COTA
For older Australians

Submission to the Community Affairs References Committee Inquiry into

The Transition of the Commonwealth Home Support Program (CHSP) to the Support at Home (SAH) Program

Prepared by

COTA Australia

February 2026

About COTA Australia

COTA Australia is the leading national peak body supporting and advocating for older Australians since 1958. COTA (Council on the Ageing) Australia promotes the rights interests and good futures of older Australians over 50.

Our broad agenda is focussed on challenging ageism, respecting diversity, and empowering people to live their best life as we age.

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Executive Summary

Currently older people can access many similar services through two separate programs – Commonwealth Home Support Program (CHSP) or Support at Home (S@H) with differing rules about what can be provided. This means that there are differential outcomes for older people based on the funding rules governing the program you end up receiving services from.

COTA Australia strongly supports an integrated, rights-based home and community care system that delivers what older people need, from low-level help through to more intensive supports, within 30 days of applying. That system must be easy to find and navigate, offer transparent and affordable pricing, and provide a true continuum of care that scales up or down as needs change.

To achieve this the Community Home Support Program and Support at Home need to be integrated, but how this is achieved matters. It shouldn't be conceived as just rolling CHSP into the Support at Home Program. Rather the creation of seamless service system is needed, utilising a range of funding approaches, set up to deliver better care and outcomes to all older Australians. The way a provider is funded should not dictate the program that services are funded through, or the way they are allocated to consumers or the outcomes for older people.

A published, participant-safe plan must outline how and when it will fix current S@H design and implementation issues as part of the move to a seamless service system. There is much funded activity in CHSP we should keep – a wide range of local, community-anchored supports such as meals, transport, social groups and centre-based respite. But CHSP also has clear shortcomings, including a postcode lottery of service availability, inequitable fees, and hidden provider-managed waitlists that leave people confused and waiting after assessment.

Support at Home commenced on 1st November and older people have been significantly disadvantaged as a result of lack of investment (not enough packages and new packages delivered at just 60% of their value), implementation problems and poor policy design particularly around the pricing regime, including delayed price caps. Self-management needs to be supported as an easy and legitimate choice with clear guidelines for how it will work.

Any further reform to care delivered in the home must ensure that older people receive more and better services as a result.

Design must avoid repeating the problems which exist in both S@H and CHSP Programs and implementation must not disadvantage any individual older person. To achieve this Government should announce a clear transition plan for a single system in the 2026 Budget. The plan should set out the participant outcomes to be achieved, the phases and readiness conditions for both Government and providers, and quarterly milestones against which

progress is publicly reported. The plan must also specify the consultations to be undertaken, publication of final design, IT build, and the issue of final rules, program settings and guidance.

Readiness conditions should include assessment and service wait times, enabling a clinician override rather than having total reliance on an automated assessment outcome and end the practice of offering only 60% interim budgets without clear protections (including maximum times on an interim package and clearer communications that declining an interim offer does not jeopardise your position for a full package). Phased approaches should consider the local area planning needed to meet demand for specific services as part of that phase.

Prices must ensure that older people can afford the services they need. This will require review and change to the current S@H pricing regime (particularly categorisation of services like showering as clinical care). Stronger price setting signals and protections such as the 1 July 2026 price caps are needed to protect older people from the unreasonable prices that have characterised the implementation of the Support at Home Program. Prices should be published and accurate. Where prices are unreasonable, the department and Commission must act. The program should allow people to use more than one provider and enable direct billing, reducing avoidable price mark-ups that is fast making care unaffordable for participants and taxpayers alike. Price caps are overdue, alongside stronger enforcement of interim consumer protections until they are introduced.

Integration should be taken as an opportunity to reset and address issues in both existing programs. And nobody should lose any services or support as a result of integrating the programs.

What we are asking the Committee to recommend:

1) **A "participant-safe" phased transition plan with readiness conditions,** published and regularly reported on, identifying the implementation and design issues in the current Support at Home program to be fixed, before integrating the two programs. The first phase of the plan must fix the current implementation and design problems with S@H implementation, as well as addresses S@H design issues.

2) **Local Area Planning to Meet Anticipated demand anticipated, by region,** so investment can match what is needed through service contracting and individualised funding. This

will improve future planning by enabling comparisons of forecasts with actual data. local area planning must also include targeted measures for low-density populations[1].

3) **Enhance transparency of availability and wait times (including for CHSP)**. Parliament mandated the wait times reporting for Support at Home and Residential Care, by local region, via s342A of the Act. Parliament must ensure this enhanced transparency is extended to CHSP services to accurately understand the current true state of CHSP services. Supports must be available within 30 days of applying.

4) **Require 'real time booking' for CHSP & S@H services.** One of the most common complaints COTA receives is that availability information is inaccurate, forcing older people and their supporters (such as assessors, care finders and care partners) to ring a number of providers to find a vacancy. This is inefficient, opaque and delays access to care. Requiring providers to publish real-time capacity and waitlist information through My Aged Care (or an equivalent system) would create transparency and enable direct booking. This would reduce administrative burden, improve system efficiency, and ensure available services are matched to clients more quickly.

