocket costs (Figure 10).

Figure 10: Fee and subsidy comparison, FDC compared to IHC for a 10-hour session of care

Financial Year	Family Day Care	In Home Care
Fees	$117.87 per day	$397.19 per day
Child Care Subsidy (after 5% withholding)	$83.33 (71% of total fee)	$323.52 (81% of total fee)
Out of Pocket Fees	$34.55 per day	$73.68 per day

Source: ORIMA Data as at 21 May 2023
Note: IHC fee per day is based on a 10-hour day at the average hourly rate charged per family ($39.71 per hour, per family). While the FDC fees and subsidies are per child, IHC fees and subsidies are per family. It should be noted that, on average, 1.8 children utilise IHC per family. In comparison, FDC has an average of 2.1 children per family attending.

52 Family survey

53 IHC provider consultations

Future IHC program options

As part of a co-design process with the Department, options for change were developed and assessed based on an agreed MCA framework (see Appendix C). The range of options are presented in Figure 11.

Figure 11 Summary of options

Focus area	Option	Families impacted
Options to improve demand management	Better support transition of some families from IHC to mainstream ECEC or alternative service systems.	
	Streamline and simplify administrative processes and responsibilities	
Expanding and supporting the provider market	Expand FDC to provide additional support to IHC eligible families	
	Alternative delivery models of IHC	
	Broaden/integrate IHC with other services/programs	
Workforce	Expand eligible qualifications	
	Support workforce pipeline for after hours and remote educators	
	Broaden pool of available educators	
	Upskill workforce to provide care to children with complex care needs	
Funding and fees	Providing funding aligned to family needs	
	Fund professional development opportunities for the workforce	
	Block funding to support provider financial viability	
Quality and Safety	Improve data and IT systems for monitoring, reporting and oversight	
	Enhance national consistency and quality of the program	

Grey = no impact to families, **Amber** = moderate impact to families, **Green** = significant impact to families. = Families with complex and challenging needs, = Families that work non-standard hours, = Geographically isolated families.

A summary of each of these options and their assessment against the MCA framework, are presented in the section below.

Options to improve demand management

Better support transition of some families from IHC to mainstream ECEC or alternative service systems.

Description

a) Better support the transition of families and children from IHC to mainstream ECEC services

b) Better support the shift in demand to other, more appropriate programs (including ISP)

c) Incentivise centre-based providers to extend operating hours

Impacted families

This option would impact families with complex needs and non-standard work hours.

Geographically isolated families are unlikely to be impacted.

Outcomes assessment summary — **Moderate impact**

This option would impact families with complex needs and non-standard work hours, by supporting them to access more appropriate ECEC and other services to meet their specific needs. This could reduce costs of the IHC program, enable families to access more affordable services with lower gap fees, and increase equity of outcomes for these families.

Implementation risk summary — **Low risk**

While operational changes to the IHC program would need to be introduced and strengthened, this option should be relatively low cost and complexity to implement over the short term.

Streamline and simply administrative processes and responsibilities

Description

a) Shift the role of making IHC eligibility decisions from Support Agencies to Services Australia or a single National Support Agency.

b) Provide details of all IHC providers on the Services Australia website or amend Starting Blocks to cater for the advertisement of IHC services.

c) Reduce the administrative requirements and frequency for families to confirm ongoing eligibility.

Impacted families

This option will impact all families in the IHC program due to the reduction in administration required for families and the clarity created through a single support agency. Additional benefits would also be experienced by families within the complex needs cohorts especially if there are improved linkages with the ISP program.

Outcomes assessment summary — **High impact**

This option would increase equity, affordability and to a degree, accessibility, to IHC. There will likely also be improvements to quality and sustainability of the IHC program.

Implementation risk summary — **High risk**

Implementation of this option will require both legislative and regulatory changes. The operational change required could be complex and will require long-term timelines (although this may lead to savings over time).

Expanding and supporting the provider market

Expand FDC to provide additional support to IHC eligible families

Description

a) Financial incentives for FDC services to provide additional ECEC for out-of-standard-hours care families

b) Develop a new category of FDC for rural, remote and regional Australia

c) Support FDC to receive more non-standard-hours fees and places through a pilot program

Impacted families

This option will predominantly impact families that work non-standard hours. Families that are geographically isolated will also be impacted if a new class of FDC is established.

Outcomes assessment summary — **Moderate impact**

This option will improve equity, affordability, and accessibility of IHC (and potentially mainstream ECEC) for families that work non-standard and variable hours, as well as some families that are geographically isolated. This will in turn improve quality of services received by families, as well as increase sustainability of the IHC program through the reduction in costs and focus on families which need it most.

Implementation risk summary — **Moderate risk**

While there would likely be savings over the longer term with these changes, implementation of this option would require regulatory (and possibly legislative) changes, significant operational changes for FDC providers, as well as long-term timelines to see an impact in supply. While there are strong interdependencies with the FDC program, stakeholder consultation suggests the sector would welcome this option. However, FDC providers and families would remain key stakeholders for implementation.

Alternative delivery models of IHC

Description

a) Centralised workforce pool that any family/IHC provider can access for after-hours IHC, similar to the relief teacher pool that has been developed in states and territories for primary and secondary education.

b) Exploring in venue care for rural/remote/regional families, and caring for more than one family in a home venue, such as remote families having multiple families on one station accessing IHC)

Impacted families

A centralised workforce pool would benefit families that work non-standard hours, while in venue care and caring for more than one family in a home venue, would impact geographically isolated families. Families with complex needs are unlikely to be impacted.

Outcomes assessment summary — **High impact**

This option will improve equity, affordability and accessibility of IHC for families that work non-standard hours, and families that are geographically isolated. However, it may be difficult to monitor and improve quality of services while the sustainability of this option relies on the ability to scale these alternative delivery models.

Alternative delivery models of IHC

Implementation risk summary	High risk

This option would likely require changes to both legislation and regulation, as well as leading to significant operational changes for IHC providers and educators. The cost to deliver these alternative models would require additional and ongoing funding which would be subject to negotiation with the Department of Treasury and Finance (DTF), either for block funding, or through the CCS/ACCS. The timelines for implementation would likely be medium to long term.

Broaden/integrate IHC with other services/programs

Description

a) Partner with local councils and communities to provide a hybrid IHC/FDC residence/venue (ECEC focused not focused on workforce participation)

b) Develop a Connected Beginnings[54] model of integrated servicing for rural and remote families

c) Grant program (or add to ISP as an additional payment) for services to pass on to educators in recognition of the additional skills required to work in an IHC environment

Impacted families

Should local government wish to re-enter and/or remain in the ECEC sector (noting they are generally shifting away from delivery of ECEC services) then families in geographically isolated areas would be impacted with councils able to address some of the demand in thin markets. A Connected Beginnings model of integrated services, and a grant program in recognition of additional skills required, would support families with complex needs and those in geographically isolated areas.

Outcomes assessment summary	Moderate impact

This option would primarily improve equity, access and affordability for families with complex needs and those that are geographically isolated. However, the challenges with delivering integrated services, including the cost to government, make this likely to be unsustainable.

Implementation risk summary	High risk

While an integrated service offering for children in remote and regional areas would be significantly beneficial to their development, a Connected Beginnings model for rural and remote areas is a highly complex initiative to implement. Local councils are shifting away from ECEC making a hybrid FDC/IHC model difficult to implement and maintain.