5) **Price protections: implement price caps by 1 July 2026**. We recognised some concerns stated within the sector about how caps are set and applied, but the current promised consumer protections during the transition year are failing. Prices are not being published, and in some cases seem inaccurate, governed by unfair terms in confusing contracts, and weak enforcement of "unreasonable" prices. These issues need to be urgently addressed while caps are finalised. Protections during the transition year are failing.

6) **Showering/personal care classified as clinical (0% co-contribution)** to avoid preventable hospitalisations, ensure older people can remain safely at home with dignity and adopt a consistent understanding of clinical practice across health and aged care.

[1] Low-density populations (previously 'thin markets') is a more human-centred term because it describes a demographic reality (the distribution and cohort size of people who need support) rather than a shortfall in market activity. COTA supports moving beyond supply/demand language that implies a market solution is the only goal. COTA understands low density populations to include (a) geographic dispersion and (b) small cohorts within diverse priority populations (e.g. First Nations, CALD, LGBTI+ etc.) who require specialist services, including in metropolitan areas where mainstream access for their diverse population may be limited.

7) **Multiple providers by 1 July 2027** with capacity for single-service registered providers to bill direct to Government will remove current price distortions, improve associate provider rules. This move should be accompanied by a care partner duty to act in the "best interests" of the participant at all times.

8) **Blended Funding Models to Deliver the best outcome.** This will include Government-led Contracting processes (such as National Tenders, Local Commissioning, Low-Density Population Grants or Provider Supplements) can complement participant-led funding allocation and secure capacity for community/entry level supports (e.g. meals with social contact, transport, centre/day programs, cottage/centre respite).

9) **A single front door for assessment that delivers timely, simpler access** where people don't wait for basic help while assessments are complete. This single front door should include better information from primary health professionals such as GPs (who can utilise long consult MBS items to complete standardised assessment tools if they were available in GP IT systems to share their results with My Aged Care) as part of a more integrated aged care referral process, to improve quality assessment outcomes. Priority access should be given as part of timely triage calls where immediate access is needed.

10) **Standardised consumer contracts with greater enforcement against unfair terms.** Government should mandate a national, plain English contract. The template should meet readability standards and include a cooling off period; sets out key information and standard terms; allow a section for provider-specific special terms; ban guarantors and other unfair terms; and require clear disclosure/consent of all fees/charges before being charged. The Commission must run a targeted compliance/ enforcement program on contracts.

System Design Principles for a Participant Safe Transition to Support at Home

The below summarises positions COTA Australia has previously stated or endorsed, including from Discussion Paper – Aged Care Reform (NACA, Nov 2025); 17 Propositions for Support at Home (NACA, Oct 2025); A New Program for In-Home Aged Care: Discussion Paper (COTA, Nov 2022); Future reform – an integrated care at home program to support older (NACA, July 2017).

Codesign and phased transition towards a future system

COTA supports a codesigned and phased transition that protects people during change and steadily builds a better system. Government should publish a detailed, codesigned roadmap that is realistic about sequencing and dependencies, and clearly assigns accountability for actions across the Department, the assessor network and providers. A defined planning period and milestones with success measures and public reporting are necessary preconditions for integrating existing programs.

This approach must allow problems in the current S@H settings to be fixed first, and ensures each phase only proceeds when readiness conditions have been met and publicly evidenced.

A single home care system

Older people need one simple system that supports them as their needs change - a seamless Continuum of Care with support that scales up or down incrementally without new administrative hoops each time needs shift. A unified pathway removes the burden on older people and their carers to learn different processes as they move from entry level supports to higher intensity care. The program should include a mix of funding approaches so people can access low level or single service help quickly; maintain an evidence based focus on reablement and prevention; and value care partnerships (case management) as a core function (with option for it to bet independent from service delivery). The program should include a mix of funding approaches so people can access low level or single service help quickly; maintain an evidence based focus on reablement and prevention; and recognise care partnerships (case management) as a valued core function, with the option to be independent from service delivery.

People should be able to choose more than one provider, including specialist single-service providers, under one set of rules and standards

We support a service list that includes options for a small, well governed innovative services able to meet service standards. We support the approach to keep Assistive Technology/Home Modifications (ATHM) funding separate from service funding to provide equity of services for people needing technology to remain safely at home. Delivering multiple providers will fix an emerging issue where outcomes an older person may be

allocated an AT-HM package by itself, or in advance of an S@H package and is unable to find a provider under the single funds holding provider who is willing to assist them.