[54] Connected Beginnings is an Australian Government place-based grants program to increase Aboriginal and Torres Strait Islander children's and families' engagement with health and ECEC. Funding is used to integrate local support services so children and families can access culturally appropriate support services. www.education.gov.au/early-childhood/community-child-care-fund/connected-beginnings

Workforce

Expand eligible qualifications

Description

a) Expansion of eligible qualifications that are aligned with education and care, such as extending the Bachelor of Teaching provisions to include additional teaching streams i.e. primary/high school

b) Review eligibility treatment of potential educators, such as retired teachers and the associated guidance around current teacher registration being required to enable these people to apply to be an IHC educator

Impacted families

Expansion of eligible workforce qualifications would increase available educators in geographically isolated areas, as well as the skills and availability of educators available to support families with complex needs. The review of treatment towards retired teachers would likely impact the ability to attract workforce in geographically isolated areas.

Outcomes assessment summary — **High impact**

This option would improve equity, affordability and accessibility by expanding the number of eligible educators available to provide IHC to families. This would provide flexibility to attract a workforce able to address some of the gaps that exist primarily for families in geographically isolated areas, although it would also impact families with complex needs and those that work non-standard hours. The quality of IHC and sustainability of the program would likely be strengthened.

Implementation risk summary — **Low risk**

Expanding eligible qualifications should be relatively straightforward through minor regulatory changes, though it would be subject to agreements with each state/territory (given there is legislation and regulation at the jurisdictional level that relates to workforce requirements). This should make it possible to implement in the short term.

Support workforce pipeline for after hours and remote educators

Description

a) Have IHC recognised as an accepted service for educators to undertake practical hours to complete qualifications

b) Engage experienced and willing ECEC staff to assist in the backfilling Certificate III participants, allowing educators to complete their qualifications

Impacted families

Expansion of eligible workforce participants and entrants would increase available educators in geographically isolated areas, as well as the availability of educators available to support families with complex needs and non-standard hours.

Outcomes assessment summary — **Moderate impact**

While increasing the available workforce would improve equity, affordability and accessibility for families, particularly in geographically isolated areas, this option is unlikely to attract large numbers of additional educators to provide IHC. Similarly, the backfill of educators to enable completion of placements will not lead to significant impact unless a large number of potential educators are attracted to delivering IHC.

Support workforce pipeline for after hours and remote educators	
Implementation risk summary	**High risk**

Implementation would require changes to regulation that may be difficult to achieve as well as require sector buy-in. While the intent is to increase workforce over the long term it may be challenging to implement given the likely difficulties with identifying and arranging suitable backfill staff.

Broaden the pool of available educators

Description

a) Leverage educators across CBC/FDC and IHC to encourage working across settings

b) Incentive payments for educators for working with specific cohorts with waitlists/limited supply of educators (i.e. remote/out of hours)

c) Incentivise educators to take up IHC - e.g. educators only working part-time at CBDC may have spare capacity to provide IHC, including some nights/weekends

d) Expansion of working visas to allow for educators to enter Australia with a similar qualification from overseas

Impacted families

This option would most significantly impact families that are geographically isolated, as well as those that work non-standard hours.

Outcomes assessment summary	**Moderate impact**

Leveraging and incentivising centre based educators to also deliver IHC would improve equity and accessibility for families that work non-standard hours, and those in geographically isolated areas. However, the scale of this impact is likely to be small. This would also be the case for expanding working visas, which could also introduce issues around quality. It is important to also note that workforce shortages are experienced across the ECEC sector, not just IHC.

Implementation risk summary	**High risk**

Leveraging and incentivising centre based educators to also deliver IHC would likely face resistance from centre based services. It may also be difficult to implement at sufficient scale. Expanding working visas would be dependent on agreements with Home Affairs, as well as states and territories. It may also require legislative and regulatory change.

While skilled migration pathway can be an avenue to help fill some roles across the sector, a report by the Care and Support Economy Taskforce in 2023 advises that this is not suitable for filling early childhood educator roles.[55]

Given the impacts this could have on quality of educators this option would likely be met with strong opposition across the ECEC sector.

[55] Drat National Care and Support Economy Strategy 2023

Upskill the workforce to provide care to children with complex care needs

Description

a) Upskill workforce (including via micro-credentialling) to gain skills required to make reasonable adjustments for children with complex needs to participate in the ECEC IHC program. This is ECEC that is still aligned with IHC and is not care and support that is within the scope of NDIS). Like all ECEC settings, IHC has a legal obligation to support reasonable adjustments for children with complex disability needs to participate in ECEC.

b) Online learning portal to support professional development and provide easier access for educators to engage in learning modules

Impacted families

This option focuses on addressing a key gap for families and children with complex needs. While some of these families may require non-standard hours, or be in geographically isolated areas, these families are not specifically targeted.

Outcomes assessment summary — **High impact**

This option would significantly improve equity and accessibility of IHC for families with complex needs, though it may lead to reduced affordability given an upskilled workforce may mean increased costs of service delivery. It will also boost quality and be sustainable over the long term.

Implementation risk summary — **Low risk**

This option should be relatively straightforward to implement in the short term and would not require any legislative or regulatory changes. However, it should be considered in the context of the Productivity Commission review and the ISP re-design to ensure alignment.

Funding and fees

Providing funding aligned to family needs

Description

a) Change funding to be based on complexity criteria

b) Include a variable hourly rate/loading based on cohort (location, experience, family complexity)

Impacted families

This option would impact all families and their children given the intent is to introduce funding reform that is tailored to specific needs of families, regardless of their circumstances.

Outcomes assessment summary — **High impact**

This option will have significant impact on the equity, affordability and accessibility for all three family cohorts – those with complex needs, that work non-standard hours, and those that are geographically isolated. It would also strengthen financial viability of IHC providers across the sector.

Implementation risk summary — **High risk**

Implementation of this option would be complex and, if changes were to be made to the CCS/ACCS scheme, would require legislative and regulatory changes. It would also be dependent on approval from DTF. The high degree of complexity involved would mean it would be a long-term option.

Fund professional development opportunities for the workforce

Description

a) Provision of funding for IHCSAs to conduct and oversee professional development of IHC educators

b) Direct funding to educators to access approved professional development

Impacted families

This option would impact on the skills and training of all educators, which would therefore impact all families receiving IHC services.

Outcomes assessment summary — **Moderate impact**

This option will improve equity and quality for families as it will build capability of the educator workforce delivering IHC. While access to professional development already exists in the form of free and online opportunities this will build from and strengthen these opportunities and make professional development more accessible to educators. Similarly, a Professional Development Subsidy is available via ECEC services to help qualified staff to complete training that adds to their skills as of 1 July 2023.[56] However, this is initially only available to services and staff in regional, remote and very remote locations, and First Nations services and educators.

Implementation risk summary — **Moderate risk**

Providing funding for workforce professional development would be a relatively low-cost option that could be rapidly implemented and with few challenges. It would need to align with any findings from the Productivity Commission's current inquiry. However, it would be inconsistent with the approach to professional development for the ECEC sector more broadly.

Block funding to support provider financial viability

Description

a) Grant program/funding to support service viability in recognition of the increased costs and risks associated with providing IHC care compared to other forms of ECEC

b) Provision of operational funding for IHC providers based on per family accessing IHC through the provider

Impacted families

This option will impact the financial viability of IHC providers and will therefore impact all three cohorts of families.

Outcomes assessment summary — **High impact**

Reverting to block/grant funding would provide significant uplift to the equity, affordability, accessibility, quality and sustainability of the program. However, this would also be a shift away from recent funding policy which has transitioned to per child and family funding arrangements.

Implementation risk summary — **Moderate risk**

While this would be a relatively straightforward option to implement in the short term there are some risks associated with reverting back to block funding to support IHC services given the deliberate shift to per child

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[56] www.education.gov.au/early-childhood/early-childhood-workforce/professional-development-opportunities

Block funding to support provider financial viability
funding across the sector. Additional, ongoing funding would need to be approved from government though block funding should ideally leverage existing schemes (e.g. CCCF).

Quality and Safety

Improve data and IT systems for monitoring, reporting an oversight

Description

a) Streamlining IT reporting systems for IHCSAs to report data

b) Creating a central data repository where IHC providers/support agencies/government can access "live" data on the program

c) Increasing the frequency of data collection processes to enhance program administration understanding and identify any potential quality and safety risks.

d) Integrating IHC data into other data/IT systems such as the Child Care Subsidy System (CCSS)

Impacted families

Data and IT system transformation will impact families indirectly by improving service quality over time and more accurate and up to date analytics on sector performance and demand.

Outcomes assessment summary — **High impact**

Improving data and IT systems will impact all families that are part of the IHC program. Data and IT systems are critical for monitoring, reporting and oversight of quality, demand and risk across the IHC program. Improving these will enable greater oversight, and more informed decision making and planning.

Implementation risk summary — **High risk**

Large scale data and IT system transformation is costly, long term, and requires considerable change management and support. There will also be legislative and regulatory changes required making this a large, complex initiative.

Enhance national consistency and quality of the program

Description

a) Further developing the Quality and Safety project under ACECQA

b) Establishing national policies and procedures for the IHCSAs and IHC providers, including expectations around family engagement

Impacted families

This option will indirectly impact all three cohorts of families.

Outcomes assessment summary — **High impact**

This option will improve equity and accessibility to quality IHC services for all families and children. There is a risk it could further increase costs, and therefore impact affordability, for families.

Enhance national consistency and quality of the program	
Implementation risk summary	**Moderate risk**

Enhancing national and consistent standards across the IHC program will have both legislative and regulatory impacts. There will also be a change management process that would need to be carefully managed with the sector, as it will lead to compliance measures and therefore operational changes for IHC providers. Given the scale and complexity of these changes this would be a long-term option.

Proposed opportunities for the future IHC program

Following the co-design and assessment of options for change, a prioritisation process was undertaken with the Department of Education to identify the six key opportunities to explore further for the future design. This section provides further description of these opportunities and implementation considerations.

Streamline and simplify administrative processes and responsibilities

Description

To address issues identified in the review it is proposed that the following changes be implemented:

- Consolidate the assessment of family eligibility function into Services Australia or a single National Support Agency.
- Publish all IHC providers details online (e.g. on the Services Australia website or Starting Blocks)
- Reduce the administrative requirements and frequency for families to confirm ongoing eligibility.

Centralising support agency functions and responsibilities within a single entity will drive further consistency, enable better oversight and efficiency, and simplify system navigation for both IHC providers and families. This will lead to improved equity and access for IHC families.

Publishing all IHC provider details online will further aid families to navigate the system while providing greater choice to families (where multiple IHC providers are available).

Reducing the frequency that families are required to re-confirm eligibility for IHC, as well as the requirements (e.g. medical certificates from specialists and other forms of evidence), will reduce the burden, costs, and therefore affordability and access to IHC for families.

Operational details

- Families seeking access to IHC will submit to, and have their applications assessed by, a single agency responsible for determining eligibility. This could be through Services Australia or a National Support Agency.
- Once a family is deemed eligible for the IHC program they will be referred to an appropriate IHC provider able to deliver services to their region, and to meet their specific needs. However, families will have access to information online via either the Services Australia website, or Starting Blocks, about IHC providers, service offerings, fees, etc, so that families can exercise choice.
- While families will need to provide evidence of eligibility upon initial entry into the IHC program they will only be required to confirm and renew eligibility annually rather than quarterly. Evidence requirements will also be revisited to be more flexible (e.g. allow GPs to provide medical certificates instead of specialists).

Implementation requirements

- Transition to a single agency responsible for assessing family eligibility will require the termination or conclusion of contracts with existing IHCSAs.
- If IHCSA functions were to transfer to Services Australia this would require integration of IHC into existing processes and systems, with possible regulatory impacts. There may also be Machinery of Government implications depending on whether the functions and/or responsibilities transition to the Social Services portfolio.
- Initial, short-term funding would be required to established and/or transition support agency functions to a single entity, and to streamline and refine administrative processes. However, this should translate into longer term savings.

Streamline and simplify administrative processes and responsibilities

- Publishing IHC provider details online will require a process and resources to manage the review and update of information. However, a platform already exists in the form of Starting Blocks that would need minor adjustments to be fit for purpose.
- Change management process would be needed to support IHC providers and families to adjust to new and adjusted processes. Recent changes mean the administrative requirements and frequency for families to confirm ongoing eligibility are already aimed at easing the burden on families.

Key risks, mitigation strategies, and residual risk

1. A key risk will be the loss of local context and knowledge by those responsible for assessing family eligibility for IHC. This could be mitigated by having a hub and spoke model for the national support agency and building in clear processes for assessments to factor in local circumstances.
2. The transition from IHCSAs to a single support agency could lead to confusion amongst IHC providers and families, and delays to eligibility assessments. To minimise this, there could be a period of overlap in time between the continued functions of the IHCSAs and those of the national support agency.

Sequencing/timeline

Changes to the eligibility requirements and frequency of review can be implemented relatively quickly (ie 12 months), especially given changes to this have already been reviewed by the Department of Education. Similarly, publishing IHC provider details online can be achieved within the next 12 months once information is collected and verified.

Planning to transition IHCSA functions to a single support agency would need to commence as soon as possible to ensure sufficient lead time, including fulfilling any contractual obligations and allowing time for any regulatory amendments. With contracts with IHCSAs currently due for renewal in June 2025, design and planning for a single support agency would need to commence immediately.

Stakeholders and acceptance

This option should be accepted by families and IHC providers, including for a single, support agency. However, there may not be sufficient appetite within government for the support agency function to be fulfilled by Services Australia.

Empowering and expanding FDC offerings

Description

As part of recent reforms to the ECEC system in Australia FDC has seen a significant uplift in quality. More than 140,000 children per year receive FDC services. FDC can be empowered and expanded to provide ECEC to families currently accessing (or waitlisted to access) the IHC program through:

- Financial incentives for FDC services to provide additional ECEC for out-of-standard-hours care families
- Developing a new category of FDC for rural, remote and regional Australia
- Supporting FDC to receive more non-standard-hours fees and places through a pilot program

Providing incentives and supporting alternative models of FDC would alleviate some of the demand for IHC. This will improve equity, accessibility and affordability for families by enabling them to access FDC instead of IHC, where appropriate, and preserve IHC places for those most in need.

Empowering and expanding FDC offerings

Operational details

- FDC providers wishing to provide ECEC to families outside-of-standard-hours and/or through alternative models of FDC would need to be approved. As part of this, IHCSA(s) (or equivalent) would need to be aware that they should be considered an appropriate provider for IHC families (under current eligibility and definitions).
- FDC providers approved to expand service offerings would be eligible to apply for one-off grant funding to support design, delivery and operational changes required to deliver outside-of-standard-hours FDC and/or alternative models of FDC.
- Families eligible for IHC that are within reasonable proximity to these FDC providers will be made aware that the options available to them include outside-of-standard-hours FDC and/or alternative models of FDC.
- FDC providers will be funded, and families will be subsidised, based on CCS/ACCS payments tailored to these new and expanded types of FDC (and ideally linked to the Fee Subsidy Scheme option below).

Implementation requirements

- Market testing would need to occur to determine the appetite of existing FDC providers to expand services and/or alternative models of FDC to meet the needs of IHC eligible families.
- Subject to FDC provider interest a pilot could be designed and implemented to test feasibility before broader expansion. FDC providers could be asked to provide a detailed proposal on how they plan to deliver services to families, including oversight and reporting of operations.
- Changes would be needed to the NQF to incorporate provision of FDC after hours and for alternative models of FDC. There may also be a need to amend existing legislation.
- Subject to the findings and outcomes of the pilot program FDC services nationally could be expanded.