One National Assessment Process

We advocate one national assessment, delivered by a single, consistent and appropriately skilled workforce that is independent of service delivery and draws on an integrated multidisciplinary team. Assessors must be empowered to use professional judgement to ensure safe, proportionate outcomes. The algorithm must not replace the professional judgement of assessors. They must have the ability to manually override the assessment algorithm (as was originally promised). Currently too many reassessments are needed creating longer waitlists for older people. A proportional review approach should be adopted prevent people from having to retell their story or undergo full reassessment for minor support changes. Assessment should lead to a support plan that is codesigned and agreed with the participant, clearly documents goals and preferences, and can be updated without starting again.

Better use of GP's should be explored for data to inform entry level assessments to overcome some of the ridiculous wait times and the impacts of those on the older person. With the use of a standardised and consistent assessment tool to obtain the data the IAT requires, and an IT build between GP systems and aged care systems, GPs should be able to undertake a component of the aged care assessment, face-to-face, such as on activities of daily living. This would be of a higher quality than the current triage telephone-based assessments increasingly used to manage long assessment wait times.

Services within 30 days

Access must be timely and managed, so people receive the services they need within 30 days of application (or within published interim targets where clinically appropriate). Over time, we should move towards an uncapped community based support and care system for entry level needs, anchored in wellness and reablement, so simple help is easy to start and prevents deterioration.

An increased number of people accessing aged care, off the back of last years public discussions about aged care, contributed to delays in assessments. We note the assessment timeframes are reported to be reducing and we are awaiting the publication of s342A wait time reports, by region, by services for Support at Home and Residential Care. CHSP must be included in that more transparent public reporting. Without its inclusion individuals and decision makers will continue to be unclear about the true waiting time for CHSP related services. Future consideration of all aged care programs and an accurate waitlist is also required.

Social capital is maintained and supported

Home and community support builds social capital – the relationships, participation and trust that keep people well. The system should measure social impact, not only activity and spend, and use those insights to accelerate meaningful outcomes for participants, such as reduced loneliness, increased participation, and community connection.

To ensure valued community supports are sustained, social capital measures (e.g., volunteer participation, connectedness/participation outcomes) should inform local planning and contracting/commissioning decisions, including regional stewardship dashboards.

Older people are active 'participants' in service decision making, design and delivery

Older people are participants in their own care, not passive recipients. The system should increase choice and control, including the option of self-management as a spectrum (from making certain decisions to managing most aspects). An allocation of some kind should attach to the participant to operationalise choice, agnostic as to the form (hours, budget, or equivalent). We recognise that choice may be constrained in some regions or cohorts such as where low density populations may have limited options. The system governor must intervene with specific supports (commissioning, contracting, supplements) so equitable access is maintained. An allocation of some kind should attach to the participant to operationalise choice, regardless of the form allocated (e.g. hours, budget, or equivalent dollars). We recognise that choice may be constrained in some regions or cohorts; where low-density populations limit options, the system governor must intervene with specific supports (commissioning, contracting, supplements) so equitable access is maintained.

Recognition of low density populations (previously 'thin markets')

COTA Australia prefers the human- centred term low-density populations because it describes a population reality rather than a transactional deficit. The policy focus must be equity of access, not just program uniformity. Genuine choice means more than a provider list. It means practical availability from more than one provider accepting new participants within target timeframes.

Government should identify and respond to demonstrated low density populations (including regional and remote areas, and small diverse or disadvantaged cohorts in metropolitan settings) to maintain specialist workforces and services (including ethno-specific supports in CHSP).

A pricing and funding framework, with supplements, grants or contracting, should be used to secure coverage where mainstream market signals do not work.

Equitable participant contributions

Contributions must be affordable, fair and transparent (fully published). Price caps or reasonable price settings are needed to ensure contributions remain reasonable. Means

testing and fee settings should be consistent (linked to pension status, Commonwealth Seniors Health Card and self-funded retiree status) with consideration of socioeconomic disadvantage.

The system should include robust hardship measures and caps to ensure older people have necessary protections. This includes ensuring current protections of lifetime co-contributions caps are providing sufficient fairness and equity, including whether all co-contributions should be included in the cap calculation, including any CHSP contributions. In addition, with older people's preferences to remain at home, should a time-based cap be introduced into Support at Home, as occurs in residential care. As a principle, people may contribute more for services that traditionally sit with personal responsibility, while ageing related supports should attract lower contributions, and care services should be free.

Government has introduced a clinical vs independence distinction of care services with an unclear rationale for why some services are classified in the way they are. COTA Australia continues to advocate that personal care/showering is treated as a clinical care service and does not attract a co-contribution.

Make the system easier to navigate for older people

Navigation should be simple and human. There should be Care Finders for higher complexity situations and Integrated Consumer Supports[2] (including lower level navigation and information supports) for everyday guidance. At the lower complexity end, people should be able to find information, compare options, and connect with services outside aged care (such as advance care planning, financial and legal advice) without being bounced between programs. The same system and language should apply from first contact through to end of life, so people and families don't have to relearn process at every step.-complexity situations and Integrated Consumer Supports -complexity end, people should be able to find information, compare options, and connect with services outside aged care-of-life, so people and families don't have to relearn process at every step.