Key risks, mitigation strategies, and residual risk

1. A pilot program was previously implemented to expand operating hours of CBDC to meet the needs of families that work non-standard and variable hours. The pilot found there was poor uptake, which could also be the case with expanded FDC. With this in mind, and to minimise risk and cost, change to FDC are proposed to be tested through an initial pilot.
2. Alternative models of FDC could risk quality and safety for families and children as these will be innovative and untested models. To mitigate against this FDC providers could be asked to submit proposals for alternative models of FDC that would need to be approved by the Department of Education, and include rigorous oversight, reporting, and review.
3. Any incentives for FDC services to provide additional ECEC for out-of-standard-hours care families would be seen as inequitable to IHC providers and families. Therefore, any incentives for FDC providers would need to be extended to IHC providers.
4. An expansion of FDC service offerings would require an increase to the FDC educator workforce. For this to be feasible strategies would need to be developed to build the FDC educator pipeline.
5. Like IHC, FDC is a home-based ECEC service that comes with inherent risk of fraud and non-compliance. Expanding FDC services could lead to increased risk of fraud and non-compliance. To prevent this there would need to be a strong focus on integrity, including legislating providers to collect gap fees from families centrally to ensure they have oversight of the of care being claimed and that fees are being collected.

Empowering and expanding FDC offerings

Sequencing/timeline

This option requires a range of operational, fiscal and regulatory changes. Therefore, it is likely to require a mid- to longer-term timeline for implementation which could commence with a pilot in the medium term. Subject to outcomes of the pilot this could then be implemented more broadly. The timeline for implementation for this would likely be between 18-24 months.

Stakeholders and acceptance

Feedback from FDCA is that FDC providers would welcome the opportunity to be part of any changes that could better support families unable to access appropriate ECEC to meet their needs. However, current IHC providers may be resistant to additional entrants into the space, although a successful pilot could see partnerships develop between FDC providers and existing IHC providers. Families may also be reluctant to take up alternative models of FDC, so would need to be made aware of, and receive assurances, over the service offerings. However, many families who at present can only access IHC, may welcome additional options for alternative ECEC services that could better meet their needs.

Providing funding aligned to family needs

Description

The review found that the IHC program hourly rate cap is too low to cover the costs associated with delivering IHC and is applied consistently to all three family cohorts despite the different needs and underlying costs to deliver the services. This impacts equity as these families are having to pay higher out-of-pocket fees compared with families accessing other forms of ECEC. To make IHC more affordable, equitable and accessible for families, and to support IHC provider financial viability, the following changes are proposed:

- Change funding to be based on complexity criteria
- Include a variable hourly rate/loading based on cohort (location, experience, family complexity)

Implementing needs-based funding could be achieved using one of three funding mechanisms:

- Amend the existing CCS/ACCS scheme
- Through block funding to IHC services (either for the total cost, or as top-up funding)
- Introducing a dedicated, per family driven, IHC subsidy scheme

These changes will lead to payments and funding that factor in the additional costs and penalty rates that are necessary to access IHC educators in geographically isolated areas and for short, ad-hoc, out of hours, and/or short notice sessions, and based on the level of complexity (and therefore educator skills needed) to provide IHC to families with complex and challenging needs.

Operational details

- To access the IHC program families may be required to provide additional information as evidence of family circumstances.
- Based on family circumstances needs-based funding will be calculated to determine the appropriate funding, and additional loadings, that should be applied to any IHC they receive.
- Payments to IHC providers, and subsidies to families, would be made using existing processes.

Providing funding aligned to family needs

Implementation requirements

- Each of the potential needs-based funding mechanisms come with their own risks, including the degree to which they align with the principles of existing policies and reforms. A selection and design process will be needed to identify the most appropriate mechanism to implement needs-based funding.
- Work would then need to be undertaken to understand and develop the tiers and amounts that would be applied to a needs-based funding model, including additional loadings and penalty rates. This would also need to factor in shortages in supply based on geography and skillsets.
- Any changes to the funding model would need to align with findings and recommendations from the ACC Inquiry currently underway.
- IHC guidelines will need to be updated to reflect changes to the funding mechanism

Key risks, mitigation strategies, and residual risk

Amend the existing CCS/ACCS scheme

1. The CCS/ACCS is a national funding scheme – making changes for a small cohort of IHC families will have impacts across Australia. For example, adjusting payments for those in rural and remote areas would need to be applied to all families eligible for CCS/ACCS, not just those accessing IHC. The consequences and costs of this, to meet the needs of a small proportion of families, would be significant.
2. Changes to the CCS/ACCS repayments system would require regulatory, and possibly legislative, amendments that can be costly and timely to navigate. To minimise costs and timelines work should commence as soon as possible to understand the regulatory and legislative impacts of these changes.
3. There is a risk that the needs-based funding and additional loadings either over-estimate funding needs or continue to under-estimate the costs and out-of-pocket fees. To overcome this scenario modelling and shadow funding should be conducted, and pricing reviews should be built into future workplans.

Block funding

1. Reforms to the ECEC system have included a transition away from block-based funding to per child and per family funding. Providing needs-based funding, even as a top-up, for IHC would be a departure from these policies.
2. The use of block-based funding would require processes to monitor, report and review enrolment of families, cohort of families, and IHC service provision as part of the program to ensure the right funding is being provided over time, and as circumstances change. This can be complex, laborious, and inaccurate.
3. If the block funding is not set at a level which encourages service viability this may lead to further exits from the market of IHC providers. Conversely, if block funding is more attractive than CCS/ACCS, it could lead to adverse outcomes for the broader ECEC provider market.

Dedicated, per family driven, IHC subsidy scheme

1. The introduction of a needs-based funding scheme specifically for the IHC program would be a very costly exercise for a small number of families across Australia.
2. Establishment of a new funding scheme would require regulatory, and possibly legislative, amendments that are both costly and timely to navigate.
3. Introducing a needs-based funding scheme specifically for IHC could act as a disincentive for families and providers to prioritise the use of other forms of ECEC with IHC as a last resort.

Sequencing/timeline

Changes of this nature and scale would mean implementation over the longer-term i.e. at least18-24 months. If this were to be implemented, given the long lead times, work to design and develop this option would need to commence as soon as possible, subject to findings and recommendations of the ACCC inquiry and the Productivity Commission Inquiry.

Providing funding aligned to family needs

Stakeholders and acceptance

These options would be well received by IHC providers and families. However, making changes to the funding model, particularly of this complexity, would require extensive consultation with families, ECEC providers (not just IHC providers), and other departments and agencies e.g. the Department of Treasury and Finance.

Funding for professional development

Description

The review heard that there is confusion reported between IHCSAs and IHC providers regarding responsibility for the professional development of IHC educators. To improve capability of the workforce, and therefore quality of IHC, as well as being a key value proposition to educators, professional development opportunities could be promoted through:

- Provision of funding for IHCSA(s) to conduct and oversee professional development
- Direct funding to educators to access approved professional development

Increasing workforce capability will also likely lead to increased equity and access as there will be a greater pool of educators better available to provide IHC that meets the specific needs of families.

Operational details

- Each year IHCSA(s) would receive an annual budget for the development, disbursement, and oversight of professional development. As part of this remit there could be a requirement to develop and deliver online courses, resource, tools, and communities of practice to support the workforce.
- While educators would have access to professional development via IHCSA(s) there would also be an allocation of funding held by IHCSA(s) to be used as grant funding, requiring formal delegation from the Department of Education. Educators could have the option of selecting an appropriate and relevant course and applying for funding to cover the costs. These could range from upskilling Certificate III educators to Diploma’s, providing micro-credentials on trauma informed practices, or other courses as approved by IHCSA(s) and aligned with Department of Education guidance.