Ensure that the system is sustainable into the future

A sustainable system delivers the right services at the right time and is funded in a way that keeps prices reasonable and supports viability. Price caps should be included, with interim action against unreasonable prices while caps are finalised and bedded in. Blended funding approaches would mean there is a mix of individualised subsidy that follows the participant, enabling continuity and portability and contracted/commissioned (block funding). Funding should support small community and volunteer based services; encourage innovation; strengthen integration with the local care ecosystems (e.g. primary health, allied health,

[2] **National Aged Care Alliance**, *NACA Discussion Paper – Integrated Consumer Supports* (Canberra: National Aged Care Alliance, July 2017), https://naca.asn.au/wp-content/uploads/2017/07/NACA-Discussion-Paper-Integrated-Consumer-Supports-July-2017.pdf.

disability, hospitals); and simplify arrangements to reduce red tape so more resources reach the frontline rather than being absorbed by administration.

Improved workforce strategies

People's outcomes depend on a capable, stable workforce. Care partners (case management) should be able to operate independently of service delivery to support impartial advice and best -interests' decision making.

Direct employment models are in place with brokerage and subcontracting used as needed to improve reach and specialist support, especially across low-making. We support direct employment models and recognise that brokerage and subcontracting can be necessary elements in delivering reach and specialist support, especially across low-density populations.

Workforce policy should focus on recruitment, retention, career pathways and supervision, as well as safe workloads and training aligned to reablement.

System Governor

Government as System Governor must act as system steward, undertaking Local Area Planning each year that analyses regional demand, supply, workforce (including allied health) and participant outcomes. As part of this, Government is responsible for monitoring and publishing unmet need information, planning/procuring to ensure a mix of services are available to meet demand, and manage escalation pathways where low-density populations are impacted.

Using this demand analysis the system governor must contract/commission services to ensure equitable access across the country. Stewardship includes publishing performance, intervening where access or outcomes fall short, and using contracting/commissioning tools to secure entry level community supports and for low density populations, so the promise of timely, person centred care is met everywhere.

COTA Australia acknowledges the Government's commitment to deliver services to older people within 90 days by 30 June 2027 as part of its package of aged care reforms. This is a welcome commitment but over time needs to be reduced to ensure people receive services within 30 days. Demand analysis outlining targets to achieve the Government's commitment must be included in any transition plan to ensure that both Support at Home and CHSP pathways achieve the Government's wait time commitments.

Prevention and early access — the economic case

The Productivity Commission's (PC) five year-year review *Shifting the Dial* (2017) argued that a health system focused on prevention, integrated care and outcomes delivers bigger long run gains than many traditional reforms. -run gains than many traditional reforms. It's

supporting papers *Why a better health system matters*[3] and *Impacts of health recommendations*[4] included a health impact modelling workbook, signalling that governments should model where, when and how prevention yields savings and productivity gains.

In its final report *Delivering Quality Care More Efficiently,* the Productivity Commission recommended a National Prevention Investment Framework,[5] explicitly linking prevention to national long-term productivity, and calling for collaborative commissioning and budget rules that recognise benefits beyond the 4 year-year forward estimates. These themes were reinforced in stakeholder submissions responding to the PC's inquiry.

Early access to low intensity supports, such as those currently provide by CHSP (e.g. meals with social contact, support to remain at home as function declines, and transport to remain connected with community) is precisely the kind of upstream prevention the PC envisages. Ensuring early access to preventative services that maintains function and prevents deterioration will reduce downstream hospital use.

Recent RoGS 2026 data show longer waits (e.g. median 245 days from assessment approval to service start under Home Care Packages), increasing the risk profile for older people.

Publishing wait stages for both S@H *and CHSP* under s342A and using contracting/commissioning to secure baseload capacity is a way to operationalise the PC's prevention logic in aged care.

Positives and Negatives of CHSP and SAH

The below is a summary of the identified positives and negatives of the Commonwealth Home Support Program (CHSP) and the Support at Home (SAH) programs, as they exist under the new Aged Care Act 2024 in January 2026.

Through our engagement over the past few years, older people have consistently told us a number of things about what is important to them a single home and community care program, including:

- Being clear/transparent about cost of services, receiving value for money & ability to compare easily

[3] Productivity Commission, *Why a Better Health System Matters*, Shifting the Dial: 5-Year Productivity Review, Supporting Paper No. 4, Canberra, 2017, https://assets.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review-supporting4.pdf.

[4] Productivity Commission, *Impacts of Health Recommendations*, Shifting the Dial: 5-Year Productivity Review, Supporting Paper No. 6, Canberra, 2017, https://assets.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review-supporting6.pdf

[5] Productivity Commission, *Delivering Quality Care More Efficiently: Inquiry Report* (Canberra: Productivity Commission, 19 December 2025), https://www.pc.gov.au/inquiries-and-research/quality-care/report/

- Easy to understand what an older person will pay
- Being clear about the services the program offers
- It is easy to access the services I need, when I need them (e.g. service list is limited)
- Need for accurate and timely information about service availability and wait times
- Participating in the development of their care/support plan (and knowing it will change as their needs change)
- Having the capacity to maintain their independence / self-manage services
- Desire for locally based service providers and workers

We have also identified through these conversations a number of positives and negatives with both the CHSP and S@H programs that people have explained to us.

In addition to COTA Australia's direct engagement with older people and their lived experience of the issues[6], the COTA National Alliance has provided a number of responses as part of the development of various submissions, including through their experiences delivering the care finders program, such as their contributions to the progress of Aged Care Royal Commission recommendations implementation.[7]

"I used the site to assess my eligibility for both my partner and myself. I failed! Rang the hot line and got a very helpful person who completed the assessment for both of us and confirmed that we qualified!" (My Aged Care User)

"I have to admit that I am confused by what is meant by ""My Aged Care", originally it seems to me it was just a website and now it appears to be referred to as though it is the Aged Care System. I have sought information about the Aged Care Program, and I guess I have used the so called "My Aged Care" perhaps no more than as a portal as which it does not always work. These kinds of websites invariably end up in a circularity that leads you around in circles asserting things but often being short an actual information." (My Aged Care User)

"The Assessment should be a safe and open space for conversation rather than an interrogation or a test and a box-ticking session. The tool must allow for cultural considerations and language diversity." (COTA Tasmania)

[6] **COTA Australia**, *Submission to the Review of the Administration of My Aged Care* (submission to the Office of the Inspector-General of Aged Care, June 2024), https://www.igac.gov.au/sites/default/files/2025-11/my-aged-care-review-submission-cota-australia.pdf.

[7] **COTA Australia**, *2024 Progress Report on Implementation of Aged Care Royal Commission Recommendations* (submission to the Inspector-General of Aged Care, 23 March 2024), https://cota.org.au/submission/implementation-aged-care-royal-commission-recommendations/.

"(The) planned single comprehensive assessment tools and processes … need to incorporate greater commitment to genuine co-design, and client and carer engagement in undertaking assessment and identification of needs." (COTA Victoria)

"My Aged Care send the client a long list of service providers to call but on calling them the client is finding the service provider does not have capacity or does not offer services in the area." (COTA Tasmania)

"When looking for residential care, notice that not all aged care facilities are listed. Also, when using the "with availability" tab, it is like looking at a car dealership - they say there is one available but when you call, no there are no vacancies." (My Aged Care User)

"When I used the 'Find a Provider' tool and provided the postcode, many 'Providers' were displayed who did not provide services in the required area. The information on the My Aged Care website wasn't up to date so it resulted in a lot of timewasting and frustration." (My Aged Care User)

"There is a fundamental failure of the system (driven from within My Aged Care as the reference point) to provide comparable information between providers. There should be a simple tool (like with finance companies providing the Comparison Rate for interest on loans) to be able to compare providers on a like-for-like basis relating to their costs of service provision - whether fully managed or self-managed. I had to create a massive spreadsheet to produce results of hours-of-service provision per $ of fees, calculated from the service providers' websites and through phone calls to providers (not My Aged Care website), to be able to 'approximate' a like-for-like comparison. Even then I was in some cases not fully sure if I had genuinely comparable information if I was unsuccessful in contacting some providers by phone. Around 20% of providers did not answer their phone contact number listed on their website." (My Aged Care User)

"It is far from easy to navigate (and would be impossible for a 94 with English as a second language, like my mother) does not clearly provide all the information needed to make reliable decisions just simply doesn't meet the requirements of the very elderly." (My Aged Care User)

"The most upsetting experience is when you have gotten up early to make sure you can have the phone answered when you call (at 8am, because if you call later than that you cannot get through), and then wait 45 minutes to an hour for the officer to get on the line to you, and then she hangs up because she thinks she cannot hear you!" (My Aged Care User)