Implementation requirements

- Some courses, such as Certificate III, are already offered for free and online. There are also professional development opportunities already available within the IHC program, as well as opportunities outside of the IHC program that can be accessed and/or tailored. Enabling better access and raising awareness of these should be included as part of implementation.
- The Department of Education would need to conduct a market scan and develop guidance to IHCSA(s) and educators on appropriate and relevant courses and professional development opportunities.
- Service agreements with IHCSA(s) (or equivalent) would need to clearly articulate expectations regarding professional development responsibilities.

Key risks, mitigation strategies, and residual risk

1. Providing funding to educators for professional development opportunities would be a departure from the approach to professional development for the broader ECEC sector. While this creates inconsistency it recognises the additional challenges experience with the IHC program, the isolated working setting of IHC educators and access to appropriate workforce. Clearly communicating this as an equity measure could help manage the response from the broader ECEC sector. As an alternative approach, the existing Professional Development Subsidy could be expanded in the short term to apply to IHC educators, including funding be applied for, and accessed, via ECEC services.

Funding for professional development

2. IHCSAs do not currently have visibility or contact with educators. Providing funding via IHCSAs would better enable funding to follow the educator and provide them with greater choice as to the type of professional development they would like to access. However, this would require IHCSA(s) to develop a database of educators. As an alternative, funding for professional development could be provided to IHC providers.
3. There may be findings and recommendations relating to professional development as part of the Productivity Commission inquiry currently underway. To ensure consistency and alignment this option should wait for the inquiry to conclude.

Sequencing/timeline

Providing funding for workforce professional development would be a relatively low-cost initiative that could be rapidly implemented (within 12 months) and with few challenges. However, the Department of Education should await the findings and recommendations of the Productivity Commission inquiry before commencing.

Stakeholders and acceptance

The IHC sector and the workforce would likely support this option. However, providers and educators working in other ECEC services will likely advocate for a similar professional development model to be implemented across all ECEC settings.

Improved data and IT systems for monitoring, reporting and oversight

Description

The review found that the current monitoring and reporting system, and the lack of real-time data and systems, makes it difficult to monitor quality and project demand for IHC services. To overcome these issues this option proposes:

- Streamlining IT reporting systems for IHCSAs to report data
- Creating a central data repository where IHC providers/support agencies/government can access "live" data on the program
- Increasing the frequency of data collection processes to enhance program administration, understanding, and identify any potential quality and safety risks.
- Integrating IHC data into other data/IT systems such as the Child Care Subsidy System (CCSS)

Developing and implementing streamlined and improved data and IT systems will increase efficiencies around monitoring and reporting while facilitating more meaningful, real-time data. This will strengthen oversight of quality, demand and risk across the IHC program, allow for a more accurate understanding and projection of demand for IHC, and support future planning and decision making. The outcome of this will be greater equity, access and quality of IHC for families.

Operational details

- Improvements to the data and IT systems would be a change in reporting processes and platform for IHC providers and IHCSAs.
- Increasing the frequency of data collection in the absence of integration with the CCSS would mean additional reporting requirements for IHC providers. Alternatively, integration with the CCSS would make reporting less burdensome.

Implementation requirements

- Scoping and design would be needed to develop detailed specifications of any future data and IT systems, including any data repository and exchange, and any integration or interoperability with other data and IT systems.

Improved data and IT systems for monitoring, reporting and oversight

- Based on specifications legislative and regulatory impacts would need to be assessed, such as in relation to data sharing, data linkage, and interoperability requirements.
- An IT solution would need to be selected and procured from an appropriate vendor, including scope for user testing with the sector as part of development.
- Guidelines on data reporting would also need to be updated to clarify the frequency and type of data collected from IHC providers and support agencies.

Key risks, mitigation strategies, and residual risk

1. Large scale data and IT system transformation and implementation are costly, long term, and require considerable change management and support. There will also be legislative and regulatory changes required making this a large, complex initiative. The small number of families accessing IHC nationally mean this may not be a worthwhile investment. To mitigate against this scoping and costing could be done to support decision making. In addition, solutions could focus on those that leverage existing data and IT systems used by government and ECEC providers.
2. If future reporting requirements are to increase in frequency and detail without investment in a new IT system this could lead to significant, additional burden on IHC providers. To avoid this burden, reporting templates and secure survey tools could be used to make some of this reporting less manual and more consistent.

Sequencing/timeline

Scoping and design could commence immediately and be used to inform future phases of work. If a revised reporting process and system is preferred, then new reporting templates and tools could be implemented in the short-term (ie next 12 months). If a new data and IT system were to be implemented this would require long-term implementation (18-24 months, if not longer).

Stakeholders and acceptance

Any solution that reduces the burden on IHC providers and IHCSA(s) (or equivalent) would be well-received by the sector. However, any changes would need to undergo user testing to optimise design for end users.

Enhance national consistency and quality

Description

A key difference between IHC and other forms of ECEC is that the IHC program is not included in the NQF (although Tasmania and South Australia have existing regulatory requirements which apply to IHC). This has implications for the quality and safety of IHC which could be addressed through:

- Further developing the Quality and Safety project under ACECQA
- Establishing national policies and procedures for IHCSAs and IHC providers, including expectations around family engagement

In addition to lifting quality of IHC this would also improve equity as the standard of ECEC delivered to families in the IHC program would be equivalent to the standards of other ECEC services.

Operational details

The Department of Education has already begun work with ACECQA to improve national consistency and quality of IHC, as well as professional practice, through a new initiative, the IHC Quality and Safety Project. An enhanced IHC national framework is due by the end of 2023 and a pilot will be implemented commencing in 2024.

Enhance national consistency and quality

Providing additional resources to create a national framework for assessing provider approvals for entry into unregulated markets will also be required in order begin operations.

Implementation requirements

The ACECQA IHC Quality and Safety Project already underway involves the development of an enhanced IHC national framework including new supporting IHC Standards. These will be piloted with a sample group of IHCSAs, IHC providers and educators.

Key risks, mitigation strategies, and residual risk

1. Additional burden to IHC providers and educators could further impact financial viability, and lead to further exits of IHC providers from the market. However, the pilot phase ACECQA will implement with a sample of IHCSAs, IHC providers and educators in 2024 will be able to test the impact of the enhanced standards on the sector, including any unintended consequences.

Sequencing/timeline

The ACECQA IHC Quality and Safety Project is already underway with an enhanced IHC national framework and new supporting IHC Standards expected by the end of 2023. Implementation of the enhanced IHC framework through a pilot, supported by a professional development program and community of practice, will commence in 2024.

Stakeholders and acceptance

IHCSAs, IHC providers and educators will likely welcome an enhanced framework and standards as it signals the further ‘professionalisation’ of the IHC program, the sector, and the role in providing ECEC[57]. However, there will likely be concern with the level of burden and compliance that may be introduced making engagement with the sector and the pilot critical.

Tasmania and South Australia have existing regulatory requirements which apply to IHC. Development and pilot of the enhanced national framework would best be delivered in collaboration with state and territory input, and in the case of Tasmania and South Australia, will be critical to aligning with jurisdictional regulatory requirements.

[57] Drat National Care and Support Economy Strategy 2023

Summary and next steps

The IHC program is intended to be a program of last resort for families who are unable to access other forms of ECEC because they are either geographically isolated, work non-standard or variable hours, or are families with complex and challenging needs. The review has found that the IHC program is partially meeting this objective. Compared to the former IHC program the current iteration of the IHC program has seen:

- More equitable access with IHCSAs established to introduce greater consistency to the assessment of family eligibility for IHC.
- Greater affordability for families due to increased subsidies brought about by the CCS/ACCS
- Improved quality of IHC due to the requirement for educators to have minimum qualifications

This review has identified several challenges that continue to impact families, IHC providers and the workforce. The barriers to access of IHC for the three cohorts of families differ in relation to affordability, eligibility, scope of service and workforce. A key challenge is that the current program design adopts a consistent approach to meeting the needs of families irrespective of circumstances. To better meet the objectives of the program, and therefore improve equity, the IHC program could be tailored to meet the specific needs of each of the three very different cohorts of families it is targeted towards.