Positives	Negatives
CHSP • Local service providers	**CHSP**

• Volunteer / social connection opportunities (but volunteer patterns are changing) • Currently low participant contributions (but fee policy requirement signal this will change) • Diverse range of providers (more ethno-specific and diversity groups funded in CHSP than operate in SAH) • CHSP unit cost seems lower than S@H 2026 unit price for same service/region • More stable workforce (greater full/part time) • More integrated into regulatory framework (Now falls under the Act, covered by standards, provider registration, complaints)	• "Hidden" provider-managed waitlist = significant wait times in some areas for CHSP services • Unfair that same service in same area (sometimes by same worker) has different contribution fees • Postcode lottery - different regions have different services available (historical HACC funding approaches & min. demand management) • Some people gamed the system to get larger quantum of services • No longer can 'top up' S@H package with CHSP (as you could with HCP) while waiting for reassessment or your assessed level of care • Service funding can mean it is inflexible / does not adapt to participant needs • Participant / provider power imbalance – provider managed waitlist = dependency dynamic – results in suppressed voice / undermined choice/control • Limited incentives to improve services in current contracts
S@H • Greater alignment between needs base and funding (8 levels rather than 4) • End of Life, Restorative Care pathways • AT-HM funding is separate to services funding • Unit prices are more transparent and comparable (no admin/other charges on top) • Clinical service (free) • The design of S@H compared to the design of HCP included a reduction in co-contributions for independence services (5%) compared to 17.5% BDF in	**S@H** • Assessment timeframes have blown out leading to a double wait time for assessment, and then allocation • S@H prices are higher than HCP prices with a lack of proactive enforcement on consumer protections • Older people were asked to sign contracts with prices, in the absence of both price caps and price transparency • Providers were able to set their own prices with no effective way of measuring whether % increase was reasonable or affordable

HCP for a pensioner. (However few providers charged these fees and this has been experienced as a new fee) • Inclusion of CSHC in contribution tiers = lower contribution for part pensioners • Tied to Gov aspiration of no more than 3 months wait (need to see this achieved)	• Price caps not being introduced until July 2026 • Single package fund provider model is resulting in increased costs for single service providers (with multiple provider option delayed until July 2027) • Showering/personal care should be classified as clinical services and without co-contributions • Contributions for Self-Funded Retirees (and high income/asset part pensioners/CSHC) may push individuals to purchase services from outside regulated aged care frameworks • Service List has no 'innovation' service type such as a bundle of funds for trialling new responses to emerging issues. (e.g. in the past development of squalor and hoarding responses) • Thin markets still have limited choice and control (because not enough providers attracted to participate) • Full model not yet commenced - Price cap / national efficient price data appears will be built on bad data, risks baking in increased unit costs • Lack of/unclear consumer protections on pricing while price caps are missing • 60% interim package = people not getting what they are assessed as needing • Some services are appearing as high unit cost in current S@H (group day therapy, regional transport)

Address current Support at Home Implementation issues

To achieve a single program, a range of current issues with the Support at Home Program must first be addressed. Older people's experiences of the implementation of Support at

Home, along with the ongoing impacts of some current policy and program settings, have not been positive. These experiences include:

- **Longer-than-expected delays in assessment completion**
  - This was due to a higher than forecast number of people seeking an aged care transition leading up to the implementation of Support at Home.
  - It has compounded existing wait times for service allocation following assessment.
- **Lack of ability for clinical professionals to override the outcome of the Integrated Assessment Tool.**
  - a safeguard that was not delivered, and anticipated, in the 1 November changes.
  - This leaves older people vulnerable to automated decisions without any human intervention to ensure it's the right outcome for an individual.
- **Offers of 60% interim packages,**
  - Interim budgets are underserving people's needs that often are greater by the time they receive their services, than when they were assessed, due to long wait timers.
  - Participants are unclear about their status "in the queue" if they decline an interim package. Clearer communications are needed that they will maintain their position for a 'full' package, if they decline an 'interim package' is needed.
  - A guaranteed maximum period of time on an interim package, of 10 weeks, should be considered.
- **Higher than reasonable price increases by some aged care providers.**
  - Median prices for five common services in HCP was on average 39% higher at 1 Feb 2026 than June 2025.[8] This includes an approx. 25% shift to an all-inclusive unit pricing (i.e. incorporation of 15% package management fees, 10% of care management fees (being half of the former 20% allowance under HCP), along with a widely understood 4% increase attributable to the October 2025 wages increase of 5.2% with wages equating to around 80% of costs. Costs above these sector-wide 29% increase should be explained by individual providers.
  - While the Governments no worse off principle means the individual won't pay more co-contributions out of their own pocket, the lack of price caps and the ability of providers to set their own prices, has meant increased unit prices resulting in a reduction of services for many older people, despite the fact that their circumstances have not changed. Older people tell us they worse off overall.

[8] StewartBrown, *Support at Home Pricing and Margin Analysis (February 2026)*, 12 February 2026, available at: https://www.stewartbrown.com.au/aged-care-articles/stewartbrown-support-at-home-pricing-and-margin-analysis-february-2026

- Ensuring services remain affordable so that people don't have to forego needed services, publishing reasonable price information (including ranges, mean, average and most commonly charged by MMM geographies) is critical.
- A stronger regulatory response to unreasonable prices is needed urgently. While Government has commenced work on this more needs to be done to ensure there are effective consumer protections.