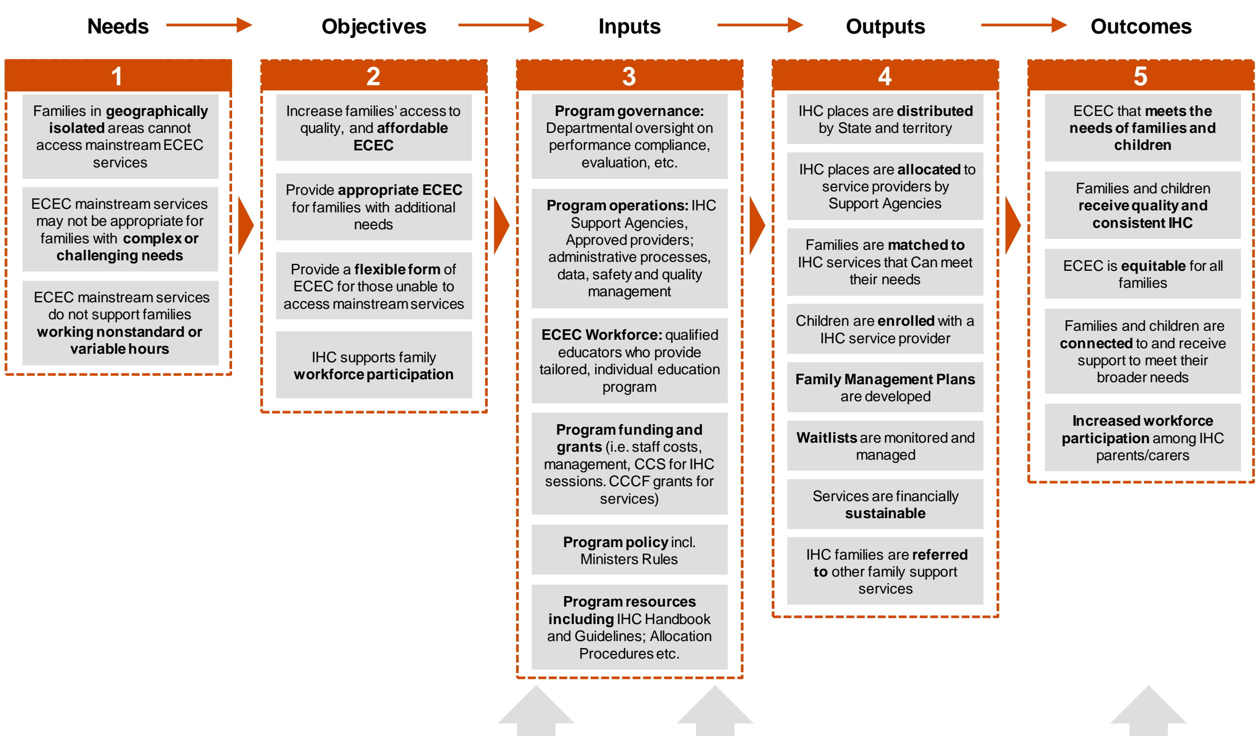
Through a co-design and assessment process a suite of opportunities was identified and prioritised for further consideration by the Department of Education:

1. Streamlining administrative processes and responsibilities to drive further consistency, enable better oversight and efficiency, and simplify system navigation for both IHC providers and families
2. Empowering and expanding FDC offerings to alleviate demand for IHC and preserve IHC places for those most in need
3. Exploring the benefits and risks of providing funding aligned to family needs through either changes to the CCS/ACCS scheme, block funding, or the creation of a new funding scheme specific for IHC
4. Funding for professional development to further build capability of the workforce
5. Improved data and IT systems to enable more meaningful, real-time data and to strengthen oversight
6. Enhance national consistency and quality

To support future government decision making the expected outcomes and implementation risks for each of these opportunities has been described.

While these opportunities range in nature, scale, impact, timelines and risk profile, taken together, they have the potential to significantly improve equity, accessibility, affordability and quality of the IHC program for all three family cohorts. This will better support the program to meet the objective and contribute to achieving the Australian Government's *National Vision for ECEC.*

Appendix A: IHC Program Logic



Enablers

Inputs contribute to program delivery and include resources, investment and activities. Broader enabling features (which will be examined as part of the review) include:

- Quality and safety architecture
- Data management architecture
- Service viability
- Building the workforce
- Integrated services (departmental/community/etc.) which support families and children

Appendix B: IHC Review framework

Review of the IHC Program – current state analysis				
Key evaluation question	**Lines of Inquiry**	**Indicators**	**Data Source**	
			Existing Data	**New Data**
1. How does the current IHC Program align with the Australian Governments' strategic policy to reform the ECEC?	a) In what ways do the current IHC objectives and structure align with policy reforms? Are these objectives clear and suitable? b) Do changes in the ECEC or IHC sector adequately support the policy objectives? c) Are the current policy settings the most effective way of delivering ECEC to children who cannot access mainstream services? d) What are the causes of any unintended consequences, positive or negative of the IHC program?	• Alignment of policy objectives to strategic objectives and priorities • Demonstrated understanding of policy objectives across the IHC sector (Support Agencies, providers, etc) • The purpose of IHC is clear across the IHC sector and distinctions with other types of other care have been clarified (i.e. disability respite) • There are clear intersections between the IHC program and other relevant childcare initiatives and programs: – IHC families understand how to apply for and receive CCS (where eligible) – Support Agencies support families to find appropriate and available places in mainstream services – Support Agencies canvass with centre-based day care services to access ISP – Support Agencies ensure families are aware of the range of services available to them (i.e. disability support) • Changes support IHC sector • Changes support IHC service viability • Uptake of changes (program processes	• Policy documents (original and current) • IHC Handbook • Timeline of key changes (inc. policy and implementation) • Program logic • Previous IHC Evaluation reports and reviews • IHC Program operation manual (i.e. for Support Agencies)	• **Data collection interviews** with relevant key stakeholders including: – The Department –Directors and operational staff – Policy officers (i.e. those related to family assistance law amendments and new policy/program areas) – **Survey** - a survey of targeted questions for IHC providers

Review of the IHC Program – current state analysis				
			Data Source	
Key evaluation question	Lines of Inquiry	Indicators	Existing Data	New Data
		etc), supports policy objectives • Changes have been implemented consistently • Changes support a nationally consistent program for all types of IHC families • The policy setting supports delivery of the IHC program		

Review of the IHC Program – current state analysis				
			Data Source	
Key evaluation question	Lines of Inquiry	Indicators	Existing Data	New Data
2. What is the demand for the IHC program?	a) Has the demand changed since the introduction of the current IHC program? b) How and to what extent is the IHC program addressing demand? c) What is likely to be the future demand for the IHC program?	• Demand has changed (increased or decreased) in line with introduction of the current program • The current IHC program is meeting (or has reduced) demand for all types of IHC families • Future demand projections for all types of IHC families • Broader ECEC employment trends that may drive demand and supply	• Administrative data (inc. program data held by the department and IHC Support Agencies) including program financial information • IHC Services Quarterly data • Previous IHC Evaluation reports and reviews • Publicly accessible reports (i.e. FIFO, industry assistance programs) • Proxy data, including ABS: population data: (i.e. population under 5 in rural areas); income data (i.e. average income in remote communities), workforce data (FIFO, emergency services, shift workers, disability data), CPI information	• **Desktop review** of other similar programs (in Australia and internationally) • **Data collection interviews** with relevant key stakeholders including: – Departmental Directors and policy officers – IHC Support Agencies and providers – Australian Home Childcare Association (AHCA); Isolated Children's Parent's Association (ICPA); FDCA; Australian Multiple Birth Association

Review of the IHC Program – current state analysis				
Key evaluation question	**Lines of Inquiry**	**Indicators**	**Data Source**	
			Existing Data	**New Data**
3. Is the current IHC model the most appropriate mechanism to meet the needs of these families?	a) Is the IHC program appropriately structured and resourced to undertake its activities? b) Does the IHC program support all types of IHC families to access suitable ECEC? c) Does the IHC program support workforce participation for all family types?	• The IHC program has effective governance arrangements in place • IHC program has the necessary resourcing to deliver its services (workforce; funding, administration systems and processes) • IHC is consistently delivered • All types of IHC families can access the program • IHC meets the needs of the three family types (is accessible, flexible and suitable) • The IHC program supports families' ECEC requirements • The IHC program supports families' workforce participation across all family types	• Previous IHC Evaluation reports and reviews • Administrative data • Financial data • Policy documents • Previous IHC Evaluation reports and reviews • Administrative data • Governance documents	• **Desktop review** of other similar programs (in Australia and internationally) including eligibility and guidelines of alternative models of care • **Data collection interviews** with relevant key stakeholders including: – Department – Directors and operational staff – IHC Support Agencies, – IHC providers and services – AHCA; ICPA; FDCA; Australian Multiple Birth Association – Families (tbc) • Survey - a survey of targeted questions for IHC providers and families (tbc)

Review of the IHC Program – current state analysis				
			Data Source	
Key evaluation question	**Lines of Inquiry**	**Indicators**	**Existing Data**	**New Data**
4. Is the IHC program cost-effective?*	a) What is the current and future costs of the IHC program? b) Is the IHC comparable to other child care services in relation to cost, access, quality and safety? c) Are IHC service providers financially viable? d) Is IHC affordable for the different types of families?	• Current cost and projected cost • Program benefits justify the costs • The cost of IHC is comparable to other programs • IHC services providers are financially sustainable • The IHC Program is sufficiently resourced • Total cost of IHC (direct/indirect) is affordable for all families and more cost-effective than other ECEC (i.e. FDC) • Families can afford IHC program (including direct/indirect costs)	• Financial data • Previous IHC Evaluation reports and reviews to identify program benefits/impacts • Cost data (i.e. IHC fees, registration/onboarding fees) • IHC Services Quarterly Data • Publicly available social data (unemployment, cost of lower education, GDP cost of unemployment) to calculate cost of unrealised benefit	• **Desktop review** of other similar programs (in Australia and internationally) • **Data collection interviews** with relevant key stakeholders including: – Department – IHC Support Agencies, – IHC providers and services – families • **Survey** - a survey of targeted questions **for** IHC providers and families

Review of the IHC Program – future design considerations				
Key evaluation question	**Lines of Inquiry**	**Indicators**	**Data Source**	
			Existing Data	**New Data**
5. What could the future program look like to achieve the intended outcomes?	a) Are there alternative ways to support families to access ECEC in a timely and cost-effective manner? b) Could adjustments to the program and policy levers enable a more effective response to IHC program demand? c) How can quality and safety of IHC be strengthened? d) What changes are required to address workforce challenges? e) What changes are required to support timely and accurate program data? f) What administrative improvements are required to support program operations?	• Alternative mechanisms or approaches are identified that: – meet the needs of each type of family – reduce program cost – reduce cost to families – reduce demand or increase workforce supply (such as relaxation of educator requirements) – reduce waitlists – reduce unfilled places (effective allocation) • Examples of other programs (nationally or internationally) that effectively manage demand	• Previous IHC Evaluation report recommendations • Administrative data (i.e. workforce numbers, attendance records) • Publicly accessible reports (i.e. FIFO workers, industry assistance programs)	• **Desktop review** of other similar programs (in Australia and internationally) that manage demand • **Desktop review** – other sectors to overcome similar challenges (i.e. workforce supply, regulation) • **Desktop review** to identify proxy data (to inform mapping exercise/policy lever adjustments • **Data collection interviews** with relevant key stakeholders including: – Department – Directors and operational staff – Policy officers (i.e. those related to family assistance law amendments and new policy/program areas) – IHC Support Agencies, ECEC providers and services – AHCA; ICPA; FDCA; Australian Multiple Birth Association – Families • **Survey** - a survey of targeted questions for IHC provider and families

Appendix C: MCA framework

An MCA was co-designed with the Department of Education to assess, compare and prioritise future-state options. The MCA is divided into two key categories of criteria: outcomes and implementation risks (**Error! Reference source not found.**). Outcomes criteria assess the impact and alignment of each option against the principles of the *National Vision for ECEC*. Implementation risks criteria assess the challenges and barriers to implementing each option.

Outcomes	Considerations
Equity	What impact do changes have on equitable access and outcomes for families?
Affordability	What impact do changes have to affordability to families and the financial viability of IHC providers?
Accessibility	What impact do changes have to accessibility of IHC (or mainstream ECEC) for families and communities? Will changes be targeted in nature?
Quality	What impact do changes have to quality and safety of IHC? Does this impact on the programs integrity?
Sustainability	What impact do changes have on the viability of the program? Will changes make the program more viable to providers or government?

Implementation Risks	Considerations
Legislative changes	Do the proposed changes face any legislative barriers/require legislative change?
Regulatory changes	Do the proposed changes face any regulatory barriers/require regulatory change?
Fiscal changes	What are the fiscal and funding implications to government of any changes?
Operational changes	What impact will changes have, and to what degree, on the operations of government, IHCSAs and providers?
Timeline	How long will it take to implement any proposed changes?
Interdependency	How can changes be sequenced? Can we align changes with other reviews?

Appendix D: Summary of additional sector research

The challenges facing the IHC in relation to the three cohorts of families are familiar to many government programs. We have analysed how other Commonwealth funded programs address the needs of the three cohorts and described over the following pages, how each program deals with the specific challenges of providing services in rural and remote areas, outside of standard business hours and for people with complex needs.

Mechanisms to address the needs of non-standard hours families in government programs

- There are specific MBS subsidies to cater for out-of-standard hours costs. This would support covering the additional costs of providing services at these times. Furthermore, the Approved Medical Deputising Services Program is also available, where non-vocationally recognised doctors can access Medicare benefits for providing after-hours services on behalf of other doctors. After the introduction of the urgent after-hours items, in the five years between 2010-11 and 2015-16, there has been substantial growth in the number of services and benefits paid for the urgent after-hours items. Considerations should be made into whether the families accessing IHC for out-of-standard hours care actually require the ECEC support during this time, or whether the parents/carers are specifically choosing out-of-standard hours shifts over standard hours shifts. If this is the case, then the issue would be a matter of choice, and IHC may not be, for them, a program of last resort, since they can choose mainstream ECEC if they work standard hours.
- Grants are available jurisdictionally for schools to establish out-of-school hours programs. For example, in NSW, grants have been designed to allow providers to deliver affordable, flexible and quality care before and after school for every NSW primary school child who requires it. An evaluation conducted by Deloitte for NSW OSHC programs found that OSHC delivers an important ECEC service offering. More than a quarter of survey respondents indicated that they are reliant on before school, after school and vacation care simultaneously, and with one third of parents and carers accessing multiple OSHC providers to secure the level of service provision they require. Furthermore, 80% (364 of 455) of parents and carers indicated they would increase their hours of work if their OSHC requirements could be met. OSHC provides out-of-standard hours care through the school system. While OSHC is unlikely to provide evening and overnight caring, OSHC accommodates times before school (e.g. 6:30am-9:30am), after school (e.g. 2:30pm-6:30pm), which may duplicate with IHC services.
- GPs are provided Medicare Benefit Schedule (MBS) subsidies to see patients and there are subsidies for specific services that they provide. The scheme has subsidies for patients with complex needs or disability, including:
  - MBS items based on length of consultation
  - MBS items for practitioners with specific skills (e.g. obstetrics)
  - MBS items for procedures of complexity
  - MBS items for health care services (e.g. mental health & chronic disease plans).