- **Not all pricing was published in a timely way**
  - Older people haven't been able to compare their providers prices against others within the 90 day period that provided guaranteed service continuity (from the time Services Australia advises them of their co-contributions).
  - As of 1 February 2026, 15.7% of outlets had no prices published at the time of scan; publication compliance needs rapid uplift.[9]
  - Older people have borne the brunt of the new prices without having adequate time for informed decision making.
  - No older person should be penalised for not signing their service agreement while waiting for this information to become available.
- **Self-management, popular with some older people, as it is with some people receiving disability services, is not well supported** or explained in the new system.
  - Providers are applying the 10% administrative charge for self-managed requests inconsistently.
  - Many are taking a conservative approach to approving such requests due to perceived risk with associated provider responsibilities.
  - The end result is that it is driving the price up for the individual (and the taxpayer) and limits flexibility for participants seeking to engage specific workers (which is available to NDIS participants).
- **Standardised contracts are needed to address confusion and misunderstandings.**
  - Older people report contracts that are excessively long (60–70 pages) and they are not able to negotiate terms, with providers adopting a "take it or leave it" approach. Some terms include inappropriate requirements for older people to have family members act as "guarantors" for their client contributions.
  - Consumer protections are not working as intended. Government should:
    a) mandate a national, plain English template with readability standards and a cooling off period;
    b) require a consistent approach that has a top sheet of key information, standard terms, and a section for provider-specific special terms.
    c) ban guarantors and other unfair terms;
    d) require clear disclosure/consent of all fees/charges before being charged;

[9] Ibid

e) direct the regulator to run a targeted compliance/enforcement program on contracts.

Address current Support at Home design issues

In addition to implementation challenges some policy decisions mean that the new program is not living up to the promise of a quality affordable support at home supporting independence. Examples of this include:

- **the delay to being able to access multiple providers to deliver services with package funding.**
  - This has resulted in participants being forced to use one provider and their subcontractors.
  - This preferred supplier approach by package fund holding providers appears to include in some cases a request for a kick back from the sub-contractor out of their fee, which is adding overhead costs into the unit price.
  - With a multiple provider approach, where people such as allied health and assistive technology providers can invoice directly to government, these inappropriate kickbacks and inflated prices can be reduced,
- **the decision to delay price caps**
  - removed checks on inappropriate price rises on day 1 of the new system,
- **requiring hardship to be a separate application process initiated by the participant,**
  - it should be automated and considered at the same time as determining the client contribution rate and
- **not including showering as a clinical service**.
  - Older people shouldn't have to "ration" the care they need, particularly personal care, such as showering, due to the co-contributions 'required.
  - With 1 in 4 older people living in poverty, 15% having less than $5,000 in savings, there needs to be a reconsideration of program affordability overall.
  - The absence of adequate hygiene support is a primary driver of acute medical crises, as evidenced by the rates of cellulitis, for example, among older Australians. [10] Cellulitis is now one of the top five most common preventable admissions for older Australians.

[10] Australian Institute of Health and Welfare. (2024). *Potentially preventable hospitalisations in Australia 2022–23*. AIHW. https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations. (Note: This report identifies the correlation between community-based support and the prevention of acute conditions like cellulitis in older cohorts).

- In addition, the risk to a person falling, increases if they have been assessed as unable to shower unaided. Falls account for 43% of all injury hospitalisations in Australia, with the home being the most common place of occurrence (44.2%).[11]
- A single complex hospital admission or a one-week delay in discharge costs the taxpayer more than an entire year of daily hygiene support. [12] By reclassifying showering as 'Clinical,' Government would be investing $120/week to avoid a $7,500/week avoidable hospital admission.

Design considerations for the future (new) Support at Home Program

Blended purchasing model

Creating an integrated program **does not** mean that all of the current CHSP service types have to be rolled into the current Support at Home individualised approach. The Royal Commission's vision that some services are better contracted by Government, particularly in relation to transport, meals, group/centre social support and cottage/centre respite has always had COTA Australia support. This does not mean it requires two separate programs, simply just two distinct contracting approaches within the one program.

A variety of contracting/commissioning approaches (such as national tenders, regional commissioning, grants to support low-density populations, volume or unit price contracts, standing panels, outcome linked contracts, regional alliances) can be adopted to create a base load capacity within the aged care system for entry level and high capital growth services.

Some CHSP services today, may be better suited to a targeted grants model, where government funding is tied to service outputs at a lower unit cost, recognising the significant capital expenses required to deliver those services. This may include meals with

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[11] Australian Institute of Health and Welfare (AIHW), *Injury in Australia: Falls* (Web Report, 25 November 2025) https://www.aihw.gov.au/reports/injury/falls

[12] The average cost of a public hospital bed is estimated at $1,075 per day (NSW Government, *Health insurers rorting public hospital beds* (Media Release/Treasury Data, September 2024).

For Australians aged 85+, the AIHW reports an average length of stay of 6.2 days for acute conditions like cellulitis. For the 75+ cohort, the average ranges from 4.8 to 5.5 days if no significant comorbidities are present. Complex presentations can result in longer stays. (AIHW, *Cost of potentially preventable hospitalisations in Australia 2023–24* (Report, November 2025) 24).

Under the Support at Home price list (effective Dec 2025), the national median for a 30-minute "Personal Care" visit (showering/dressing) is approximately $58.30 for a weekday service. (Aged Care Decisions, *Support at Home Price List: Latest Updates* (December 2025))

If a 15minute visit for showering is all that is required, the cost drops to ~$40/visit, at three visits a week ($120) totalling $6,240 per year.

social contact, transport (direct), Group/centre programs (day therapy/group social support) and cottage/centre based respite. While funding for meals (delivery only), meals (Prep), and transport (indirect – such as Uber/Taxis) may not require grant based approaches.

Program design should determine which services will provide better outcomes for older people with block funding and which with individualised approaches. When Government contracts/commissions services – it should define and measure "choice" as at least two viable providers with capacity to accept new clients within target start times in each region, with direct intervention where this is impracticable for low density populations. A publicly reported Choice KPI should be established in low-density population strategies and how commissioning/contracting responses have resulted in this threshold not being met.

Some services in CHSP are broader than a future blended program and are better suited to support the whole of aged care system. This includes such things as Sector Support and Development (SSD) and volunteer management As well as information and navigation funding to connect older people to mainstream health, disability and social participation services. This base level of support for non-complex clients is a lower intensity, wider available service than the functions of care finders and the Elder Care Support program for First Nations people.

Other CHSP funding such as that spent on Assistive Technology and Home Modifications, which currently are geographically restricted in CHSP, may be better suited to enhancing the number of AT-HM allocations within the Support at Home AT-HM streams. These CHSP services may form part of an earlier phase of integration into the future blended Support at Home program given their cleaner alignment.

Further work to determine how to maintain specialist CHSP providers who are servicing low-density populations with contracted approaches, compared to more integrated approaches for general services must be considered to ensure that diverse populations are not inappropriately forced into the mainstream service system due to a lack of appropriate specialised providers.

Blended funding approaches and greater investment are needed to remove the postcode lottery by equalising access to services.

Better integration between provider systems can enable booking services, clearer availability of services and better demand management

Currently older people complain of the lack of accurate availability information. They rightly identify the added burden and stress of making dozens of phone calls in their local area to be turned away due to a lack of accurate information about who has and has not got capacity to deliver services. Some providers manage a waitlist as they anticipate extra capacity in the near future, some have no waitlist or it is already full. These no availabilities and waitlist only queues are 'hidden' and not transparent.

The System Governor, not individual providers, must allocate to older people the funded places that Government purchases in order to address the numerous issues that older people experience with the current hidden CHSP provider managed waitlists.

Addressing the ability for an individual to 'book' their service utilising My Aged Care talking to provider IT infrastructure will begin to address the number one pain point reported by participants navigating aged care – a lack of accurate real-time availability of services – while also supporting choice, self-management and transparency.

Implementing Multiple Providers in Support at Home

Implementing the Government's commitment to permit 'multiple providers' no later than 1 July 2027, would:

- better integrate the system (as it was originally designed, but not yet fully implemented),
- allow older people to maintain their current CHSP worker if stepping up to a Support at Home classification,
- remove a driver of unit price increases (inflated prices to manage subcontractors),
- increase the empowerment of participants and improve an older person's choice of who to invite into their home,
- begin to curtail reports of mandatory financial kickbacks from sub-contracted providers (in order to receive referrals from funds-holding-providers),
- reduce the sometimes onerous associated providers requirements faced by sub-contracted providers (resulting in some exiting from aged care), due to inconsistently imposed obligations by different aged care providers,
- improve the pathway for participants to select their preferred worker/provider (in the face of increasing reports of requests being denied by funds holding providers,
- improve the technology that supports care plans (along with the ability to 'book' the provider) so that an older person, and their care partner (or assessor), would have the ability to allocate funds or occasions of service to a registered provider of their choice. (If this isn't possible within the time frame, manual processes could be utilised while IT processes are built).

Care partners must work in the 'best interest of' the participant. They can be embedded in a single provider who delivers care management and service delivery or could in the future be separate from specialist service providers who only deliver one or more service types.

These blended approaches to funding the provider can then be converted into participant allocations, either by converting the contract into a unit price, or allocating the participant a number of occasions of service (hours, trips, meals, visits etc).

A clear transition plan

A clear transition plan committing to the Government's agreed end state should be announced in the upcoming Budget. The transition plan should:

1) State the clear consumer outcome/s Government is committed to delivering as part of each phase,
2) Identify measurable readiness conditions for both providers and government required to deliver each phase. These readiness conditions should be regularly reported on publicly. Some of the readiness conditions may include policy and implementation issues we have outlined above,
3) Include clear timeframes for consultations, publishing of final design, IT build requirements completed, final rules and program guidelines being published and other implementation elements, and
4) At a minimum, identify quarterly milestones and six-monthly phases that maintain focus on Government progress to achieving its consumer outcomes that have been committed to.