  The MBS is a program that has continuously changing items in response to need and the healthcare environment. The Medicare Benefits Schedule was reviewed 2020, which identified that some policy changes relating the MBS have benefited consumers.

Mechanisms that address needs of complex needs families within other government programs

- NDIS participants receive individualised funding depending on their needs to obtain services themselves. The more complex the needs of an individual, the higher the needs, and the greater the funding in their NDIS package. The funding allows people with disability to access services that they would like, ensuring that they can choose services they would like and supporting greater independence over their care. The 2018 evaluation of the NDIS found that 64 per cent of all NDIS participants reported that they accessed more disability supports under the NDIS than previously. 20 per cent of participants had the same number of supports and 15 per cent had fewer supports.
- Disability Standards for Education (2005) were developed so that principals and teachers have legal obligations to ensure that every student can participate in the Australian education curriculum on the same basis as their peers. This can be achieved through making reasonable adjustments to suit each individual student's education needs. With the proposal for IHC to be included within the NQF, considerations should be made into how the ECEC program offered under IHC for children with challenging and complex needs aligns with the Standards, and whether adjustments need to be made.
- NDIS Quality and Safeguards Commission was established for quality control, and responds to concerns, complaints and reportable incidents, registers and regulates NDIS providers, monitors compliance against the NDIS Code of Conduct and NDIS Practice Standards, monitors the use of restrictive practices within the NDIS, and supports the implementation of a national NDIS Worker Screening Check. The Annual Pricing Review 2021-22 found that the introduction of the NDIS Quality and Safeguards Commission improved the quality of support flowing from its measures. While a Commission may not be the most appropriate option for IHC given the small size of the program, considerations could be made into how they regulate and monitor safety, manage complaints, and how Standards were developed.
- The Australian Curriculum is an inclusive curriculum for all students, with states and territories required to develop inclusive practices, and make reasonable adjustments to allow for the education of students with disability. Research has identified that providing educational staff with training on inclusive education and disability allowed them to be more aware of the needs of students with disabilities, and to be better-trained and better-informed in relation to disability.
- In order to provide inclusion and support educational outcomes, additional studies such as CPD and post graduate qualifications can be accessed to help build on baseline skills obtained as apart of Bachelor studies. In the IHC sector, this can be applied through additional training for inclusion for educators. Each school is also provided additional funding in the form of the Students with Disability Loading, depending on the complexity needs of the child. For IHC, this can be applied through a similar loading based on an assessment of the child's complexity.
- Students with Disability Loading is additional funding depending on complexity of need of each student provided to schools. This loading provides additional assistance to allow students with disability to access and participate in education on the same basis as other students. Funding allocation is based on the Nationally Consistent Collection of Data on School Students with Disability (NCCD). Having sufficient funding to fund students with disability in schools is essential to allow for reasonable adjustments. Proposed changes with costing have resulted in concerns that the real value of the loading may change and impact the quality provision of education, indicating the importance of providing funding to support schools.

Mechanisms to address the needs of geographically isolated families in government programs

- A remote accord for remote and very remote areas is made up of a group of employers and experts delivering aged care services in remote and very remote areas of Australia. The accord includes opportunities in designing training and education and supporting the safety of the aged care workforce. Multi-Purpose Services (MPS) were also developed that combine health and aged care services for some rural and remote communities, with some MPS services delivering care in the home. A 2019 report on the MPS program found that individuals achieved access to a mix of services in most instances through the program. The report also found that the delivery of aged care services through the MPS is a sound model. Within the limits of the terms of reference and information provided to the study, the research concluded that MPS delivered integrated health and aged care services that flexibly met the needs of individual rural and remote communities. Offering services in remote and rural communities collaboratively with other services can address service provision shortages in these areas. IHC could consider collaborating with other programs such as FDC or CBDC to consider whether there are some cohorts that can be serviced through these other programs
- Specific programs are available for GPs operating in remote and regional areas. The Rural Bulk Billing Incentive pays higher benefits to regional, rural and remote doctors to bulk bill children and people with a concession card. The Workforce Incentive Program (formerly known as General Practice Rural Incentives Program (GPRIP)) provides doctors financial incentives to practise in regional, rural and remote communities. Under the program, a policy reform of providing financial incentives to certain locations that were eligible for GPRIP increased the entry of newly-qualified GPs to newly eligible locations but had no effect on the entry and exit of other GPs. Therefore, the impact of location incentives is primarily on newly qualified GPs.
- Workforce strategies specific for remote and regional areas (2021-24 Rural and Remote Education Strategy, Aged Care Rural Locum Assistance Program) have assisted other areas in enhancing workforce capability and capacity, in turn creating channels for access. A rural locum assistance program in South East Arnhem has enabled more than 7,000 placements to be filled across rural and remote Australia since its 2011 inception.
- Loadings and incentives assist in providing NDIS services in remote areas, including
  - NDIS higher price limits (price limits 40% higher in Remote areas and 50% higher in Very Remote areas under the Modified Monash Model (MMM))
  - Travel allowances
- The Annual Pricing Review 2021-22 found that in regional, remote and very remote supports, there was some support of higher costs in these areas, but that these issues were either sufficiently addressed by the current higher price limits for remote and very remote supports; or were similar to the challenges faced by providers around the country. Therefore, higher price limits are sufficiently able to cover the higher costs of providing services in these areas. Costs for providing services in regional and remote areas are higher, which can be accommodated through higher price limits. As one of the key cohorts of the IHC program is families in remote and regional areas, a higher subsidy rate or similar initiatives could be considered to address the costs of servicing such areas and families.
- Different levels of funding based on need (NDIS package and Commonwealth Home Care Packages). NDIS Price Guide for remote communities provides additional loading of 40% for participants. 2020 changes also allowed for providers to claim other non-labour travel costs. This lead to an increase of participation by 15% in remote areas in FY23
- Support such as reduced Higher Education Loan Program debts for teachers in very remote areas, promotional campaigns, teacher education programs specifically for remote/regional areas, and incentives such as salary loading, cost of living adjustments, availability of housing, rental assistance and accelerated promotion are designed to attract and retain teachers. Research has identified that providing government incentives, financial or otherwise, can encourage appointment to rural and remote location teaching. Furthermore, promotional campaigns and programs through universities such as placements can create positive attitudinal changes, which can encourage future educators to apply for rural and remote placements after graduation.

Mechanisms to address the needs of geographically isolated families in government programs

- Remote Vocational Training Scheme offers structured distance education and supervision to doctors while they provide general medical services in a remote or isolated community. The program runs for three to four years. It offers an alternative way into Fellowship of the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine. The program has demonstrated that GP and Rural Generalist medical education and training can support the retention of doctors in rural, remote, and First Nations communities across Australia. The program also provides workforce stability for the medical practice, career progression, and continuity of care for patients in their communities. Incentive structures for career progression should be considered for IHC educators in rural and remote communities, such as providing fast-tracking for certifications, to encourage educators to work in geographically-isolated communities.
- Funding through loadings and incentives, including the Assistance for Isolated Children Scheme which is a group of payments for parents and carers of children who cannot attend a local state school due to factors such as geographical isolation have been used to tackle thin market challenges. Reviews into rural and remote education have identified the importance of providing additional loading and funding to schools in remote and regional areas. A Review of the Regional Schooling Resource Standard Loadings is being conducted, and the paper will be released assessing the current settings for the loadings. To address thin markets in rural and remote areas, additional funding is provided to support provision of services in these geographically isolated areas, where it generally costs more to offer education. Similar loadings could be considered for IHC for families in remote and regional areas.

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